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SOCIAL PROTECTION AND ACCESS TO HEALTH SERVICES

IN

**ETHIOPIA, MOZAMBIQUE, TANZANIA AND
ZIMBABWE**

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LIST OF ACRONYMS

ACS - Community Health Activist (Agente Comunitário de Saúde) (Mozambique)
AMTO - Assistance Medical Treatment Order (Zimbabwe)
ARV - Anti-retroviral drugs
APEs - Health Extension Workers (Agentes Polivalentes Elementares) (Mozambique)
BEAM - Basic Education Assistance Model (Zimbabwe)
BHOPA - Better health for older people programme Africa (HelpAge International)
B/MOLSA - Bureau/Ministry of Labour and Social Affairs, Ethiopia
CBO - Community Based Organisation
CCC - Community Care Coalition (Ethiopia)
CCDS - Centre for Community Development Solutions (Zimbabwe)
CBHI - Community-based Health Insurance (Ethiopia)
CCT - Conditional Cash Transfer
CT - Cash Transfer
CHE - catastrophic health expenditure
CHF - Community health fund (Tanzania)
CHEW - Community Health Extension Workers
DALY - Disability Adjusted Life Year
DFID UK Department for International Development
DHS - Demographic and Health Survey
EEPNA - Ethiopian Elderly and Pensioners National Association
ENSSB - National Strategy for Basic Social Protection (Mozambique)
FGD Focus Group Discussion
GDP - Gross Domestic Product
HEW - Health extension worker
H/H - Household
HSCT - Harmonised Social Cash Transfer
HSDP IV - Health Service Development Plan (Ethiopia)
INAS - National Institute for Social Action (Instituto Nacional da Acção Social) (Mozambique)
KII - Key Informant Interview
LLID - Limiting longstanding illness or disability
MoH - Ministry of Health (Ethiopia)
MISAU - Ministry of Health (Ministério da Saúde) (Mozambique)
MPSLSW - Ministry of Public Service, Labour and Social Welfare (Zimbabwe)
MTS - Meticals (Mozambique currency)
NAP - National Action Plan
NCD Non-Communicable Disease
NGO - Non-Government Organisation

OOP - Out of pocket
OP - older people/persons
OVC - Orphan and Vulnerable Children
PES - Social and Economic Plan (Plano Económico e Social) (Mozambique)
PSNP - Productive Safety Net Programme (Ethiopia)
PSSB - Basic Social Subsidy Programme (Programa de Subsídio Social Básico) (Mozambique)
PSSN - Productive Social Safety Nets (Tanzania)
PASD - Programme for Direct Social Action (Programa de Apoio Social Directo) (Mozambique)
SCTPP - Social Cash Transfer Pilot Programme (Ethiopia)
SDSMAS - District Services for Health, Women and Social Action (Mozambique)
SHI - Social health insurance (Ethiopia)
TB - Tuberculosis
TSAF - Tanzania Social Action Fund
TZS - Tanzanian Shilling
UN OCHA - United Nations Office for the Coordination of Humanitarian Affairs
USD - United States Dollar
WASH - Water, Sanitation and Hygiene
WHO - World Health Organisation
ZOPA - Zimbabwe Older People's Association



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EXECUTIVE SUMMARY

Introduction

This research was conducted by Development Action and commissioned by Help Age International to investigate the impact of cash transfers on older people's access to health care in Ethiopia, Mozambique, Tanzania and Zimbabwe. It was part of HelpAge Better Health for Older People regional programme, funded by Age International and DFID. The research considers the following six research questions:

1. What is the health status of older men and women in the target countries?
2. What are older people's recognised social protection entitlements and what evidence is there of older people's actual access to cash transfers?
3. What are older people's health service entitlements and what evidence is there of older people's actual access to health services?
4. What are the direct and indirect costs of accessing health services for older people? What are the barriers to accessing health services?
5. How do older men and women pay for the costs of accessing health services?
6. What is the impact of cash transfer on improving access to health services for older people?

Methodology

The overarching design was a mixed methods approach largely qualitative but complemented by quantitative approaches. The study had five phases: 1. desk-based review of data and literature, including a context analysis for each country; 2. qualitative data collection using focus group discussions, key informant interviews, and in-depth interviews/case studies; 3. small-scale quantitative survey in Mozambique.; 4. Analysis; 5. Report writing. While the results of the different components were triangulated to increase their validity, the numbers of people covered in total are too few to generalise at national level. The results therefore need to be read with a degree of caution. In addition, while we attempted to reduce risks of bias in the sampling of participants it was not possible to select participants randomly, it is therefore likely that the respondents to the survey were under-representative of older people with chronic impairments, such as, for example, dementia.

Main findings

Country Overviews

The country-level literature review found limited data and research available on both older people's health status and their access to social protection and health services. Nevertheless, the evidence that does exist illustrates that the target countries have similar age profiles and health trends. All these countries are at the beginning of the epidemiological transition, where the majority of both mortality and morbidity is still caused by communicable disease but where the prevalence of NCDs is increasing.

Policy information on social protection and health care entitlements was found in all countries, though implementation appeared patchy. Where cash transfers for older people were discussed in the literature, they were reported to have limited coverage with a low level of benefit. There were limited data on older people's access to and use of cash transfers, as well as to older people's access to health services. Where research was identified, it highlighted numerous barriers that

older people face in accessing adequate health services, with service inadequacy, financial constraints and distance to health facilities cited as the leading issues.

Virtually no country-level evidence on the impact of cash transfers on older people's access to health care was found in the literature, highlighting the importance of the present research. There were some reports, based on qualitative data, of the positive effect of cash transfers on accessing health services in evaluations of cash transfer schemes in Ethiopia, Mozambique and Tanzania where money from the cash transfer was said to be spent on health care-related costs and some evidence of the positive impact of cash transfers on health, irrespective of access to services. However, quantitative analysis of associations between cash transfers and measured health effects does not exist.

Key informant interviews and focus group discussions

Key informant interviews (KIIs) and focus group discussions (FGDs) identified a range of formal and informal social protection mechanisms, including cash transfers, available to older people. However, in line with the literature review, these were found to be limited in both level and coverage.

Despite the identification of policies for older people to receive free health care in some countries, implementation of these policies appears mixed and numerous barriers to accessing services were identified, including, cost, transport, physical access; demand-side issues, such as the prioritisation of household resources; and supply-side challenges, including a lack of medicines, staff shortages, inadequate facilities and the lack of geriatric knowledge among health professionals.

Some evidence was found of the potential impact of cash transfers on older people's access to health services and on older people's health status, independent of their ability to access care. Various pathways in which cash transfers were used to access health care were identified, including:

- Meeting the costs of transport to hospitals or health facilities;
- Supplementing the costs of medicines or costs of consultation and treatment;
- Enabling the older persons to support grandchildren's access to health services, including by purchasing community health insurance cards for grandchildren;
- Improving older people's ability to borrow money which could then be spent on healthcare related costs;
- Increasing older people's ability to invest in income generating activities which generated money which could be used to pay for health-related costs; and
- Strengthening older people's resilience and improving their confidence in their ability to meet healthcare related costs.

Evidence was also found of the positive effect of cash transfers on older people's health status, largely as a result of improved access to food/nutrition, hygiene and sanitation.

However, the study also demonstrates that the capacity of cash transfers to have significant impacts on the health status of older people will remain very limited unless substantial improvements are made to the suitability, quality and accessibility of health services in these countries. This includes a focus on the health awareness of older people, as this is a key determinant of health-seeking behaviour. It calls for a combination of demand and supply-side interventions: cash transfers should not be viewed as a stand-alone intervention.

Quantitative survey in Mozambique

The data collected in the sample survey Mozambique found that the ability of a household's consolidated income to meet healthcare costs and personal needs increased by at least 30% when the household member received a cash transfer. However, food expenditure was the most important costs reported by survey respondents and took precedence over healthcare and other expenditures. Older people who self-reported chronic conditions claimed to allocate larger amounts of the transfer to health services. A regression analysis (detailed in the main body of the report) found a significant association between income and health service utilization for older women, but not for older men.

Aside from specific cash transfer effects, the most important factor in relation to access to health care across the board appeared to be the perceived quality of the care – including the perceived level of skill of health-workers and the availability of medications. This supports the view that cash transfers will have limited effects on the health of older people, unless accompanied by enhanced service provision.

Discussion

The data from both the qualitative and quantitative research show some potential positive impacts of cash transfers on access to health services. Variables which appeared to affect the impact of the cash transfer include: gender; household income and spending prioritisation; health status; perceived quality of health services; country and health system context; and the operation of the cash transfer, including level, coverage, and conditionality or modality of payment.

Despite some positive experiences, the data show cash transfers have a limited impact on access to health services. This appears to be due to a number of issues, including the low level and low coverage of the cash transfer, and more general demand-side and supply-side barriers to accessing healthcare.

However, the qualitative data suggests that cash transfers have the potential to improve the health status of older men and women, regardless of access to health services, by increasing their access to food and improved nutrition, hygiene and sanitation.

The findings add to the very limited country-level research on the impact of cash transfers on access to health services for older people in Ethiopia, Mozambique, Tanzania and Zimbabwe. The findings also add to the international literature on links between cash transfers, social protection programmes and access to health services. They provide evidence of some potential effects and the pathways through which these occur. However, the key take-home message is that the most cost-effective strategy to enhance the health of older people in these countries must also focus on the adequacy of primary health care for people in later life.

Conclusion

Across all the four countries, there was evidence of the potential impacts of cash transfers in facilitating older people's access to health services and upon the health status of older people, regardless of access to health services. There was evidence that the amount and mode of distribution of cash transfers may have an impact on older person's ability to access health services.

However, the impact of the cash transfer was found to be limited and evidence illustrates that significant barriers to access to health services remain, including: service adequacy, high costs of transport and medicines, the high burden on the cash transfer due to other basic needs such as food and school requirements for the children under older persons' care, and generally poor quality of care at the available health facilities. It was also noted that in some situations where older

persons may feel that their health access should be a priority, the decision is not in their power to make. This appeared to be the case especially for the very old and frail, whose problems are perceived (sometimes wrongly) to be chronic/incurable. The study also shows that there is a dearth of suitable health services available for older people and highlights significant issues over the perceived quality of the services which do exist. Older people's perception of the quality of services appeared to be a key issue in their decision to seek health services.

Cash transfers and their impact on health care for older persons should not be seen in isolation. They affect and are affected by structural (policy, socio-economic and socio-cultural) as well as individual dynamics, such as the agency (abilities, skills, networks, age, education and gender) of an individual. The critical building blocks of the health care system, such as sufficient skilled staff, an adequate stock of medicines and other health supplies, appropriate health infrastructure and equipment, combine with other contextual factors to affect the overall effect of cash transfers on access to health services for older persons.

Policy recommendations

Our overarching policy recommendation, grounded in our research findings, is that enhancing the health status of older people must be a multi-sectoral endeavour. Improved health services will only enhance the health of older people if financial barriers are manageable. Equally, extending cash transfer coverage will only generate limited impacts, without good health services. Consequently, we recommend a combined strategy, which gives equal priority to both areas of intervention.

1. Improve coverage and adequacy of cash transfers

This study provides evidence of the positive impact of cash transfers on access to health services, but this impact is limited by the facts that health services are generally inadequate, cash transfer schemes have limited coverage and benefit levels are low.

- 1.1 Expand older people's access to cash transfers, preferably through the introduction of adequate social pensions.
 - **Ethiopia:** Prioritise scaling up cash transfers to older people via the direct support component of the Productive Safety Net Programme (PSNP) while working towards implementation of a non-contributory pension, in line with the Social Protection Strategy for Ethiopia published in 2016.
 - **Mozambique:** Increase coverage of the PSSB to 62 per cent of eligible older people by 2024, in line with the strategy ambitions of ENSSB II.
 - **Tanzania:** Introduce a universal social pension for all older people aged 60 years and over, building on from the successful experience of the scheme in Zanzibar.¹
 - **Zimbabwe:** Commit government funding for an adequate cash transfer programme for all vulnerable older people.

¹ In April 2016, Zanzibar became the first country in East Africa to introduce a social pension for all people over the age of 70

- 1.2 Improve the adequacy of cash transfers to a level that allows recipients to meet their basic needs, and supports access to healthcare services. The levels should be reviewed regularly and adjusted to reflect price inflation and inter-generational transfers that could affect how money in a household is spent.

2. Ensure health entitlements and service delivery include older people

Cash transfers cannot compensate for major weaknesses in health systems that are often the main barriers for the full realisation of older people's entitlements to access quality and affordable health service delivery. Specific recommendations for improvements are:

- 2.1 Ensure entitlements to free healthcare are implemented (where they exist). This requires sufficient infrastructure, staff and medicines, but can also be supported by awareness raising programmes (for older people and health professionals) and monitoring and holding service providers to account for those policy provisions.
 - **Mozambique:** Ensure that health professionals respect older people's existing health service entitlements – including access to free health services and priority care.
 - **2.1.2 Tanzania:** Establish a legal framework that guarantees sustainable provision of free health services to older people by enacting the National Ageing Policy 2013 and ensuring the Health Service Act and the National Universal Health Coverage Strategy (currently at draft stage) include health and care entitlements for older people.
 - **Zimbabwe:** Revive older people's health service entitlements, including access to free health services through the Assistance Medical Treatment Order programme.
 -
- 2.2 Introduce entitlements to free healthcare where they currently do not exist:
 - **Ethiopia:** Introduce specific entitlements for older people's access to health services alongside the development of those that exist for poorer people, in line with the National Action Plan of the Elderly and the National Action Plan of Persons with Disabilities.²
- 2.3 Integrate the health needs of older people more comprehensively into health strategies and programmes, including:
 - Ensuring outreach and prevention services address older people's needs specifically.
 - Ensuring availability of relevant treatment (including medicine) for age-related conditions, especially NCDs.
 - Incorporating older people's health needs into training of existing and new health staff

² GoE (2016)

- Mainstream ageing issues into health service policy.

3. Promote links between cash transfer programmes and other social protection and health promotion initiatives

Cash transfer programmes were found to be effective in encouraging the adoption of healthy behaviour and increased use of health services in some cases when accompanied by health promotion activities.

- 3.1 Strengthen awareness of cash transfer programmes as a means of supporting health awareness and healthy behaviours in conjunction with health promotion activities.
- 3.2 Coordinate cash transfer with other social protection programmes to optimise capacity and generate synergies. Examples include the bundling of cash transfer delivery with outreach health services: an approach currently being piloted in rural South Africa.

4. Ensure age-disaggregated data and evidence on older age, social protection and health at all ages is available

The study helped to highlight that the evidence base on older age, and specifically social protection and health status and health needs, is very limited. Some specific suggestions to improve this include:

- 4.1 Improve national statistical systems to build a clearer picture of the situation of older people, and their health needs, including:
 - Expanding Demographic and Health Surveys to include questions relating to people above the age of 49 – the current cut-off point in most countries.
 - Presenting age-disaggregated data in regular national surveys (such as household surveys and Labour Force Surveys).
- 4.2 Integrate the collection of age-disaggregated data into the implementation of cash transfer programmes.

1. INTRODUCTION

Project overview

This research was commissioned by HelpAge International to investigate the impact of cash transfers on older people's access to healthcare in four countries: Ethiopia, Mozambique, Tanzania and Zimbabwe. The research was an integral component of the Better Health for Older People Programme promoted by HelpAge International (HAI) Africa region in collaboration with Age International and the UK Department for International Development (DFID). This programme aims to improve the health and well-being of older women and men by building the capacity of health services and promoting social protection programmes for older people; strengthening older people's capacity to access social protection and healthcare; and increasing both the demand and accountability for these services. Considering the WHO definition of health needs in older age, which goes beyond diseases and focuses on how these and the environment impact on the ability of the person to function, the programme is addressing holistically two important elements of older people's lives: the provision of and access to relevant health services and social protection mechanisms, especially cash transfers. This research project reviews the evidence of how social protection, and especially cash transfers, increase access to health services and impact on older people's health status, focusing on the four target countries where the project is operating.

Key findings from the literature

Several recent global reviews have assessed the effect of cash transfers on health service access and their impact on the health outcomes of their recipients in low and middle-income country contexts. These reviews have analysed an extensive sample of rigorous studies on the effects of both conditional and non-conditional cash transfer programmes in Latin America, Africa and Asia.¹ The outcomes of these reviews point to a moderately positive impact of cash transfers on health and, more specifically, they provide evidence of an increase in the use of health services, greater dietary diversity and improvements in biometric measures, with an increase in the uptake of health services being the strongest result. These studies find that access to regular cash transfers can strengthen people's ability to pay for the direct and indirect costs of health services, especially amongst the poorest sectors of society. For example, a recent review of the Uganda cash transfer programme (SAGE) which includes a direct transfer to older people, identified that this group uses the cash transfer for the payment of medications and in some cases, also for facilitating access to private health care services.²

Nevertheless, the evidence suggests that any improvement in the health status of cash transfer recipients seems to be more strongly and directly correlated with better diet and nutrition than with the increase in access to health services. This appears to be related to two key factors: the prioritisation by poor households of food expenditure over health care access and the limited availability, and quality, of health service provision in many low-income contexts.³

In addition to improved food security, cash transfers have been found to have a positive impact on access to sanitation and better hygiene for recipients, resulting in better health outcomes, especially for children.⁴

Although many researchers have provided evidence that cash transfers have been used for costs related to accessing health services and to reduce the shock of catastrophic health expenditure, there is an increasing understanding of other important factors that influence the health-seeking behaviour of individuals and households. There is growing evidence of the importance of the knowledge people need to have of health conditions to know when and how to seek medical advice and access diagnostic services and treatment.⁵ For example, older people's awareness of conditions such as hypertension, diabetes, depression or dementia is often limited, reducing their disposition to seek appropriate forms of health service.

The critical role played by health awareness in increasing health service demand is seen in programmes that provide health promotion activities to complement cash transfer programmes and in conditional cash transfers that require recipients to attend health services and/or access health information.⁶

Alongside health awareness and knowledge, the social capital and the empowerment of individuals are other key elements that affect people's health-seeking behaviour. For example, a recent study in Ghana identified a strong correlation between social inclusion and enrolment in social protection programmes for older people.⁷ The ability to mobilise family or community support to access health services is particularly critical for vulnerable groups including, potentially, children, older people, people with disabilities and women. There is significant evidence that cash transfers can support the expansion of social networks and increase the self-esteem of recipients as was, for example, identified in a recent study of cash transfers in Uganda.⁸

The core characteristics of the cash transfer programmes can also have an impact on the health outcomes of recipients. These include the amount of the transfer, the timing of payments, their regularity and their modality, or the way they are paid. The level of the cash transfer and the length of the exposure to the programme were found to be particularly significant in many studies.⁹ With specific reference to cash transfers for older people, little attention has been paid to building health objectives into delivery modalities more directly by offering services at the point of pension delivery.

The literature on the relationship between cash transfer and health outcomes tends to focus more on health outcomes for children than on other groups, including older people. However, studies focusing on older people have identified that poverty, perception of quality of services and chronic health conditions are particularly significant factors in determining older people's health-seeking behaviour.¹⁰¹¹ Evidence is also emerging that older people use health services less than younger generations because of a complex set of supply and demand side factors. From the supply side these factors include: age discrimination; unfriendly services; lack of adequate services; non-accessible services (distance); and direct and indirect costs of the services. From the demand side, health awareness, prioritization of health needs within the household, and especially, lack of financial resources have been found to play a significant role.¹²¹³

Conceptual framework

The conceptual framework adopted considers how the pathway to access to health service is affected by both the supply and the demand sides of health care. It shows how cash transfers can potentially play positive direct and indirect roles on the demand side and how this can in turn potentially benefit older people's health outcomes and well-being.

The supply side of health services is analysed through five dimensions which define the relationship between the health service and its users. These are

the availability, accessibility, affordability, adequacy and acceptability of the health services.¹⁴ These dimensions are interdependent and are defined in the following way:

Availability reflects the relationship between the health needs and the physical availability of the health services. It refers to the physical availability of physicians, health staff and programmes; primary, secondary and emergency health care infrastructures.

Accessibility refers to the distance between the health service's and the user's locations. It focuses on how far the health service user needs to go to access the services and the modes of transport available.

Affordability focuses on the direct and indirect costs of accessing health services and the ability of health service users to afford the services offered. These include the direct costs of consultations, diagnostic services and medications but also the indirect cost for users and carers such as transport, living costs during the use of the services, and paying for others to cover work needs.

Adequacy captures whether the health services meet the health needs of the users. It focuses on the relevance and quality of the services provided for users including what services are provided and how they are provided.

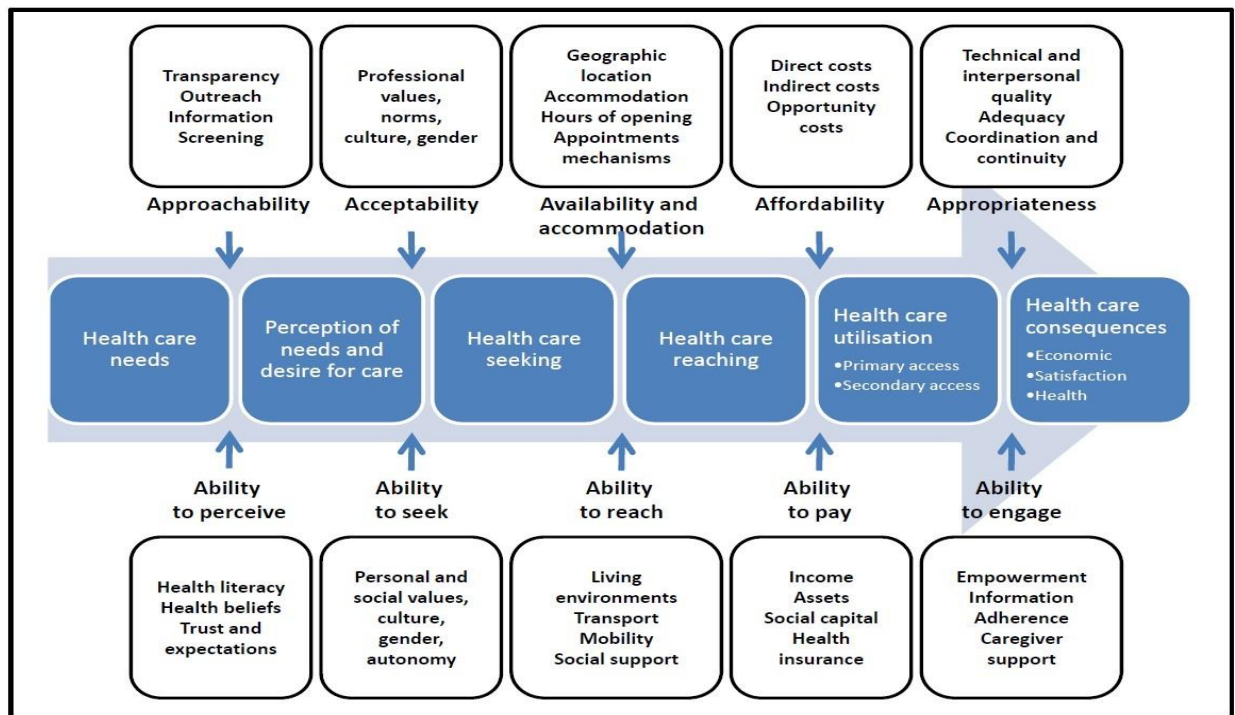
Acceptability defines the relationship between the users' expectations of the health service and what is actually delivered. It concerns how acceptable the health services and the way they are provided are to the users.

The five dimensions of access to health services from the perspective of the supply side have a direct influence on people's pathways for addressing ill health. The pathway people typically follow includes: the emergence of health care needs; the recognition of the need and the desire for health care; the seeking of health care services; the reaching of the services; the utilisation of the services; the adequacy of the services; and the outcomes on the individual's health status and well-being.

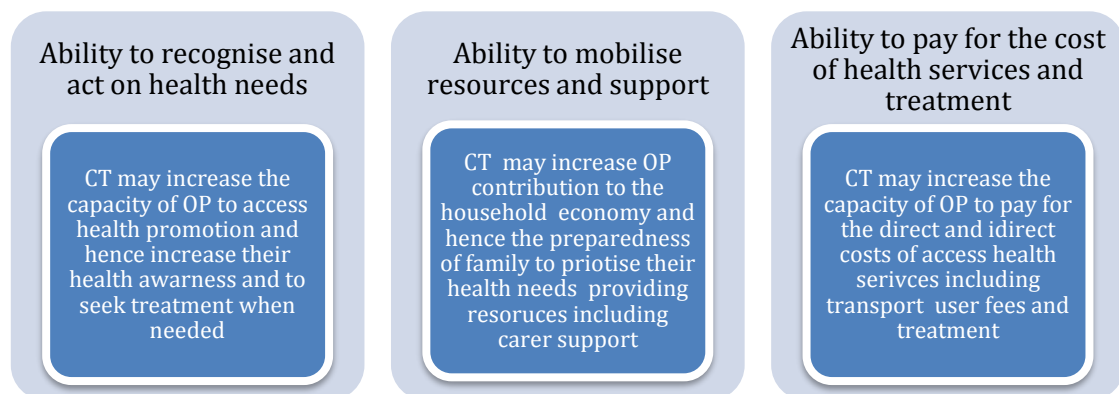
The analytical framework in the table below illustrates how the supply side effects individual pathways to improved health. It also shows how this interacts with the demand side, in terms of the ability of the users to access the health services.¹⁵ These aspects or capabilities are central to the analysis of the impact of cash transfers on older people's health and more specifically on their access to the services.



Photo: Development Action (CamillaWilliamson) Mozambique



Similarly, in analysing the demand side and the impact cash transfers can have upon it, this policy report considers the three following pathways: ability to recognise and act on health needs; ability to mobilise resources and support; and, ability to pay for the cost of health services and follow up treatment.



In addition to these three pathways for accessing health services, the analysis considers a fourth pathway related to how cash transfers can be used by older people to improve directly their health outcomes and well-being. This includes strengthening the ability to pay for more/better food and nutrition, sanitation, soap, clothing, heating, and other basic needs. This is a form of health promotion which stops older people from getting ill in the first place. It also includes the capacity of cash transfers to improve the resilience and mental health of older people by, for example, reducing the stress of financial insecurity or by increasing their ability to participate in the life of their families and communities and thus improve their social inclusion. Cash transfers can also be used by frail older people to pay for a person, for example, a neighbour, to care for them at home or to look after the grandchildren in their care. These different uses of cash transfers, although not directly related to an increase in the access to health care services, are

important as they can have a direct impact on older people's health outcomes and well-being.

As part of a balanced research design, it is necessary to go beyond assessing the extent to which cash transfers may enhance health and the factors that determine this effect. It is also possible that cash transfers may be harmful to the health of older people and family members. This can, in theory, occur through two potential pathways.

First, cash transfer income may be spent on unhealthy forms of consumption, such as tobacco, alcohol and unhealthy food items. For example there is evidence in Latin America of an association between cash transfer receipt and obesity.¹⁶ There is evidence in the literature¹⁷ that countries in sub-Saharan Africa are experiencing a rapid nutritional transition, leading to a growing prevalence of obesity, high salt and sugar consumption, and increased market penetration by tobacco and alcohol producers. In both the qualitative and quantitative surveys, there is potential response bias, whereby informants under-report spending on items like alcohol and tobacco. These concerns should be offset against the substantial evidence that many parts of the study countries are highly food-insecure environments, and that older people may be discriminated against in the allocation of food within households. To some extent, the risk that recipients may spend the cash transfer on unhealthy consumption can be reduced through targeted health promotion interventions, raising awareness of the harmful health effects of such consumption.

Second, cash transfers might potentially expose older people to violence from household or community members, who make attempts to forcibly obtain the transfer income for their own use. This issue has not been widely studied in low or middle-income countries, but has been shown to be prevalent in high income countries. There is evidence that cash transfers for mothers have sometimes provoked domestic violence. Respondents in this study did not refer to this issue, but the study design did not include specific elements to capture such behaviours (such as full privacy and reassurances for participants). As such, it is not possible to comment on the prevalence of this problem, and it would be useful to conduct more specific research in this area. There is scope to include protective interventions with cash transfer delivery, including training for pension providers to identify signs of potential abuse, as well as the provision of advice and counselling, helplines and information.

Both these potential pathways between cash transfers and harmful health outcomes should not be neglected, regardless of the lack of evidence for such effects in our study. That said, both are amenable to policies that link pension delivery to health awareness.

The level of the transfer and, more broadly, the different elements of the design and implementation of cash transfers programmes, are significant factors in determining their ability to increase older people's access to health services and, more directly, older people's ability to improve their health and well-being. The research considers the impact that the amount, coverage, targeting, conditionality, modality of access, duration and predictability of the cash transfers have upon this.¹⁸ It also considers older people's ability to decide how to prioritise the allocation of cash transfers within the context of the household's expenditure and, more generally, older men and women's access to, and control of, the cash transfer.

Key research questions

The key research questions the study addresses are:

1. What is the health status of older men and women in the target countries?

In addressing this question, the study draws on, and analyses, available evidence, both self-reported and diagnosed, on older people's health status, including impairments.

2. What are older people's recognised social protection entitlements (including their coverage and value) and what evidence is there of older people's actual access to cash transfer?

In addressing this question, the study maps all form of cash transfers to older men and women through government, private pensions/insurance and non-government organisations and examines the extent to which older people obtain their entitlements – exploring barriers and potential methods for overcoming such barriers.

3. What are older people's health service entitlements and what evidence is there of older people's actual access to health services?

In addressing this question, the study explores the extent to which goals of providing universal free access to health services are being achieved as well older people's access to specific age-related entitlements.

4. What are the direct and indirect costs of accessing health services for older people? What are the barriers to accessing health services?

In addressing this question, the study examines the cost of: transport; additional food and accommodation; communications; medication; diagnostic examinations and tests; out and in patient services; related care; and loss of work. It also examines the role of family and community in facilitating access and the extent to which older people's access is affected by their capacity to draw on social capital.

5. How do older men and women pay for the costs of accessing health services?

In addressing this question, the study documents how older people access a diverse range of resources to pay for health services including: savings; loans; household support; family support; neighbour/community support; cash transfers; and health insurance.

6. What is the impact of cash transfers on improving access to health services for older people?

In addressing this question, the study examines the evidence which exists on not only how cash transfers are used to directly pay for costs related to accessing health services but also how they are used to mobilise family or community support and/or wider resources. The question also addresses how the modality in which cash transfers are accessed have a direct or indirect impact on health-seeking behaviour, including in raising awareness of health needs.

2. METHODOLOGY

The overarching design was a mixed methods approach that was largely qualitative but completed by quantitative approaches. The study had five phases: desk review, including a context analysis for each country; qualitative data collection using focus groups discussions (FGDs), key informant interviews and in-depth interviews/case studies; a small scale quantitative survey; data analysis; identification and validation of key findings; and the report write-up.

Desk based research

The study commenced with a review of evidence on the impact of cash transfers on health outcomes and, more specifically, on the impact of cash transfers on access to healthcare with a focus on Ethiopia, Mozambique, Tanzania and Zimbabwe, as well as regional and international studies produced in the last five years. Based on the literature review, an initial draft report was written to provide a brief description of the main research publications, programme evaluations and government policies and programmes of relevance to the understanding of the relationship between social protection and access to health services. A summary of the key findings from this review was provided for each of the four target countries. In addition, the literature review was used to refine the study questions and to inform the design of the key study tools – the questionnaire, interview schedules and focus group discussion guides.

Context analysis of each country

To obtain a comprehensive understanding the social protection and health situation for older people in each of the four target countries.

The context analysis focused on:

- Identifying the main health needs of old (60-74) to very old (75 and above) women and men including identifying the three most common diseases;
- Mapping social protection programmes and how they benefit disadvantaged older people, including cash transfers and health insurance schemes;
- Assessing how older people and their households use formal and informal sources to pay for the costs of accessing health services including the extent to which they use cash transfers; and
- Identifying key variances and variables affecting the use of health services, including ability to pay, to inform the qualitative and quantitative analysis.

Qualitative data collection and analysis

The qualitative data were collected through FGDs and in-depth interviews with older people and key informants. FGDs involved the participation of 8-10 older people, where possible of the same gender, and representatives of the general older population. In one location in Mozambique it proved impossible to organise separate FGDs with men and women. However, in this case, responses to questions were sequenced to enable differentiation.

Working with the HelpAge country offices, the Development Action team conducted on average four FGDs in each of the four countries. The criteria used to select the areas for the FGDs included whether or not there were

older people receiving cash transfers and whether there were HelpAge project partners not involved in the delivery of cash transfers who were able to identify FGDs participants. The areas where the FGDs were conducted were also areas where the BHOPA programme was operating. The selection of FGD participants aimed to achieve a representation of the older population with a focus on gender; living in rural/urban settings; socio-economic status; and, old and very old groups, including, as far as possible, a representation of frail older people. As the research focus was the relationship between cash transfers and access to health services an additional criterion for selecting participants of FGDs and in depth interviews was to have a significant representation of older people receiving cash transfers. This means that older people receiving cash transfers were over represented in the FGDs compared to the general population.

Table 1: Focus Group Discussions in target countries

Country	Focus group locations	Rural or urban	Male	Female	Totals
Ethiopia	Bahrtseba, Tigray ()	Rural	1	1	2
	Addis Ababa	Urban	1		1
Mozambique	Maputo	Urban	1	1	2
	Manhica	Rural	1	1	2
Tanzania	Mbarali	Rural	1	1	2
	Umbaruku	Urban	1	1	2
Zimbabwe	Goromonzi	Rural	1	1	2
	Svishavane	Urban	1	1	2

With each of the FGDs, participatory tools were used to encourage active engagement from participants including: ranking /scoring; before/after vulnerability; coping mapping and gender analysis. Guidelines for the setting up, running and recording of the FGDs were developed to ensure consistency across the four countries and standardised templates for note-taking and write-up were agreed. The focus was on ensuring that the direct voices and experiences of the participants were recorded and the commonalities and disparities of views expressed identified.

The results of the FGDs were validated and expanded through semi-structured, in-depth interviews with selected FGD participants to develop case studies.

Qualitative data analysis using the agreed conceptual framework explored how older men and women and their households manage health risks, including accessing health care services, and if and how older people who received cash transfers used this to support their access to health services.

Key informant interviews were conducted with senior figures in health and social protection to gather information on programme contexts and the issues facing older people in accessing health services. The following interviews were conducted:

Ethiopia:

6 interviews with representatives from: Director at the District Health Facility, Bahrtseba; Cash Transfer Implementer, Ministry of Labour and Social Affairs (MOLSA), Mekele; Head of Directorate, MOLSA, Addis Ababa; Ministry of Health, Addis Ababa; Ethiopian Elderly and Pensioners National Association (EEPNA), Addis Ababa; St George Welfare Association, Addis Ababa.

Mozambique

8 interviews with representatives from: Department of Prevention and Education, Ministry of Health, Addis Ababa; Department for Older People, Ministry of Gender, Addis Ababa; Social Welfare Technician, Manhica; Prevention Worker (Health), Manhica; PSSB lead, HelpAge Mozambique; District Coordinator Community Health and APEs, Moatize, Tete; Assistant for Social Action at Chiuta District Services for Health, Women and Social Action (SDSMAS), Tete; Public Health and Community Involvement, Department of Health (DPS), and Provincial coordinator of APEs at DPS, Tete.

Tanzania

7 interviews with representatives from: Three members of Ministry of Social Welfare and Health, Dar es Salaam; HelpAge Tanzania, Dar es Salaam; Health Economist, WHO, Dar es Salaam; Community Development Workers, Mbeya; and Health Worker at Mbarali Hospital.

Zimbabwe

9 interviews with representatives from: HelpAge Zimbabwe, Harare; National Older Person's Board, Harare; Svishavane Hospital, Svishavane; Zimbabwe Older Persons Association (ZOPA), Harare; CCDS, Svishavane; Makumbe District Hospital, Goromonzi; NCD Department at Zimbabwe's Ministry of Health and Child Care, Harare; UNICEF, Harare; and a Social Services Officer at the Goromonzi District Department of Social Services, Goromonzi.

Small-scale sample quantitative survey

The quantitative component of the study was carried out in Mozambique. This country was chosen because it was possible to identify older men and women who were recipients of cash transfers and to obtain the government authorisation required to conduct the survey. The survey focused on the key research questions of the study and provides evidence to triangulate the findings from other parts of the research project.

Sampling plan

For the survey, a total of 212 older persons were interviewed, selected through a two-stage stratified random sample in the two provinces of Maputo and Tete to provide both an urban and a rural perspective. In the first stage, a random sample of three to five communities was selected from the two provinces. From this sample, a total of 12 communities were selected: four peri-urban and eight rural, representing the preponderance of older people residing in rural areas. In the second stage, a random sample of 15 older persons was selected. The profile of participants selected in each community for interview was 60% women and 40% men. This is higher than the male female balance in the general population in Mozambique but aimed to reflect the greater longevity of women. To allow for a focus on the health needs of those over 75 we stratified the sample so that some 42% of respondents were aged 75 years and above. In Tete province, there was a

large population of older old and we interviewed 20 older persons per selected community.

Table 2: Sample allocation and selected communities

District	Locality	Community	Peri-urban	No. of older persons sampled
Manhiça	Posto administrativo de 3 de Fevereiro	3 de Fevereiro	Rural	15
		Malavela	Rural	15
		Palmeira	Rural	15
	Maciana	Maciana	Rural	15
	Manhiça – Sede	Manhiça Sede	Urban	15
Distrito Urbano Kamavot a – Maputo City and Maputo Province	Kamavota	Mahotas/FPLM	Urban	15
	Machava	S. Damanso	Urban	15
Provincia de Maputo	Posto administrativo de Matola Rio	Beluluane/Boane	Rural	15
Chiuta		Kaunda	Rural	20
		Mabvuzi Ponte	Rural	20
Moatize		Cateme	Rural	20
		Capirizang	Rural	20

Recruitment and training of the data collection team

Ten research assistants (RAs) who were native speakers of the local languages spoken in the selected communities were provided with two-days training. They were trained in interviewing skills, research ethics, questionnaire administration, informed consent administration, data quality and integrity, introduction to the code of conduct, an overview of the data management system, pilot testing, and use of mobile data collection devices, among other topics.

Questionnaire design, piloting and programming

A draft questionnaire was designed and translated into Portuguese. It was piloted in Mozambique with three older men and women for acceptability, feasibility, and flow of questions.

The pilot took place on September 14th 2016 with a team of three people, including a consultant for the survey, a manager of HAI BHOPA programme in Mozambique, and a student from S.Tomas University in Maputo and volunteer in a reproductive health programme, who took on the task of enumerator.

In preparation, three partner organisations were contacted and the location where the interviews should be held was discussed and places selected: ProIdoso in Bebeluane, Synyameruvi in Trevo and Tinena in Kongolote. Bebeluane and Kongolote are rural areas while Trevo is an urban environment. It was decided that two of the three interviewees should be female and the third male. It was also planned that among the three interviewees at least one should be a non-cash transfer receiver. Two enumerators able to translate from Portuguese into local languages were also identified and the most appropriate translation for certain questions discussed. The questionnaire was copied so that one hard copy would be available for each interview. A consent form was also prepared for each interview.

Following the pilot, changes to the questionnaire were suggested and discussed. At this point, feedback was also sought from the wider team. Additional input was received from HelpAge International who had recently conducted a similar survey in Zanzibar. Following discussion, changes were agreed and the questionnaire was finalised and translated. (see Annex 1)

The survey was programmed using ODK software and uploaded on handheld computer tablets for data collection. Samsung Tab 4 tablets were used as they had the capacity to take high quality photographs. These tablets were fitted with 8 megapixel cameras and had SD cards with 8GB memory for storage.

Fieldwork

During the fieldwork phase, two members of the Development Action team were involved in providing support to the research assistants, liaising with the HAI country teams and other relevant staff, and ensuring that the logistics functioned as planned. They also provided quality assurance, reviewing a sample of questionnaires at least nightly and providing feedback to the research assistants and answering any questions which they had.

Data analysis

A data analysis plan was developed and agreed by the project team before the data analysis was carried out. The quantitative data related to the questionnaires was synchronised, exported and analysed in STATA (version 13). The analysis considered appropriate sampling weights for the estimated parameters to reflect the probability of sampling as well as adjustments for non-response conditions. Statistical (quantitative) analyses were both exploratory and confirmatory for the sample statistics to answer the key research questions. Cross-tabulations were done. Data disaggregation by gender, age group, disability, location (rural or urban) and socio-economic status was also carried out.

Identification and validation of key findings

This phase of the research project focused on triangulating the evidence emerging from the literature and desk reviews, the qualitative research and the sample survey and validating the key findings and conclusions with input and quality assurance by Prof Lloyd Sherlock. It also included a virtual

debrief with the steering group to validate the preliminary findings and refine the conclusions and recommendations. The Steering Committee provided feedback on the initial findings report.

Methodological constraints

While the methodology for this study involved a variety of research methods so that findings from the literature review, interviews, survey and FGDs could be triangulated; the results need to be read with a degree of caution. Given budget availability for the research, the number of people covered in total is too few to generalise to the populations of older people in the countries reviewed and while we attempted to reduce risks of bias in the sampling of participants, it was not possible to select participants randomly. Therefore to a significant extent the findings are likely to be country and context specific. In both the FGDs and the survey there was a deliberate bias toward older people receiving cash transfers and to certain extent towards the older old group, although frail older people and people suffering from dementia might have been under represented as not specific effort was made to identify them and include them.

Nonetheless, the findings help to deepen the understanding of the potential impact of cash transfer programmes on older people's health and especially access to health in low and middle-income countries in Sub-Saharan Africa. There are lessons which can be drawn from these diverse sources of data and which emerge in the body of the report as the findings from each country are described and comparisons made.



Photo: Development Action (CamillaWilliamson) Mozambique

3. FINDINGS: COUNTRY OVERVIEWS

The country overviews present information gathered through the literature and data review alongside additional material collected as part of the field research. In addition, information on institutional arrangements, policy and programmes gathered from key informant interviews (KII) are included in separate boxes. This is presented to give an indication of additional issues and developments discussed in the four surveyed countries. The full data collected in the KIIs regarding the specific research questions is included in Section 4 alongside data from the focus group discussions. Analysis on the information collected and the findings is provided in Section 6 of the report.

Ethiopia: Country Overview

What is the health status of older men and women in Ethiopia?

Ethiopia is a country characterized by a predominantly rural and poor population with limited access to safe water, housing, sanitation, food and health care.¹⁹ The 2007 Central Statistical Authority report (the latest available figures) shows that some 3.6 million (4.8 %) of the total Ethiopian population are 60 years and above. Of these, about 540,000 (14.9 %) live in urban areas, whereas the rest live in rural areas of the country.²⁰ Life expectancy at birth is estimated at 64.8 (2015) with healthy life expectancy averaging 55 years (2012). Life expectancy at 60 in Ethiopia is estimated at 18 years.²¹

The national disease burden, responsible for 74% of deaths and 81% of disability adjusted life years lost per year, is dominated by malaria, prenatal and maternal death, acute respiratory infection, nutrition deficiency, diarrhoea and HIV/AIDS.²² Non-communicable diseases are estimated to be responsible for 30% of total deaths, although it is likely that they account for a higher proportion of deaths that occur at older ages. Additional information on causes of mortality and morbidity is included in the literature review.

No other large-scale or national self-reported or objective data on older people's health were found in the literature, with Ethiopia's latest Demographic and Health Survey (2011) only providing information on women aged 15-49 and men aged 15-59. However, a few smaller studies were found.

The most geographically representative of these is HelpAge's 2013 report which collected self-reported health data from 768 participants aged 60+ in five regions. The vast majority of respondents reported living with one or two chronic diseases and impairments (75 % of the respondents reported having at least one chronic disease and of these 77.5 % were undergoing medical treatment). Most commonly these were: eye problems (29 %), followed by arthritis (20.17 %) and hypertension (11.83 %). Urinary tract, hearing, and heart conditions were also important health problems for which older people noted they were seeking medical treatment.²³ A distinction was found between urban and rural residents in terms of the kinds of disease they are exposed to, though the report notes the distinction may not be significant. Other studies identified additional NCDs, malnutrition and psychological stress were present amongst older people. More detailed information is included in the Literature Review.

The literature illustrates that Ethiopia is a country where communicable diseases still dominate as the leading causes of both mortality and morbidity, but where NCDs also represent a significant proportion of both. Available studies show surprisingly high rates of obesity in the adult population²⁴. There is a lack of national self-reported or objective data on older people's health.

What are older people's recognised social protection and health service entitlements? What evidence is there on older people's actual access to cash transfer?

Ethiopia has several social protection programmes, including mandated social security schemes; non-statutory and non-contributory schemes provided by both public and private sector; NGO-provided schemes; and non-contributory services provided by both public and private providers.²⁵ However, there is currently no system in place to determine the aggregate volume and coverage of transfers by NGOs or the aggregate coverage of social assistance measures.

The most important public social protection scheme is the Productive Safety Net Programme (PSNP) which provides 8.3 million beneficiaries of all ages with predictable cash transfers during lean months.²⁶ The PSNP includes a direct support element which is delivered to 'persons in target woredas that require social protection and who live-in households without persons able to contribute work in return for food or cash. Direct support beneficiaries constitute 20 per cent (about 1.3 millions) of total beneficiaries'.²⁷ No information is currently available on how many of these recipients are older people.

In addition to the PSNP, a Social Cash Transfer Pilot Programme (SCTPP) ran in the Tigray region in northern Ethiopia from 2011-2016. The Bureau of Labour and Social Affairs (BOLSA) and Regional Government of Tigray delivered this, with support from the United Nations Children's Fund (UNICEF) and HelpAge International. The SCTPP was introduced in two Woredas, Abi Adi and Hintalo Wajirat and provided a monthly cash transfer to vulnerable children, older persons, and persons with disabilities. In total, the programme reached 3,767 (2825 female headed) households (6,716 beneficiaries), of which around 40% had children under 18 and 75% were female-headed.²⁸

In 2015, The Social Protection Strategy for Ethiopia was agreed and the latest version of this was published in March 2016. The Social Protection Strategy includes commitments to: 'Expand predictable social transfers...and protect vulnerable groups from falling in to extreme poverty, food insecurity and malnutrition' and to 'Introduce social pension schemes for older and other vulnerable persons'.²⁹ The Government pledges to 'allocate between 2 - 3 per cent of GDP to finance social protection and will provide, on an incremental basis, resources from the national budget to finance the National Social Protection Strategy and Action Plan'.³⁰

In regard to health service entitlement, the constitution of Ethiopia gives all Ethiopians the 'right to social services including health care, education and good nutrition'.³¹ To support this right, the Government has recently set in place several measures to reduce out of the pocket expenditures for health. The most important measures include:

- 'Fee exemptions for basic maternal and child health, HIV and TB services in government facilities.
- 'An Indigent Fee Waiver program which provides the poorest with free access to specific health services provided in government health centres and hospitals. The screening and identification of eligible beneficiaries is conducted through community participation, vetted by community councils, Kebele and district authorities. The beneficiaries receive a certificate entitling them to free health care.
- 'The Community-based Health Insurance (CBHI) provides financial protection in case of illness for informal sector employees and rural

residents. Kebeles decide collectively to establish CBHI scheme, but enrolment decisions are made at household level.

- 'The Social Health Insurance (SHI) covers expenditures in public facilities for formal sector employees and their family members'.³²

In 2016, UNICEF noted 'The Indigent Health Fee Waiver scheme is implemented in all regions and has identified over 1.8 million beneficiaries. CBHI, which was piloted initially in 13 pilot districts, expanded last year towards a total of 199 districts and is currently covering over 6.5 million clients'.³³ The Government's Social Protection Strategy states that 'both the community - based health insurance and social health insurance aim to cover about 50 per cent of people by the end of the HSDP IV period' (p. 10).

A National Action Plan of the Elderly and the National Action Plan of Persons with Disabilities exist, but these have not yet been translated into budgeted programmes and remain poorly implemented.³⁴

The Social Cash Transfer Pilot Programme (SCTPP) and the National Social Protection Strategy

The Key Informant Interviews provided information on the SCTPP and the National Social Protection Strategy (2015).

The SCTPP programme started in 2011 and now covers 3,367 households in Tigray. All these households together equal about 6'000 beneficiaries and every household receives a minimum of 155 Birr (about USD \$4.50) monthly which increases depending on the number of eligible beneficiaries.

At the national level, the government established a Social Protection Platform to bring stakeholders together. This platform includes EEPNA, HelpAge, UNICEF and other key stakeholders. It engages with the Ministry of Labour and Social Affairs (MOLSA) in particular, and has gained knowledge and experience from work with both regional and international agencies. In recent years, it has focused upon the development of the new Social Protection Strategy which was approved in 2015.

The Social Protection Strategy includes plans for the direct support provided by the PSNP programme, currently under the leadership of the Ministry of Agriculture and Labour, to be moved to the portfolio of MOLSA in 2017. The evaluations carried out on the SCTPP have been drawn upon in the development of the PSNP and in the development of the cash transfer element. The direct support element is now being rolled out in the Southern Nation and Oromia regions and it is hoped it will be spread further in future. The development of the programme is now being funded by a loan from the World Bank.

The roll-out of the direct support element will reportedly lead to 1 million people, including older, disabled and vulnerable children, receiving the cash transfer. It is hoped this direct support will close the food gap although, currently, due to the drought, this is apparently not the case.

With the transfer of the direct support element of the PSNP, there will be a new registration process. MOSLA is working with the National Statistics Agency and stakeholders on designing this, incorporating lessons learned during the SCTPP in Tigray. It is hoped this will enable the collection of more data and understanding about beneficiaries than is currently the case. EEPNA had been engaging in this process, promoting age-related issues and the collection of age-disaggregated data.

Key informant interviews: Community Care Coalitions (CCCs)

In addition to the discussed mechanisms of support, in Ethiopia information was provided on community organisations known as Community Care Coalitions (CCCs). CCCs are locally established, community-led organisations which provide support to vulnerable populations, including older people, persons with disabilities and vulnerable children. The CCCs operate as committees and collect money from households in the village which they then redistribute according to need. The CCCs provide different forms of support depending on the need. This style of CCCs reportedly came from Tanzania and was established in communities with support from World Vision. MOLSA now has responsibility for providing CCCs with capacity building, resource mobilizing and support with targeting. Most of the current funding for this work comes from UNICEF, but they do not provide funds directly to the CCCs – these are all raised locally by communities. The programme reportedly covers all districts in Tigray – but the work of MOLSA is only directly supported by UNICEF funding in seven districts.

What health services are available in Ethiopia and what evidence is there of older people's access to health services?

Ethiopia has a decentralized three-tier health system of primary, secondary and tertiary care.³⁵ Health care facility expansion in recent years has improved physical access to health services resulting in a potential health service coverage estimated at 92.2%. However, health care utilisation is still low, with a 0.36% utilisation rate, partly due to the burden of high out-of-pocket spending.³⁶

Ethiopia is among 57 countries in the world identified by WHO to be facing a critical shortage of health workers as well as an unreliable supply of medicines.³⁷ Nationally, households of all ages contribute 31% of all health expenditure in Ethiopia.³⁸

Key health data includes:

- Health expenditure, total (% of GDP): 5 (2014)
- Private health expenditure (% of total health expenditure): 41 (2014)
- Health expenditure per capita (US\$) 27 (2014) (Average sub-Saharan Africa: 99).
- Out of pocket health expenditure (% of total health expenditure) 32 (2014).
- Population using improved drinking-water sources (%) (2014): 57
- Population using improved sanitation facilities (%) (2014): 27
- Skilled health professionals' density (per 10 000 population) 2.8 (2005-13)³⁹

Limited evidence was available on older people's actual access to health services. Two studies were found. The first, by HelpAge International, was a survey conducted in five regions of Ethiopia, collecting data from 768 sampled households. The study found that 56.8% of interviewed older people (58.9 % urban and 53.0% rural) who were sick in the last six months said they went to a health centre, while 46.8% said they were sick in the last six months and received treatment at a health facility.⁴⁰ The second by Falaha et al (2016), conducted a community based cross-sectional study in a rural Woreda in southern Ethiopia. The study interviewed 795 people over age 60 and found that 460 (72.3%) of reported that they had visited a health facility during their last episode of illness.⁴¹

What are the barriers to accessing health services, considering both direct and indirect costs of accessing care?

Numerous barriers to older people accessing health care were identified in the literature with financial constraint being the most significant. Other barriers included: shortage or non-existence of people trained in geriatrics and management of chronic non-communicable diseases (NCDs) and over-stretched health workforces; de-prioritizing of older people for essential services; under-financing of health systems; poor health management information systems; lack of clear criteria and guidelines for granting fee-wavers; age-discrimination; non-age-friendly health facilities; distance from health facilities, physical incapacity to get to the health service; lack of family support to help with transport; and lack of trust in the healthcare service and other attitudinal and behavioural barriers.⁴²⁴³⁴⁴⁴⁵

How do older men and women pay for the costs of accessing health services?

The HelpAge International 2013 study was the only literature found on how older people pay for health services. This found that half (50%) of older persons use their own savings; 36% rely on family support; and 8% have to borrow money from someone whenever they fall ill. 4.2% said they found money from other sources, including begging.⁴⁶

Key informant interviews: health entitlements and services

Representatives from MOLSA, the Public Health service and EEPNA all confirmed that the fee-waver programme is in place for the poorest poor and that the registration process for this takes place at the kebele (small village) level. Issues of migration, discrepancies in the targeting strategies adopted by different Kebeles and bureaucracy in the application process were raised. All key informants also confirmed the health insurance that the government has introduced and the conditions that it covers.

Regarding health service provision, the district health centre visited in Bahrtseba in Tigray, provided preventative services or treatments for common conditions (discussed in the following section). Health professionals come every three months for more serious cases to be handled. Health extension workers complete household visits, though they are reportedly few – “around two per 5000 population” and are focused on child and maternal health. For secondary care people have to go to hospital.

No interviewees were aware of any materials or guidelines specifically considering older people’s health. The health professionals that were met had received no training in older people’s health care. A Non-Communicable Disease (NCD) strategy and guidelines was published in June 2016, however, and some information on specific conditions which are common among older people is also available. EEPNA said that older people are not given priority, that services are not age friendly and that older people’s health issues are not well understood.

The impact of cash transfers on access to health services

There is limited information on the impact of cash transfers on older people’s access to health services. Evaluation was carried out on the five-year (2011-2016) SCTPP in Tigray region by Berhane et al (2015).⁴⁷ The main findings from this evaluation, which measured the impact on recipients of all ages with a focus on child and maternal health, concluded that ‘The SCTPP improved household food security and reduced hunger’ and that ‘The SCTPP

had modest effects on schooling and asset formation'. It notes that 'There were no large or measurable impacts on a range of other outcomes' (p. 13).

Additional findings that may relate to older people's access to health care included qualitative examples of the SCTPP providing working capital for participants to start small businesses' (p. 15). However, the final evaluation focused upon the impact of the SCTPP on child and maternal health and did not examine general access to health services.

More detail on access to health services was provided in qualitative evidence included in monitoring reports for the SCTPP. These include evidence that: 'At household level, the transfer improved beneficiaries' capacity to meet their basic needs and improved access to basic services like health institution visits – and improved health status'.⁴⁸ However, the impact of the involvement of local Community Care Coalitions in the operating of the SCTPP and their role in helping older people access health services needs to be considered.

In addition to this, a 2006 evaluation of the impact of the PSNP in Ethiopia, including the direct cash transfer element, found that significant numbers of beneficiaries spent some of the cash transfer on health (29%), with the poorest beneficiaries almost twice as likely to use some PSNP cash to pay for health care⁴⁹. However, these results were not age-disaggregated and those on non-conditional, direct support only were not considered independently in the results.

Key informant interview: the integration of social welfare and access to health services

The Social Protection and Welfare Specialist we spoke to at MOLSA in Mekele spoke about the structures at local level that enable the integration of social welfare programmes and health services. In particular, he stated that at regional level, there is a social protection forum which is mirrored by structures at the ward/district level and also at the community level through the Community Care Coalitions (CCCs). These bring together local individuals working in different sectors. At every level, quarterly meetings take place to exchange information, discuss challenges, and agree on solutions. There are also annual review meetings for the social protection and cash transfer programme. At regional level, NGOs are members of the social protection forum, though at district levels participation of NGO's is quite limited.

During the time when PSNP public works and cash transfer delivery takes place each month in communities, representatives from all sectors are present, including people from health, education, social welfare, productivity, and environment protection and development. On these occasions representatives are there to talk and to provide information to the public, and to deliver services. These events are coordinated by development agents at the sub-district levels. The public works activities reportedly attract a large proportion of the population of communities meaning they provide a good opportunity for engaging people. Both the structural arrangements and coordination of these mechanisms are reportedly well managed and these occasions were said to be a good example of a successful, integrated approach.

Conclusions

A National Action Plan of the Elderly and the National Action Plan of Persons with Disabilities exist in Ethiopia, but these have not yet been translated into budgeted programmes and remain poorly implemented. Attention should be given to using these mechanisms to bring stakeholders together to influence the government on these agendas. This will require that more data is

collected on older people's health, especially through age extension and age disaggregation of the data collected by the demographic and health surveys. Data on older people receiving cash transfer through the PSNP programme is also required and the new social protection strategy registration process will hopefully address this.

The current social protection strategy provides a number of positive programmes that could help older people in terms of both help and income if delivered. The Government's pledge to allocate between 2 - 3 per cent of GDP to finance social protection and to provide, on an incremental basis, resources from the national budget to finance the National Social Protection Strategy and Action Plan is positive. The government should be supported and encouraged to realise these ambitions by national and international stakeholders.

Significant barriers were identified to older people's access to health care, both direct (lack of population-wide quality health service provision) and indirect (affordability and accessibility). The social protection strategy offers opportunities to address several these issues if delivered. However, there is also a need for wide-scale health service development for all, which is a significant challenge, especially considering the joint-burden the country faces of communicable and non-communicable disease, the size of the population and the country. In the meantime, older people's needs should be addressed in the service provision that exists and their issues represented in diverse policy areas. Action on the development and implementation of a broad policy/strategy/plan for older people would support this process.

There is some limited evidence in Ethiopia on the impact of cash transfers on people's ability to access health services. More quantitative data is needed on this issue. In the meantime, the qualitative data that exists should be used to communicate messages to the government and to campaign for greater access to cash transfers, on the realisation of the social protection strategy, and upon mainstreaming older people's needs into current health services.

The evidence suggests that there is occasionally some good integration of health and welfare services and provision. Where this exists, it should be recognised and promoted alongside development in both areas. At the national level, this was less clear and the mechanisms already in place to bring stakeholders together – e.g. the social protection platform – should be used as a vehicle for promoting other important agendas, such as health.

Mozambique: Country Overview

What is the health status of older men and women in Mozambique?

Mozambique has a population of 27.9 million, of which 5% (around 1.3 million) is estimated to be over 60 years of age.⁵⁰ Life expectancy at birth was estimated at 57.6 for both sexes in 2015. Life expectancy at 60 is estimated at 15 years.

Non-communicable diseases were estimated in 2014 to account for 23% of total deaths. The leading causes of death in 2012 were: HIV/AIDS (81.8%); lower respiratory infections (23.8%); malaria (17.4%); and diarrhoea diseases (4.8%). The burden of disease, measured in years of life lost, was estimated in 2015 as 73% for communicable diseases and 16% for NCDs, with HIV/AIDS, TB and malaria the leading causes.⁵¹ The most common NCDs in Mozambique are: cardiovascular disease (responsible for 7% of DALYs), malignant neoplasms (4.2%), and respiratory diseases (3.4%).⁵²

Little self-reported or objective data specifically on older people's health were found in the literature. The 2011 Mozambique Demographic and Health

Survey covered only people between 15 and 49 years of age. The Mid-Term Review of the HelpAge International Programme 'Better Health for Older People' showed a high prevalence of some non-communicable diseases (NCD). Among 558 older people interviewed in 3 provinces (Nampula, Gaza and Maputo), 42% self-reported that they were suffering from hypertension and 51% from eye illnesses, while 36% had complaints of osteoporosis and 47% of arthritis.⁵³ Beyond this, the Strategic Plan 2014-2019 of the Health Sector (PESS) states that 5.6% of the total population are older people and most these suffer from illnesses like hypertension, diabetes, cancer, arthritis, osteoporosis, alongside other NCDs. It states that these conditions are aggravated by nutritional problems and physical inactivity.⁵⁴ The same document states that 8.5% of Mozambicans between 50 and 65 years are HIV-positive. More general research on NCDs in the country, reports rapid rises in prevalence, increased exposure to risk factors such as alcohol and tobacco, and low levels of awareness of conditions such as hypertension and diabetes⁵⁵.

The literature illustrates that Mozambique is a country at the beginning of the epidemiological transition, where the clear majority of both mortality and morbidity is still caused by communicable disease but where the prevalence of NCDs is increasing.

What are older people's recognised social protection and health service entitlements? What evidence is there on older people's actual access to cash transfer?

The current social protection system in Mozambique, as laid out in the National Strategy for Basic Social Protection (ENSSB), is structured around four programmes. For older people, the Basic Social Subsidy Programme (PSSB) and the Programme for Direct Social Action (PASD) are the most important, alongside social action in the health sector. Cash transfers are provided under the PSSB; transfers range from \$4.3 per month for a single-person households, to a maximum of \$8.7 per month for a six-person household.⁵⁶ These amounts are well below the national minimum salary, currently standing at some \$50/month, and the United Nations poverty line of US\$1.25 per day. No adjustments of cash transfer amounts were made in 2015 due to Mozambique's economic and financial crisis. No adjustments are expected to take place in 2016.

The Government of Mozambique is gradually recognising the necessity of including older people's issues in poverty reduction policies. The Mozambican Council of Ministers established, in 2012, the National Council for the Elderly and the Law on Promotion and Protection of the Rights of Older People was approved in 2013.

Older people (F over 55, M over 60) are entitled to free inpatient admittance in General and Central Public Hospitals, free outpatient services and free access to most drugs at health centres, including free access to antiretroviral drugs. Health insurance is only available to those in the formal sector.

In 2013, HelpAge International Mozambique and its partners conducted a survey among 100 households benefiting from the government cash transfer (PSSB) in 8 districts in 5 provinces of the country: Nampula, Sofala, Tete, Maputo Cidade and Maputo Province. The findings showed that the cash transfers contributed between 76 and 100% of the income for 78% of the household who participated in the survey.⁵⁷

The ENNSB II strategy (2016-2024) states that in 2014, there were 427,000 beneficiaries of the programme. Data on the numbers of older people in receipt of a cash transfer is not available, though the strategy aims to

achieve a coverage rate of at least 62% of older people eligible for the allowances and 1 million older people in receipt of the allowances by 2024.

Social protection and cash transfers

Key informants spoke about several social protection programmes that exist in Mozambique, including formal sector pensions, the *combatentes* pension scheme, and the PSSB programme. These include both cash transfers and monthly food baskets. The Ministry for Gender also spoke about older people's centres which provide direct assistance in some provinces and about some private centres running activities for older people. Income generating programmes were also discussed as part of INAS (Programme for Direct Social Action - PASD) for those who have some ability to work.

Key informants raised the, the following key issues in relation to the PSSB cash transfer for the elderly programme:

1. Access to the PSSB is hindered by the fact that older people do not have the necessary ID to register;
2. Grandparents who are providing care to grandchildren receive support from the PSSB, but this is limited to five people
3. Corruption was reported in some places as was a lack of transparency in the selection process
4. HelpAge Mozambique and APITE said the government is in the process of reorganising the PSSB. The idea is to outsource the payment process and start using ATM banking services. Concern was raised about older people living in rural areas who do not have access to banks.
5. In the future, families will no longer be the basic unit to assess the need for social assistance. It will be done per family member and there will be a separate subsidy for adults/older people, for children and for disabled people. Outsourcing of the payment process is also taking place.

Coverage

HelpAge Mozambique stated that national data shows that 390,000 households are currently receiving the PSSB social cash transfer and that about 94% are older households, while around 4% are people with disabilities and less than 1% are people with chronic illness. In Manhica, 4,032 are reportedly receiving the PSSB social cash transfer, including people with disability and chronic illness. The large majority of these people are reportedly women. For example, in Moatize district the 2015 data states that 946 of the 1,462 PSSB beneficiaries were female.

What health services are available in Mozambique and what evidence is there of older people's access to health services?

Health services in Mozambique are provided at the primary level by health posts and health centres. In 2011 the Mozambican National Health System had approximately 1,400 Health Units distributed over the country, first level or basic health centres accounting for 1,314 of these units. Less than 60% of the population had access to these basic health services and the average distance to a health unit is about 10 km. The remainder of the population is covered by traditional medicine, community health agents, elementary agents and traditional birth attendants. A very small part of the population is covered by private healthcare, mainly concentrated in the big cities.⁵⁸ Key health service statistics include:

- Health expenditure, total (% of GDP): 7 (2014)

- Private health expenditure (% of total health expenditure): 44 (2014)
- Health expenditure per capita (US\$) 42 (2014)
- Out of pocket health expenditure (% of total health expenditure) 9 (2014)
- Population with access to improved water sources (%) 51 (2014)
- Population with access to improved sanitation facilities (%) 20 (2014)
- Skilled health professionals' density (per 10 000 population) 4.5 (2005-13)⁵⁹

In regard to older people specifically, a 2013 survey of older people's rights by HelpAge International found that of 100 older people interviewed, 18% indicated that there was no health facility within 30 minutes travel time of their home. The proportion with no access was higher among those living in rural locations. Lack of access was higher among older people with a limiting long standing illness or disability (LLID) and among those from the Shangaan, Tsonga and Sena ethnic groups.⁶⁰

Samuel Hall notes there are no more than 2 geriatric specialists in the country, both expatriates.⁶¹ However, the Ministry for Health recently started a 5-day in-service training for health professionals in subjects including geriatrics.

What are the barriers to accessing health services, considering both direct and indirect costs of accessing care?

Despite improving regulations, reports suggest that these entitlements are often not honoured and many end up paying fees. A survey in Gaza province in 2011 showed that 86% and 85% of older people pay for consultation and medication, respectively.⁶² Furthermore, the health facilities are often located far from some of the households. The community health workers (known as *agentes polivalentes elementares* - APEs) and those at health facilities are not trained in the provision of geriatric care.⁶³

Approximately 80% of Mozambique's 1.3 million older people live in rural areas, where distances to health units are mostly very long and transport to a health centre may not be readily available. In rural areas 'older people travel long distances in search of the nearest health centre when they hardly have the physical strength and the money to do so. And then, even when they reach the site, the medicine they need is often not available'.⁶⁴ As a result, people have to look for those drugs in private pharmacies that are hard to find in rural areas. It has been estimated that over 90 per cent of the country is located over an hour away from government health care centres⁶⁵.

In urban areas, health service coverage is better and health centres are not so far away from the places where older people live. But also in this situation, prescribed drugs are often not available in the public health facilities; in the private pharmacies, older people have to pay the full price when they find the medicine they need. Moreover, the official MISAU list of essential drugs does not include drugs for NCDs such as diabetes and hypertension thereby increasing the risk of not finding adequate drugs in the public pharmacies.⁶⁶

In Selvester et al's 2013 analysis on cash transfers, additional barriers to health were raised in some interviews with older people, including poor health care-seeking behaviour; under-utilisation of health services for cultural or religious reasons; long waiting times; and discrimination from health care staff on the basis of age and/or disability. Additionally, the report

notes that differences between wealth categories arose in terms of access to medication and treatment by health staff.⁶⁷

Health services

Key informant interviews confirmed that the law states that older people receive free health services and other health units and that they receive priority treatment. This is administered upon presentation of a valid ID. However, multiple interviewees said often older people do not receive free services, as they should and are asked to pay for services, and that often medicines, especially medicines for conditions faced by older people, are not available at public health services, forcing older people to access medicine from private pharmacies which many cannot afford. Additional costs in accessing health services were also discussed by many, including transport. These issues are addressed further in the FGD and KII findings section, below. One informant also mentioned a fee waiver for treatment not included within the free healthcare regulations for people who obtain a poverty certificate.

Interviewees outlined the following health services as being available to older people:

1. APEs - health extension workers who receive training from the government and whose role is to promote health through education and preventative action. We heard from many interviewees that APEs have recently been trained on older people's health in a 1 week seminar financed by HelpAge and APITE, another NGO working on older people's issues in Mozambique.

2. Community Health Activist (ACS) apparently complement the task of APEs.

3. Health units and district hospitals – In Manhica the furthest community from the health centre is reportedly 26km away.

4. Private companies have their own health facilities, but these only serve those employed in formal work.

No facilities for **long term treatment** of older people are available in Manhica.

Beyond the regulations regarding older people's free access to health services and priority treatment, interviewees were not aware of any **guidelines on older people's health**. The national health system does not have Older Persons as a specific target group (such as mother and child care). However, consciousness is increasing about the specific health needs that come with age but it is yet to be translated into a comprehensive policy for the assistance of older persons. An important obstacle for adequate policy definition has apparently been the lack of data on the health and well-being of older people (see box below on data).

How do older men and women pay for the costs of accessing health services?

In their research on cash transfers, Kerry Selvester et al, found that older people rely on a small set of actors with whom they interact and who they rely upon in times of difficulties. Elderly and disabled people are reliant on the goodwill of family and neighbours.⁶⁸ Older people, particularly women, rely heavily on their daughters-in-law to provide support and care for them. Church organisations and community based organisations also have a supporting role, but coverage is patchy and often *ad hoc* as they do not have

secure funding. Maintaining good relations with local leaders was also cited as an important strategy for survival and accessing social services. Differently from rural zones, neighbours' support in the cities for older people appeared to be less common.

In an interview in Kairós Gerontologia, Terezinha da Silva points out that most Mozambican households, particularly those living in rural areas, are composed of extended families, where grandparents, parents and grandchildren live together, care for each other and, when needed, pay health and education expenditures of household members (dos Santos, 2011). Support from family, friends and neighbours includes both moral encouragement and material support for the payment of medicine.⁶⁹

No other information on how older men and women pay for costs of accessing health services was found.

The impact of cash transfers on access to health

Very limited information on the impact of cash transfers on older people's access to health care was found in the literature. HelpAge International's 2015 survey of 100 older person-headed households who were recipients of the cash transfer, found that 38% of respondents said they spent some of the money on 'health'.⁷⁰ There were differences in both gender and geography here, with male-headed households more likely than female-headed households to spend the money on health (45% compared to 33%) and beneficiaries in Gaza and Maputo Province spending 100% of their cash transfer on food.

Regarding the general population, the 2013 analysis of cash transfers by Selvester et al found that a limited number of beneficiaries in Chokwe and Chibuto said they spent the cash transfer on medicine. However, this information is not age-disaggregated.

There appears to be limited evaluation on the PSSB more broadly. What does exist found that the level of the benefit was too low to have meaningful impact on beneficiaries' income.⁷¹ At a system level, evaluation has also found limited linkages between health services and the INAS, even though health staff are required to certify the clinical status of people who have chronic degenerative disease or severe disability for them to access the programme.⁷²

Institutional arrangement and coordination of social welfare and health

HelpAge Mozambique spoke about the legislation and action plan on older people and the various groups and mechanisms that relate to older people at national level. All departments have responsibilities for the action plan and all have different targets that relate to it. There used to be regular meetings regarding this but a lot has now changed owing to a government reshuffle this year. Regular evaluation meetings are known to take place between some departments with a view to making revisions of the policy. In addition to this, four relevant bodies exist: The National Council on Ageing, which brings ministries together on ageing issues; NGOs work through the Christian Council of Mozambique which is civil society led; The Platform for Civil Society which exists to work on social protection issues; and the Third Age Forum, which is an umbrella group.

Problems with consistent organisation and lack of funding for these bodies were raised.

At a local level, a social welfare technician who is employed by a district welfare centre in Manhica described the role of the welfare centre which includes providing older people, children of school age, and people with disabilities with assistance by linking them with the right services. This organization delivers the cash transfer but also provides non-financial assistance. In addition, they reportedly work with hospitals to ensure that older people's rights are met.

Data and evaluation

HelpAge Mozambique is currently working with INAS and other civil society organisations on a longitudinal study evaluating the impact of the PSSB. This work is funded by the Dutch Government and the European Union. The first wave of data gathering took place in 2015. The second wave of results has now been collected and was expected to be published before the end of March 2017. HelpAge Mozambique also informed us that there is currently a survey to register beneficiaries for the implementation of the new social protection programme. It is hoped that this will deliver a better registration process and improved data.

The Better Health for Older People in Africa programme undertakes community monitoring. The Mid-Term evaluation has already taken place, providing some data on older people's health and another round of data collection was due to begin in January 2017.

Data are also reportedly collected at local level by the social welfare department, who holds information on the number of beneficiaries of different government social protection schemes.

Evidence on the health status of older people is also collected from the monthly reports of APEs and Health Posts and statistics are reportedly entered into a national data base. APEs are also supposed to refer people who might be eligible for the PSSB. However, on the monthly report forms, there is no special line dedicated to the health or social wellbeing of older people, so this information is sometimes missed.

Conclusion

With less than 60% of the population reportedly having access to basic health services, Mozambique needs to focus on expanding health care services for the general population. Older people's needs should be mainstreamed into national health and development plans and attention should be given to ensure that consultations are free and that older people receive priority care. The availability of medicines for age-related conditions at government health-centres should be improved.

There is evidence emerging from the literature suggesting that older people have limited resources with which to pay for health care-related costs. Policies that help older people overcome these barriers should be promoted – including the expansion of free and reliable transport, or the reflection of health care costs in the amount provided in the cash transfer. This assertion is supported by the limited evaluation that has taken place on the PSSB which finds that the level of the benefit was too low to have meaningful impact on beneficiaries' income.

At an institutional level, it seems more could be done to promote integration between health services and the INAS programme, considering how adaptations could be made to benefit people's access to health care. For

example, in Ethiopia, health services were made available at the cash transfer pay point on the day of payment each month.

Tanzania: Country Overview

What is the health status of older men and women in Tanzania?

Tanzania is a country characterized by a predominantly rural and poor population with limited access to safe water, housing, sanitation, and health care.⁷³ According to the United Republic of Tanzania Factsheets of Health Statistics (2016) 2,673,500 million (5 %) of the total Tanzania population are 60 years and above⁷⁴. Of these, about 802,050 (30 %) live in urban areas, whereas the rest live in rural areas of the country. Life expectancy at birth is estimated at 61.8 (2015) with healthy life expectancy averaging 52 years (2014). Life expectancy at 60 in Tanzania is estimated at 18 years. Communicable diseases, especially HIV (18.2%), TB, malaria (5.2%), lower respiratory infections (8.7%) and maternal, new-born and childhood illnesses are the main causes of morbidity and mortality in Tanzania⁷⁵. Non-communicable diseases are estimated to be responsible for 31% of total deaths.⁷⁶ Additional information on causes of mortality and morbidity is included in the literature review.

No other large-scale or national self-reported or objective data on older people's health were found in the literature. However, the 2011 country projections indicate that more than half of NCD deaths in Tanzania were attributed to people above sixty years of age⁷⁷. A national survey showed that at least 51% of the older persons suffered from some form of impairment or a chronic disease in the past six months⁷⁸. The most common health problems of older people were hypertension (39%), followed by eye problems (29%) and osteoporosis (12%)⁷⁹. A study on the pattern of risk factors for cardiovascular diseases in Dar-Es-Salaam also revealed high prevalence in this urban setting.⁸⁰ The literature illustrates that Tanzania is a country where communicable diseases still dominate as both the leading causes of mortality and morbidity, but where NCDs also represent a significant proportion of both.

What are older people's recognised social protection and health service entitlements? What evidence is there on older people's actual access to cash transfer?

Tanzania has several social protection programmes, including mandated social security schemes; non-statutory and non-contributory schemes provided by both public and private sector; and non-contributory services provided by both public and private providers.

The existing mandatory Social Security Schemes currently cover about 8.1% of the population. This is low compared to most low-income countries where it is about 25%. Social assistance coverage is also limited. Overall, over 90% of the population, including almost all informal sector workers, the self-employed and the unemployed, do not have protection in case of vulnerability. The current planned expansion of TASAF III/Productive Social Safety Net (PSSN) to cover about 6 million extremely poor people and the on-going work on developing a National Social Protection Framework (NSPF) are important steps towards addressing this gap. The country has witnessed a steady increase in its public investments in social protection, which currently stands at 6.8% of the GDP, or 2.3% excluding health spending. Key contributory instruments are: National Social Security Fund (for private sector workers); Parastatal Pension Fund (for parastatal and private), Public Service Pension Fund (for central government employees), Local Authorities

Pension Fund (for local government employees only), Government Employees Provident Fund (for non-pensionable government employees), and Public Service Retirement Benefit Scheme (for politicians).

Non-contributory systems (social assistance) schemes which relate to older people include the Subsidized Food Distribution, and the Tanzania Social Action Fund (TSAF). Designed in 2013 this includes the Productive Social Safety Net programme (TASAF III – PSSN) which is a country-wide cash transfer programme and targets the extreme poor. The programme provides cash transfers conditioned on family's participation in education and health related services, as well as community sessions on health, nutrition and sanitation every two months (UN Tanzania 2014:3).⁸¹

According to Ulriksen (2016)⁸², there were moves to finalise a National Social Protection Framework (NSPF) and discussion of introducing an old age pension. However, 'the NSPF did not get enacted by government and no actual committed starting date for the pension was confirmed by the time the national elections came in October 2015' (1-2). There is general agreement that the current programmes are inadequate, fragmented, uncoordinated, and limited in scope and coverage.^{83,84} This implies that 'the majority of Tanzanians have no access to social protection provisions and rely instead only on informal systems of support'.⁸⁵

In relation to health care, the 2007 MIPAA Review from Tanzania⁸⁶ states that government policy includes: free health care for older people; provision, through local government and voluntary agencies of institutional care to older people and others who have no one to care for; encouragement by government authorities and voluntary agencies of older people to save through Ward Banks, Primary Cooperative Societies and Savings and Credit Cooperative Societies; and development by local government authorities and voluntary agencies of a mechanism to provide direct assistance to needy older people (9-10). Despite the policy of free health care for older people, however, it is reported that only 10% of older people are receiving free health services from public facilities (URT 2007b).⁸⁷ Health system challenges, especially severe shortages in human resources and drugs at public health facilities, have forced people to turn to private sector providers. It is estimated that 40% of Tanzanians get their medication from private and faith-based health facilities.⁸⁸ Similarly, access to 'community-based health insurance is in its infancy in most districts. In total, 94% of women and 93% of men do not have health insurance.⁸⁹ Tanzania is ranked among countries with the lowest pension coverage rate in the Africa region (3.2%) and a 17% old age poverty rate.⁹⁰

Key informant interviews: Social Protection and cash transfers

Some older persons have been included in TSAF cash transfer programmes and 70% of older people are reportedly benefiting from it. In Mbarali, 10,000 out of the 16,700 elderlies are receiving CTs under TSAF. TSAF III covers over 623,000 older people. At the district level, KIIs noted that there were some inclusion and exclusion errors; "it is unfortunate that we were not involved in identification of beneficiaries of CT because there are elderly who are extremely vulnerable but they are not accessing CT-TSAF. They mostly consider productive assets and households with more dependants...But some households have dependants but have more capabilities to earn income than those with no dependants". Poverty among households with older people is high; they are 20% poorer than the average poor. By targeting poor households, you end up targeting older persons through poor households".

"There is variation in the amount received by households based on the number of dependants. Households without dependants get 20,000 Tanzanian

shillings. and the value increases as the number of dependants increase to a maximum payment of 40,000 TZS”.

A number of challenges faced by those receiving CTs were outlined. These are outlined below.

Older people who are physically disabled or who are poor experience difficulties reaching pay points; they may be bedridden with no one to send to the pay points. These people are more vulnerable than those who are healthy and physically able.

Overarching social protection legal framework: It was noted that CTs and provisions of health services for older persons are not protected by any legal framework and that this makes the provision challenging. It is dependent upon the willingness of the duty-bearer and accountability mechanisms. These however need legal backing to be systemic and effective. “In Zanzibar, we worked with government and have a national social protection system. In the mainland, the government is developing a National Social Protection framework but this is yet to be approved. For the last 8 years, we have been part of the taskforce. If we can have the bill passed that will provide legal rights for older people which would be a plus” (KII, HelpAge, Tanzania).

Key informant interviews: Health Insurance, Community Health Fund (CHF)

CHF payments are generally the responsibility of households and/or families. However, there has been increasing recognition of older people’s inability to earn income to pay for CHFs. The local governments, especially the district council of Mbarali, made a resolution to use a proportion of its income to pay contributions to the CHF for older persons’ households. For example, when a given community contributes a certain amount of money for CHF and deposits it on the account, the central government provides matching funds. The community contributions in Mbarali local government started with 400 households and now the local government provides matching funds to extend the number to 800. The intention is to gradually cover all older persons. Some KIIs said they had been encouraging the local government to pay the CHF for the elderly and currently 15 districts are doing so.

Universal pension and health insurance debates: KIIs noted that beyond the blanket free access to health care policy for older person, there is a need to cover the older persons with the insurance. “If you are a member of an insurance scheme, it widens your choices beyond the public sector and you can choose to go to either private or public facilities [...] Insurance also gives you more entitlement to medicines”. (KII, National Level, UN Agency).

KIIs especially from CSOs highlighted debates on universal pensions and recommended that Tanzania has a lot to learn from Zanzibar which is ahead of the main land in terms of policy and implementation arrangements for universal pensions and insurance coverage.

What health services are available in Tanzania and what evidence is there of older people’s access to health services?

The health services in Tanzania are organized in a decentralised pyramidal pattern with the primary care facilities at the base, the district hospitals at the next level, and the referral hospitals, which include regional and national/tertiary hospitals, at the apex⁹¹. The governance of primary care services and district hospitals is

devolved to the local government authorities, while regional and national/tertiary hospitals are under the control of central government⁹². At the front-line, dispensaries provide preventive and curative outpatient services, while health centres also admit patients and might provide minor surgical services. At the grassroots level, community health care providers work to link the community to the health care system. These are complemented by NGOs and civil society organisations, particularly in the provision of outreach health services.

Health care facility expansion in recent years has improved physical access to health services. However, health care utilization is still low, partly due to the burden of high out-of-pocket spending (private expenditure on health as % of total expenditure on health was 63.7%).⁹³ Despite some improvements in healthcare financing, the health sector is severely underfunded. About US\$ 44 per capita is spent on health care, which is low compared with the US\$54 per capita recommended for developing countries⁹⁴. About 48% of the total expenditure on health is donor support. The general government expenditure on health as % of total government expenditure (2013) is 11.2%. In Tanzania, Out-of-pocket (OOP) payments account for about 2% of people's income and about 2% of the population incurs catastrophic health care expenditures and 1% becomes impoverished because of OOP payments.⁹⁵ The burden of OOP payments is significantly large among the poorest segment of the population and only 15% of the population is covered by health insurance schemes.⁹⁶ Tanzania is experiencing a widespread shortage of qualified health workers of about 50–70% at all Levels—this is more severe in rural districts. Disparities also exist in the distribution of human resources between urban and rural areas.⁹⁷ These shortages are made worse by the shortage of essential medicines and health technologies at the Medical Stores Department on the mainland, the Central Medical Stores in Zanzibar and the health facilities.

Key health data includes⁹⁸:

Total expenditure on health as % of GDP (2014): 6

Private expenditure on health as % of total expenditure on health (2014): 54

Health expenditure per capita (US\$) 52 (2014)

Out of pocket health expenditure as % of total expenditure on health: 23 (2014)

Population access to improved water sources (%) (2014): 56

Population access to improved sanitation facilities (%) (2014): 15

Density of nurses and midwives per 1000 population (2012): 0.436

Density of physicians per 1000 population (2012): 0.031

Limited evidence is available on older people's actual access to health services. The World Health Organization (WHO) country projections on NCDs indicate that NCDs contribute to 31% of deaths in Tanzania.⁹⁹ The 2011 country projections also indicate that more than half of NCD deaths in Tanzania were attributed to people above sixty years of age.¹⁰⁰ The studies from the Adult Morbidity and Mortality Project showed that older people are the most affected group by NCDs due to their vulnerability and age, suggesting that older people suffer more from NCDs compared to other age groups.¹⁰¹ Little national data on the health of older people are available, either because they are not collected or because data are not age-disaggregated. Even the few small-scale studies carried out on NCDs are not age disaggregated.¹⁰²

It is estimated that 5.4% of people aged 50 and over in Tanzania are living with HIV, constituting 15.3% of all people living with the virus.¹⁰³¹⁰⁴ A study on health status and quality of life among adults aged 50 and over in rural Tanzania found

that having a good quality of life and health status was significantly associated with being male, married and not being among the oldest old.¹⁰⁵

What are the barriers to accessing health services, considering both direct and indirect costs of accessing care?

Numerous barriers to older people accessing health care were identified in the literature with financial constraint being the most significant. This is happening in a context where the health care system spends a small fraction of the budget on treating older adult illness and access to care is limited and not a policy priority in most developing countries including Tanzania.¹⁰⁶ In Tanzania, most older people especially in rural areas belong to the poorest and most vulnerable groups. Their capacity to satisfy their basic needs including health reduces as age increases.¹⁰⁷ Despite government policy of free health care for older people, research suggests that only 10% of older people are receiving free health services from public facilities.¹⁰⁸ This correlates to trends in the wider population. In 2010, households provided 32% of total health expenditure in Tanzania.¹⁰⁹

Transport costs are a significant factor in preventing older people accessing health care and costs for hospital care or for medication are high, amounting to 4.3% of spending for older people included in the study^{110,111} Transport was found not only to be expensive but also inaccessible and inappropriate for older people, especially women carers who often appear to be among the poorest.

Other issues found in the literature include: unavailability of medicines at community health care providers, a lack of financial means to pay for health services; and a lack of government assistance when medical treatment is needed¹¹²; shortage of staff; the lack of expertise in geriatrics care among healthcare workers; instances of ageism and discrimination — in one study, 40% of older people said the tone of language used by medical staff was mocking;¹¹³ older people's failure to claim their entitlements due to lack of information and appropriate structures¹¹⁴ and inability to prove their age¹¹⁵; bureaucratic hindrances; and reluctance of health care staff and local government officials to adequately deliver older people their entitled services'.¹¹⁶ Other broader issues include: poverty; unequal distribution of income and resources; poor budget allocation for health care, including poor resource distribution; lack of human resources for health care affecting in turn health care provision and quality of health care; gender inequality, particularly discrimination of women; lack of social protection and specialised health care for elderly; geographical location; and poor links between policy and practice.¹¹⁷



Photo: Development Action (CamillaWilliamson) Mozambique

Key informant interviews: Barriers to access to care for older persons

KIIs at all levels emphasised the supply side barriers to older people accessing health care, especially inadequate services and sometimes lack of equipment (and laboratory apparatus and supplies) to enable staff to do proper diagnosis of older people's health conditions. In dispensaries very few investigations (maybe only for malaria and clinical diagnosis) are available. Lack of essential medicines and other health supplies limits older people's access to proper medication and diagnosis. As remarked by KII at national level, "We have the policy of free medical access to health care for older persons but the health system has a lot of challenges. For example, there are sometimes no medicines, so even if services are free, if there are no medicines, there are no services".

Inadequate human resources for health, especially low staffing, are the biggest problem. In Mbarali district, the shortage is reportedly about 52-57% in the health care system. A common problem of mismatch between the staff needed and those recruited was raised. It was noted in KIIs that several posts are covered by those with no qualifications. KIIs, particularly those with UN agencies like WHO, emphasized the issue of inadequate accountability mechanisms or poor enforcement of existing mechanisms to hold duty bearers to account. They also alluded to resource shortages that are exacerbated by inefficient use of limited resources. It was further noted that medicines for NCDs are very expensive and may not be part of essential medicines and health supply packages in many facilities. Demand related factors, especially financial difficulties, further hinder older persons from effectively using referrals to hospitals that provide more specialised care.

How do older men and women pay for the costs of accessing health services?

There is limited literature on how older persons pay for their health costs. However, it is clear that the out of pocket expenditure for health services in Tanzania is high, particularly for older persons in respect to meeting transport costs¹¹⁸, food while at health facilities, as well as buying medicines that are in many cases not available in the health facilities.¹¹⁹

The impact of cash transfers on access to health services

There is limited information on the impact of cash transfers on older people's access to health services. Since 2013, the Tanzanian government has worked to implement the nation-wide Productive Social Safety Nets (PSSN) programme, which is a cash transfer conditioned on family's participation in education and health related services and elements of public works and livelihood enhancement, depending on the situation of the recipient. This targets the extreme poor (calculated as about 10% of the population of 50 million).¹²⁰ The key criteria for the cash transfer programme among others include: vulnerable children and elderly people with poor health, with no caregivers and those experiencing severe deprivation. Benefits are provided based on the numbers of vulnerable children and older people (aged 60+) and households are paid bimonthly or six times each year. The amount ranges from a minimum of \$12 to a maximum of \$36. Conditions attached to the cash transfer are related to ensuring that children go to primary school and that both children and the elderly visit health clinics.¹²¹ A 2014 World Bank-led evaluation provided information about the impact of the

Conditional Cash Transfer pilot, highlighting, amongst other benefits that 31-34 months into the programme participating households were attending clinics less often but were healthier and their members were 5% less likely to be sick (average across all ages). Health improvements due to the Conditional Cash Transfer programme were even more marked for the poorest half of the treatment households. They experienced a half a day per month reduction in sick days (average across all ages). Participating households were also found to be much more likely to finance medical care with insurance and much more likely to purchase insurance than were their comparison counterparts. Findings indicated that households focused on reducing risk and on improving livelihoods rather than principally on increasing consumption.¹²²

Another programme providing cash transfers to older people in Tanzania is the Kwa Wazee cash transfer programme which has been running in the Muleba district since 2003. Kwa Wazee, a small NGO, has operated a comprehensive support programme for older people on the basis of pensions and child supplements from its headquarters in Nshamba in the Muleba district in Kagera. Findings from the 2014 study, which focused upon the Ngenge ward in the Muleba district in Kagera Region, found more positive results about the impact of the programme on health outcomes. Findings included that the cash transfers increased the average income of recipient households by almost 80% leading to higher expenditures on food, but also higher spending on investments, household items and healthcare; and households receiving a pension spent substantially more on expenses for hospital and medication (5% versus 2%). Despite this, the report notes that: 'healthcare expenditure still remained low, and inability to buy medicine or to get adequate treatment at a health centre were dominant themes in most interviews with pensioners'.¹²³

Zimbabwe: Country Overview

What is the health status of older men and women in Zimbabwe?

Zimbabwe is a country characterized by a predominantly poor rural (33% living in urban areas) with limited access to safe water, housing, sanitation, and health care¹²⁴. People older than 60 make up 6% of the 14.15 million total population of Zimbabwe (World Bank 2013). Life expectancy at birth was estimated at 60.7 for both sexes (2015), life expectancy at 60 was reported to be 17.8 years, and Healthy Life expectancy is calculated at 11 years.¹²⁵ The 1996 Poverty Assessment Study Survey classified 78.5% of older persons in Zimbabwe as poor or very poor.¹²⁶

Communicable diseases especially HIV (26.8%), lower respiratory infections (8.3%), preterm birth complications (4.6%), diarrheal diseases (4.6%), birth asphyxia and birth trauma (3.9%), TB (2.8%), acute respiratory infections and maternal, new-born and childhood illnesses are the main causes of morbidity and mortality in Zimbabwe.¹²⁷ In Zimbabwe, NCDs, especially cardiovascular diseases, cancers, chronic respiratory diseases and diabetes have been reported to increase in prevalence with age (among populations between 30 and 70 years).¹²⁸ Non-communicable diseases are estimated to be responsible for 31% of total deaths in Zimbabwe.¹²⁹ Additional information on causes of mortality and morbidity is included in the literature review.

No other large-scale or national self-reported or objective data on older people's health was found in the literature. However, the impact of HIV/AIDS on older people in Zimbabwe, in particular, and in Africa in general is high. WHO undertook a study to assess the impact of AIDS on older people, with a focus on the 50-years and-above age group¹³⁰ and provided evidence on the disastrous impact of HIV/AIDS witnessed in Zimbabwe. A lack of financial resources was identified as one of the greatest hindrances to older people's ability to provide adequate and sustainable care. The burden of care is generally on the 60 years and higher age

group who care for 73% of the orphans living with respondents interviewed in the study.^{131,132} A study on older caregivers' health by WHO found that only 30.4% reported being in good or very good health. Of those in poor health, 58.4% attributed it to providing care to others. Older caregivers suffer from emotional and physical illnesses, such as worry/stress, blood pressure, headache, dizziness, chest pains, heart problems, asthma and stomach problems. This study found that a significant number of older people are infected (about 4%).¹³³ The mental health situation of older persons was reported as a concern.

Care for the mentally ill is usually poor. For example, Okello cited in Tawona¹³⁴ argues that there is lack of awareness and understanding of dementia and depression, resulting in stigmatization, as well as barriers to diagnosis and care which impact on caregivers, families and societies physically, psychologically and economically.¹³⁵

What are older people's recognised social protection and health service entitlements? What evidence is there on older people's actual access to cash transfers?

As a United Nations member state, Zimbabwe adopted the Principles for Older Persons, Resolution 46/91 passed by the General Assembly in 1991, and the Madrid International Plan on Ageing adopted by the World Assembly on Ageing in 2002. This notwithstanding, Dhemba and Jotham argue that older people in Zimbabwe are languishing in poverty mainly due to the absence of comprehensive policies focusing specifically on the elderly.¹³⁶

Existing legislation to address some of the needs of the older population include: the Social Welfare Assistance Act of 1988, the Disability Act of 1992, the Private Voluntary Organization's Act and the National Social Security Act with respect to the Pensions and Other Benefits Scheme. On July 16, 2012, Zimbabwe's House of Assembly, passed the Older Persons Bill. This legislation was first introduced in 2002¹³⁷ and aims to promote the welfare of the elderly community in Zimbabwe. The legislation includes provisions on the distribution of social welfare assistance to needy older persons. To finance these functions, the legislation requires the establishment of the Older Persons Fund.¹³⁸

The state operates two mainstream social protection measures: a) Public Assistance Programme and b) the Pensions and Other Benefits Scheme. The Public Assistance Programme, which is administered by the Department of Social Services, caters for the elderly and other vulnerable groups in the population. This scheme provides for means-tested non-contributory maintenance allowances to the poor, inclusive of the elderly. The public assistance allowance is US\$20 a month (as per 10 November 2012) which is far below the United Nations "official" poverty line of US\$1.25 per day.¹³⁹

The state also operates the Pensions and Other Benefits Scheme under the auspices of the National Social Security Authority of Zimbabwe. This scheme, which is contributory and compulsory was introduced in 1994. Because of its contributory nature it only caters for employees in the formal sector and since unemployment levels are very high in Zimbabwe most elderly do not profit from this scheme.¹⁴⁰

Zimbabwe's Older Persons Act of 2012 does not guarantee social and economic security in old age as applicants are means-tested. It also excludes those aged 60 to 64 years as the minimum qualifying age threshold for the public assistance is 65 years and above and yet the onset of old age as defined by the United Nations is 60 years.¹⁴¹ Similarly, all the social protection schemes apply to those that are formally employed.¹⁴² Hence, large sections of workers in the informal sector are not covered by existing public social security systems.

In 2013, Zimbabwe's Ministry of Public Service, Labour and Social Welfare (MPSLSW) began implementing the Harmonised Social Cash Transfer (HSCT) programme in 10 new districts. The HSCT targets households that are both labour

constrained and food poor, as defined by MPSSLW. Eligible households receive \$10 to \$25 a month depending on the household size. By February 2014, 55,509 households in 20 out of 65 districts in the country were covered. Coverage of the whole country was to be reached by 2015, with 250,000 poor families in all 65 districts of Zimbabwe to be included in the programme.¹⁴³ In addition, 'Support to the Older Persons' programme is a public non-contributory scheme funded by the Government which caters for older persons above the age of 65 years who are in institutions where admission is means-tested.

A wide range of other programmes have been put in place to support vulnerable people, such as the Assisted Medical Treatment Order, the Food Deficit Mitigation Strategy, Child Protection Services and the Support to Persons Living with Disability Programme.

Government policy is to provide free-of-charge health services for pregnant and lactating mothers, children under five and those aged 60 years and over, but the policy has proved to be difficult to implement. Currently, in the absence of substantial government financial support, user fees provide the main income for many health care facilities, enabling them to provide at least the minimum service.¹⁴⁴

Key informant interviews: cash transfers

UNICEF reported that the donor funded cash transfer, provided as part of the Harmonized Cash Transfer Programme, is functioning today in 19 districts covering 18% of the poorest households (55,000 households), benefiting approximately 245,000 people. Information on the number of older people covered by the programme is not available. However, it was reported that, in fact, the Harmonized Cash Transfer Programme ceased operating in May 2016. Donors reportedly expected the government to gradually take over the cash transfer programme but this has not occurred and donors feel the government's commitment is insufficient. KIs are therefore expecting the programme to resume in March 2017 but with significant reductions, with it being limited to 8 districts (24,000 households).

Additional issues with this cash transfer when it is operating were also raised by KIs, particularly in regard to its low coverage. It was also stated that the selection criteria for beneficiaries is unclear causing confusion and anger. There were a number of stories about people thinking they had been enrolled, as they were assessed by ZimStat, but then not hearing back from them and not receiving the cash transfer. Consequently, there are lots of complaints about corruption. It was felt that there is need for a communication strategy on how it operates.

Key informant interviews: caring for grandchildren

The challenge of caring for grandchildren, either as a result of parents dying or as a result of them abandoning their children, is a significant issue facing older people in Zimbabwe. One KI said that according to the 2012 population census a total number of 5,787,838 orphans were registered (either father, mother or both dead) and that most of these orphans are taken care of by their grandparents. The Government programme for orphans is reportedly insufficient to provide support to all older caregivers and the programme to support poor families to send their children to school, the Basic Education Assistance Model (BEAM), does not cover all older caregivers. UNICEF in fact reported that the programme had ended in 2014. Consequently, KIs said older people do not have money enough to feed grandchildren properly or to pay for their school fees, uniforms and transport to school.

What health services are available in Zimbabwe and what evidence is there of older people's access to health services?

The Government of Zimbabwe adopted the Primary Health Care Approach as a strategy to deliver health services. During the 1990s, the deteriorating economic environment resulted in the unavailability of essential medicines and critical health care workers¹⁴⁵. The 2009-2013 National Health Strategy for Zimbabwe aimed to provide a framework for immediate resuscitation of the health sector (Health System Strengthening), and to put Zimbabwe back on track towards achieving the Millennium Development Goals. Service coverage in Zimbabwe improved between 2009 and 2014, but lower quality of care and inequities in service utilization continue to disproportionately affect poor populations. A recent study identified serious quality shortcomings in the capacity of several hospitals to screen for and treat hypertension¹⁴⁶.

The Government of Zimbabwe is now implementing a results-based health provision programme, which has become widely known among people living in rural areas across Zimbabwe. The programme, which is funded by a \$15 million grant from the World Bank's multi-donor Health Results Innovation Trust Fund, provides subsidies to rural health clinics and hospitals based on their performance in delivering a package of free health services to pregnant women and children under five. As of March, the programme covered 387 health facilities – mainly rural clinics – in 18 of the country's 62 districts, with a population of 3.46 million.¹⁴⁷

Older people in Zimbabwe are entitled to free health services. However, as Kasere argues 'there is almost a total absence of a health care delivery system specifically for the health needs of the elderly'.¹⁴⁸ Furthermore, older people are not benefitting from free health services because hospitals and clinics are always congested and there is shortage of drugs and medical personnel.¹⁴⁹ According to Kasere, specific health care services for older people are practically non-existent: 'the elderly have to make do with an existing general care system which is not only inadequate for their specific needs but is also not easily accessible to them'.¹⁵⁰ A WHO study found that health service centres and clinics are often inaccessible to the older people, due to long distances and of little use because of a shortages of drugs. This study suggests the government has not demonstrated concrete commitment to the health of older people in the country; thus the health system tends to overlook the health of this section of the population. The situation is worse for older care-givers in the context of high HIV prevalence. The study found that access to and use of health services among older care-givers were very poor due to the extreme poverty of many of the care giving households.¹⁵¹

Key health system statistics include:

Health expenditure, total (% of GDP): 6 (2014)

Private health expenditure (% of total health expenditure): 62 (2014)

Health expenditure per capita (US\$) 58 (2014)

Out of pocket health expenditure (% of total expenditure on health) 36 (2014)

Population with access to improved water source (%) 77 (2014)

Population with access to improved sanitation facilities (%) 37 (2014)¹⁵²

Skilled health professionals' density (per 10 000 population) 14.2 (2005-13)¹⁵³

Key informant interviews: access to health care

A number of KIs indicated that the AMTO document (Assistance Medical Treatment Order) under which older people can access free medical treatment, does not work anymore, since the Government is under severe economic pressure. As a one KI said, "Though health services are said to be

free at public health facilities, the reality is different. In fact, public health services have widely collapsed”.

No specialised geriatric care was reported to exist in Zimbabwe and KIs reported that the training of doctors and nurses does not include a subject on geriatrics. For that reason, ZOPA and other KIs spoke positively about the BHOPA’s work in Zimbabwe, in which health staff have been given some basic knowledge about gerontology. Community health workers have also reportedly been trained under this project, helping to fill some of the gaps in the health system in relation to palliative care for older people.

What are the barriers to accessing health services, considering both direct and indirect costs of accessing care?

Despite Government policy being to provide free-of-charge health services for people aged 65 years and above, the policy has proved difficult to implement. The decline in government funding has not only caused a deterioration in Zimbabwe’s health-care services, but it has also transferred the financial burden onto patients in the form of user fees, that obstruct poor people’s access to health services.¹⁵⁴ User fees that are often applied in an ad hoc way and vary from provider to provider, are the main source of income for many health care facilities, enabling them to provide the minimum service.¹⁵⁵

In addition to costs, the other barriers to access of health services experienced by older people are congestion in hospitals and clinics, the shortage of drugs, and the absence of medical personnel trained in geriatrics.¹⁵⁶

How do older men and women pay for the costs of accessing health services?

There is limited literature on how older persons pay for their health costs. However, it is clear that the out-of-pocket expenditure for health services in Zimbabwe is high, particularly for older persons. Not only do they have to meet their own costs but they also often shoulder the burden of orphans and vulnerable children. Even where older persons can obtain free health services, they are faced with the high transport costs of reaching health facilities, paying for food and accommodation while at the health facilities, as well as buying medicines and other health supplies.¹⁵⁷ Maredza collected data from 499 households in Harare urban and Seke rural districts of Zimbabwe to investigate the economic consequences of illness and of paying for health care in Zimbabwe. This study found that households at all levels of wealth incurred catastrophic health expenditure (CHE). Poor households, households with members above 65 years, female headed households, households with member(s) suffering from chronic illness and households with greater use of health services were at higher risk of incurring CHEs.¹⁵⁸ Moreover, less than 10% of the population has health insurance, of which employer-based health insurance accounts for 50%. Thus, most of the population, especially those not formally employed, remain vulnerable to financial shocks from healthcare expenditures¹⁵⁹.

The impact of cash transfers on access to health services

There is limited information on the impact of cash transfers on older people’s access to health services. Some evaluation reports on emergency cash transfers in Zimbabwe show that in using cash transfers, poor people prioritise basic needs – food, shelter, healthcare and education – for the majority of their expenditure^{160,161}. This information is not age-disaggregated.

Documents provided by KIs during the field research provided some more information. A 12-month impact evaluation of the Harmonized Cash Transfer

programme found that baseline impacts on consumption were mostly found for small households with limited or no impacts among larger households.¹⁶² This pattern was reportedly true for food poverty rates, diet diversity, welfare, school attendance, asset ownership and exposure to shocks. The impacts on consumption were deemed relatively small compared to other cash transfer programmes because the programme was too young to have generated a perceived change in permanent income. In regard to health, the study found some positive impacts on care received by the chronically ill in labour-constrained households, though the study did not look specifically at access to health services. Further information including findings of a recent evaluation showed improved health status as a result of the cash transfer, but again this does not discuss access to health services specifically.¹⁶³

Cross country overview

The country-level literature review found limited data and research available on older people's health status, their access to health care and social protection. In addition, inconsistencies in the data that are available in each country hinder the ability to make comparisons. However, a number of general points emerge from the literature review.

Health status

Limited country-level data was available on older people's health in all target countries with available studies largely being independent, covering small numbers of older people and focusing on self-reported health. There is a clear need in all settings for age-specific and age-disaggregated data. In particular, the national demographic and health surveys should include older men and women (most currently end at age 59), and data should be age-disaggregated.

Nevertheless, the evidence that does exist illustrates that the target countries have similar age profiles, with the proportions of the population over the age of 60 ranging from 4.8% in Ethiopia to 6% in Zimbabwe, while life expectancy at birth for both sexes ranges from 57.6 for both sexes in Mozambique (2015) to 64 for both sexes in Ethiopia. Leading causes of deaths in all countries are also similar and include malaria, prenatal and maternal death, acute respiratory infection, nutrition deficiency, diarrhoea and HIV/AIDS. Non-communicable diseases in the target countries are said to account for 30% of total deaths in Ethiopia, 23% of total deaths in Mozambique, and 31% in Tanzania and Zimbabwe.

The available data illustrates that the target countries are at the beginning of the epidemiological transition, where the vast majority of both mortality and morbidity is still caused by communicable disease but where the prevalence of NCDs and of associated risk factors is rapidly increasing.

Social protection and health care entitlements

Mozambique, Tanzania and Zimbabwe were all found to have both social protection and health policies specifying entitlement for older people, including cash transfers, though the coverage and level of cash transfers are low in each setting. In regard to health care, Mozambique, Tanzania and Zimbabwe all had a policy of fee exemptions for older people. In Ethiopia, older people were included as potential beneficiaries of the PSNP programme but no health policies or entitlements for older people specifically exist. In Ethiopia, a small number of older people are also beneficiaries of NGO-initiated social protection schemes; these kinds of schemes were also found in Tanzania. In all countries, data on older people receiving support from national social protection programmes is unavailable

or extremely limited, meaning a comprehensive picture of older people receiving cash transfers or other social protection entitlements is not possible.

The literature illustrates that access to health insurance is extremely limited in all countries, even where Community Health Insurance Schemes were found, as in Tanzania and Ethiopia.

Access to adequate health services

Evidence of older people's access to health services was similarly difficult to obtain in all countries. Limited funding and scarce material and human resources were reported as significant challenges in delivering health care to the general population in all settings. Distance to health facilities is often significant in all countries and high out-of-pocket health costs per capita were reported in Tanzania (\$28), Ethiopia (\$32) and Zimbabwe (\$36).

Few policies regarding older people's health were found in the target countries, and reports of no training of health professionals in geriatric care and a lack or non-existence of specialists were frequent.

Some research focusing on older people's access to health services was found in Ethiopia, Mozambique and Tanzania, in which numerous barriers to older people accessing health care were identified. Across the studies, financial constraints were reportedly a significant barrier, while other issues identified included: distance to health facilities; transportation; physical incapacity to get to the health service; lack of medicines at health centres; shortage of staff; lack of expertise in geriatric care and/or NCDs among healthcare workers; de-prioritizing of older people for essential services; under-financing of health systems; age-discrimination; non-age-friendly health facilities; lack of family support to help with transport; lack of trust in the healthcare service; older people's failure to claim their entitlements; and bureaucratic hindrances.

Little evidence was available on how older people pay for health services, with only one or two studies being found on this in Ethiopia and Mozambique.

The impact of cash transfers on access to health services

Virtually no evidence on the impact of cash transfers on older people's access to health care was found in the literature, highlighting the importance of the present research. There were some reports of the positive effect of cash transfers on accessing health services in evaluations of cash transfer schemes in Ethiopia, Mozambique and Tanzania where money from the cash transfers was said to be spent on health care-related costs and some evidence, in the literature, of the positive impact of cash transfers on health, irrespective of access to services.

In Ethiopia, the discussion by a KI in Tigray of the joint delivery of health and welfare services when cash transfers were paid and at public works days, suggest a positive example of how services could be integrated to improve access to health services for older people and, if those services are of sufficient quality, to improve health status more broadly. These issues are discussed further in the following Sections of the report.

4. FINDINGS FROM FOCUS GROUP DISCUSSIONS AND KEY INFORMANT INTERVIEWS

Introduction

This section focuses on the outcomes of the Focus Group Discussions (FGDs) and the Key Informant Interviews (KIIs), which were conducted in Ethiopia, Mozambique, Tanzania and Zimbabwe by Development Action in October 2016. The findings are discussed by research question. These are introduced with detail of the 15 Focus Group Discussions, including 134 participants, and 30 Key Informant Interviews, together with an overview of the socio-economic status of older people who participated in the FGDs.

Each section is structured according to themes that emerged from the data, and evidence from the FGDs is compared and contrasted. Individual case studies are included at the beginning of each section. These were chosen to reflect some of the issues that are addressed within each section and are not necessarily representative of all the data which is discussed.

Field research

Ethiopia

- 2 FGDs in Bahrtseba, Tigray (1 male group, 1 female group) (rural)
- 1 FGD in Addis Ababa (male group) (urban)
- 6 KIIs with representatives from:
 - Director at the District Health Facility, Bahrtseba;
 - Cash Transfer Implementer, Ministry of Labour and Social Affairs, Mekele;
 - Head of Directorate, MOLSA, Addis Ababa;
 - Ministry of Health, Addis Ababa;
 - Ethiopian Elderly and Pensioners National Association (EEPNA), Addis Ababa;
 - St George Welfare Association, Addis Ababa.

Mozambique

- 2 FGDs in Maputo (1 male group, 1 female group) (urban)
- 2 FGDs in Manhica (1 male group, 1 female group) (rural)
- 8 KIIs with representatives from:
 - Department of Prevention and Education, Ministry of Health, Addis Ababa;
 - Department for Older People, Ministry of Gender, Addis Ababa;
 - Social Welfare Technician, Manhica;
 - Prevention Worker (Health), Manhica;
 - PSSB lead, HelpAge Mozambique;
 - District Coordinator Community Health and APEs, Moatize, Tete;
 - Assistant for Social Action, Chiuta District Services for Health, Women and Social Action (SDSMAS), Tete;
 - Public Health and Community Involvement, Department of Health;
 - Provincial coordinator Department of Health, Tete.

Tanzania

- 2 FGDs in Mbarali (1 male group, 1 female group) (rural)
- 2 FGDs in Umbaruku (1 male group, 1 female group) (urban)
- 7 KIIs with representatives from:
 - Three members of Ministry of Social Welfare and Health, Dar es Salaam;
 - HelpAge Tanzania, Dar es Salaam;
 - Health Economist, WHO, Dar es Salaam;
 - Community Development Worker, Mbeya;
 - Health Worker at Mbarali Hospital.

Zimbabwe

- 2 FGDs in Goromonzi (1 male group, 1 female group) (rural)
- 2 FGDs in Svishavane (1 male group, 1 female group) (urban)
- 9 KIIs with representatives from:
 - HelpAge Zimbabwe, Harare;
 - National Older Person's Board, Harare;
 - Svishavane Hospital, Svishavane;
 - Zimbabwe Older Persons Association (ZOPA), Harare;
 - CCDS, Svishavane;
 - Makumbe District Hospital, Goromonzi;
 - NCD Department at Zimbabwe's Ministry of Health and Child Care, Harare;
 - UNICEF, Harare;
 - Social Services Officer at the Goromonzi District Department of Social Services, Goromonzi.

Socio-economic status of older people participating in FGDs

While the general situation of older people, their vulnerabilities and their sources of income were not key research questions, information on these aspects were collected in order to contextualise the research.

Hazel, 50, Goromonzi, Zimbabwe

Hazel is a 50 year old women, who lives with her husband, a 73 year old, and 10 children, one of which is their own; the others are those of her sisters who died.

Hazel's husband was a farm worker for many years but now he is not able to work anymore. Like most farm workers, he was not on a pension scheme, so he has no income today. Hazel does piece work whenever an opportunity comes up, such as washing clothes and brick making. But these opportunities have become scarce due to water shortage in the community. Moreover, there is always the risk that clients do not pay the agreed amount: "One ends up receiving nothing after the work has been done".

Hazel and her husband have a small garden where the couple produces vegetables for consumption. Whenever needed they sell some vegetables for cash to provide for other needs.

Other needs are many as there is a household of 12 people to look after. The orphans are grown up children that should go to school, but it is very hard to keep them in school due to the economic crisis the country is experiencing meaning less support is available for children's education. "It is very hard to see the youngsters hanging around, willing to go to school, but we do not have the money to send them. Instead, the children have to contribute for the household income, doing piece work. I am very worried about their future".

Hazel would love to have her own business, a small income generating activity, like chicken breeding, but she does not have the money for the initial investment. "I feel I am really struggling for survival; one never knows if there will be something for the children to eat the next day". Hazel says, "I am glad to receive some food aid from the church every now and then, but this support is too irregular to count on it".

Hazel struggles with health problems. She went to the hospital to treat hypertension and diabetes but says, "now I don't go anymore". "There is no money to pay for the medicines. I hoped to be included in the Cash Transfer Programme but these young people came into the village only to ask many, many questions. They wanted to see inside our house, who was there, who earns money, how many chairs and tables we have, all these silly questions. But in the end my family was not considered and we don't know why".

Hazel says that one of her grandchildren, a young boy, suffers from asthma. "We are now using herbs and other traditional remedies. A neighbour recommended goat milk to treat the asthma of my boy. I am not sure if it worked, but he feels better now".

Hazel thinks that the future is not bright for her and her family. She sees that her own children and grandchildren are struggling and she wonders: "what future will there be for them?"

Challenges facing older people

All the older people who participated in the FGDs live in poverty and identified numerous challenges in their lives.

In Bahrsteba, a remote village in the Tigray region of Northern **Ethiopia**, key challenges identified by men and women included shortage of food, as a result of both drought and lack of income; difficulty accessing water as a result of distance and poor mobility; health, particularly in regard to receiving adequate treatment for common health conditions; and their ability to meet other basic needs, including clothing, shelter and soap. Participants in Addis Ababa also identified the struggle for adequate amounts of food, for access to quality health care and shelter and clothing. Other general challenges facing older people in Ethiopia, included being unable to work because of labour constraint, included relying on a small plot of land to support large families; having no family or no family support; and disability.

In **Mozambique**, as in Ethiopia, the leading challenges facing older men and women in urban and rural areas were also a lack of food, income insecurity, health problems and a lack of access to health care. Other general issues discussed by older people in Mozambique included the impact of inflation and drought and its effect on work opportunities and food production. People also spoke about not being able to work as a result of physical problems due to old age. A number of women in Manhica said they were widows.

In **Tanzania**, older people in all settings spoke about lack of income for basic needs, including food. In Mbarali, they discussed the drought and its effect on agricultural production. In addition, in this community, both women and men identified supporting grandchildren and having enough money to provide for their basic needs, including education needs, as a key challenge. These were children who had reportedly been abandoned by their parents and were now relying on grandparents with no support from their fathers and mothers. A lack of energy to engage in economic activities like farming was also discussed. Women in Mbarali also raised being faced by accusations of being witches and the discrimination and stigma faced as a result of psychological problems, such as dementia.

Women in Umbaruku, Tanzania, also identified looking after grandchildren as a key challenge in addition to access to health care, income insecurity and widowhood. In regard to the latter, women spoke about not getting sufficient support and the effect of related disintegration of social networks. Men in Umbaruku also discussed a lack of access to land for cultivation, which was associated with food insecurity, the low coverage of the TSAF cash transfer and, listed as the top challenge, disease and access to appropriate medicines.

Women in Goromonzi, **Zimbabwe**, discussed the discrimination older people face because of their age and the feeling of being useless because they perceive that they cannot contribute to society. They said they were rejected in development activities in the community and in leadership and decision-making. Men in Goromonzi also spoke about difficulties in finding work, a lack of housing and having no family for support.

In Zimbabwe, challenges facing older men and women again focused on a lack of food and nutrition, and poor health and lack of medical attention or money for transport and medication. In Goromonzi, women also discussed the exclusion from cash transfer programmes and a lack of farming equipment, while both men and women also identified the burden of caring for vulnerable and orphaned children. Many of these were said to be from young mothers who did not have support from the father and stayed at home also relying on the help of the grandparents. These issues were also discussed in Svishavane, but when asked to identify the top three challenges, people spoke about lack of food and income, and suffering from chronic disease. Men in Svishavane also identified drought, which all other communities in Zimbabwe had discussed as general challenges for older people. Other issues discussed included discrimination as a result of poverty and care giving.

KIIs in Zimbabwe identified climate change as a threat to older people's livelihood through its effect on subsistence farming and access to clean water; although this was not a challenge identified by older people. Similarly, the erosion of traditional family structures in Zimbabwe was mentioned as a major threat to the care of older people.

Vulnerabilities

Considering these challenges, FGD participants across all four target countries identified a range of variables upon which older people's level of vulnerability depend. These included: physical and mental health status; access to housing; access to income; inclusion in social networks; access to family support; number of meals per day; age (people felt the older you are the more vulnerable); receipt of a cash transfer; ability to work; access to work; access to health services; providing care for grandchildren; providing care for a family member; having economic assets, for example, land or livestock; having a voice in the community and inclusion in decision making; and respect.

Sources of income

Older people who participated in FGDs across all countries identified a range of income sources.

In **Ethiopia**, people said that for the least vulnerable, the most common sources of income were agriculture, subsistence farming and government support. People said the more vulnerable among them relied on family and community support as well as government, church and charity donations and begging. In Addis Ababa, few ways of making money were identified. Most said they received support from family members and also relied on cooperatives, which helped them to loan money for income generating activities. Men in Addis said the most common source of income for more vulnerable groups was begging. For many of those who were receiving a cash transfer this was the main source of income.

In **Mozambique**, both men and women in Manhica and Maputo spoke about trying to get work on farms – particularly day work. However, as a result of the drought this work was reported to be very scarce at the moment. To survive when there is no work, people in Mahnica said they would try and get money in advance for the promise of work on land. In Maputo, both women and men spoke about odd jobs they were able to do or income generation activities, such as investing their PSSB money in fruit and vegetables to sell, or, for men, finding a plant that was used for roofing and selling that.

One woman in the FGD in Maputo said she had children who are working and are able to give her some money, however she was in the minority. Participants in Maputo also said that some were benefitting from NGO support but none were present in the FGDs. People in Manhica said they did not receive money from family or the community, nor from the church or other organisations.

As in Ethiopia, for many in Mozambique, the PSSB cash transfer was the only source of income, though in every community it was said to be very little, only affording them one meal.

In **Tanzania**, men and women spoke about work they engaged in at farms, vegetable growing, small cultivation or gardening, wood chopping or rice milling, and selling food or sewing. In Mbarali, the most vulnerable were said to benefit from their grandchildren working in similar roles. In some communities, FGD participants said local leaders help older people with orphans and provide them with food and uniforms for their grandchildren, but this was identified as very isolated help. Men in Mbarali also spoke about support from children, for the least vulnerable, or renting out farm land to earn some rent. For the most vulnerable people in both Mbarali and Ubaruku, begging was also a means of survival and in Ubaruku people said some received support from the church.

Similar income sources were described in **Zimbabwe** where again older people in all FGDs discussed piece jobs, such as brick making, gardening, trading vegetables, gold panning (in Svishavane) or livestock breeding, though they said that agricultural activities were severely hindered because of the drought. In Goromonzi, women said that children would sometimes skip school to fetch water for shop owners who would give them money. Others in both Goromonzi and Svishavane mentioned food aid, support from the church or other donors (particularly for orphaned and vulnerable children), and food for work schemes. Others said some received support from children, but that this was very little. For those with their own house, older men said they could rent a room or space. People said the most vulnerable had no source of income. People also spoke about reducing the number of meals per day when they have no income. Again, cash transfers were a critical source of income for the few who received them.

Overall, it is interesting to note the common trends across the four countries in terms of livelihood for older men and women, which include:

- Agriculture activities especially small vegetable gardening for subsistence agriculture and day agriculture labour to farms – although these were severely affected by the drought in all countries and the ability/energy to continue to work, as well as age discrimination.
- Other sources of income, including begging for the most vulnerable and support from the church or charitable organisations were discussed in all countries.
- Cash transfers were identified as critical sources of income by people receiving them in all countries.

Family and community support

The support older people receive from their families appeared to vary across the four countries. In Ethiopia, the family seemed to still be an important source of support to research participants, whilst in the other countries children were rarely or never identified as a source of support or income by older people. As women in Ubaruku, Tanzania said, there's been a "Disintegration of the social network - communal support has declined – this is not how it used to be". In Manhica, Mozambique, older women said, "children can't offer support as they don't have the money and don't care". However, in a few cases in each of the other three countries, grandchildren were said to provide support and income for their grandparents, despite being only children. For example, supporting the family by working or providing care to a grandparent when sick.

In all countries, widows or those without support from family were also identified as being more vulnerable because of the lack of family support and more broadly as a result of exclusion from social networks. Poverty was reported to exacerbate this exclusion, meaning that people could not participate in community events or ceremonies, as they could not contribute. This meant that important opportunities for interaction, which might lead to support, were denied them. As one man in Bahrtseba, Ethiopia said, "I am isolated from community because neighbourhood activities require something being taken to offer to the hosts. I am not able to offer anything and so I cannot go".

In all countries, as detailed above, access to family and community support was identified as a key variable in an older person's vulnerability: those with support from family were said to be less vulnerable and those without more vulnerable. The role of family and community support in regard to access to health care services is discussed further below.

Health status of older men and women in the target countries

The self-reported health status of the older men and women in the four countries included in this study presented similar trends. These data should be interpreted with care, since limited health literacy and limited engagement with health providers may mean that older people have health conditions, but are unaware that they do.

Interactions with officials and in focus group discussions indicated that older people commonly suffer from non-communicable diseases (NCDs), including: cancer, hypertension, cardiovascular diseases, diabetes, general body pains, especially around joints (arthritis), urine and faecal incontinence, and eye and hearing problems. A range of mental health issues also appeared common, especially dementia and depression. In regard to infectious diseases, older persons reported suffering from respiratory tract infections and throat illnesses. Typhoid and diarrhoea were also identified as common illnesses among older men and women. HIV/AIDS, which most of the people who are infected do not want to reveal because of fear of stigma, was also identified.

In regard to data related to the health status of older people, although there is some information which has been reported in the country overviews of this report (Section 1), the availability of useful statistics based on diagnosed and not just self-reported health status remains a challenge. As one of the key informant said:

“Data (on health status) is not disaggregated by age groups and no national representative survey on NCDs, including cardiovascular conditions, has been conducted. We focus on the programme and the population as a whole – not on particular age categories like the aged. We do not focus on the elderly as such but on all population groups”. (KII, MOH Ethiopia).

This means that the magnitude of the health challenges faced by older people are not visible in the aggregation of data nationally. The lack of data affects age-specific planning and service delivery and ultimately affects the health status of the older population who are most likely to bear a higher proportion of the disease burden.

The ill health situation of most elderly is exacerbated by intervening variables like poverty and living in rural areas. In most rural areas, access to health is less than the national average and usually rural health facilities are ill equipped, under staffed and the personnel not sufficiently specialised to handle specific health problems that affect the older population. This is discussed further in Question Three.

A major issue affecting health status of older persons that was raised in all four countries is limited access to food. In all FGDs food insecurity was ranked among the top two challenges older persons and their households face. Indeed, even when older people seemed to have access to some land, their households might be labour insufficient. They therefore rarely use the land for productive agriculture that could help them to meet food needs. In their characterisation of vulnerability, access to food – nothing to eat, not being sure of the next meal and having a labour insufficient household – was an indicator of being among the most vulnerable households.

In Ethiopia, Zimbabwe and Mozambique older persons in FGDs and KIIs alluded to the long droughts that had exacerbated the food insecurity for the general population. This negatively affected the health status of the older persons and their dependents. This may also explain why in almost all FGDs, it was reported that food takes the biggest portion of the cash transfer for older persons in both rural and urban areas.

“Food security is one of the main challenges for older men in the group. “Drought is a consistent challenge in our region leading to food insecurity”. The cash transfer (CT) assisted a great deal in us to meet their basic needs – especially food”. (FGD, Men Addis Ababa)

“Food is begged from the church during baptism. It is an obligation to carry food to church – this is given to beggars but baptism does not happen every day this puts some elderly at the risk of starving” (FGD, Men, Mekele)

“Food – we cannot do anything if there is no food, we only pray to God to provide, we can even spend a day without food... We do not have money to buy anything – we can spend the whole day without eating”. (FGD, Women Mbarali-Mbeya Tanzania)

Older people, especially the very old, appeared to have little or no influence when it comes to decision-making for health, affecting their health status. The very elderly described reaching a point where other members of the family make the decisions on whether and when they should access health care. This is similar to the notion of the therapy-managing group described by Jansen¹⁶⁴. Usually, a cost

benefit analysis is usually made concerning this decision and the very elderly are disadvantaged when the younger members of the community, and sometimes older people themselves, feel that the benefits to healthcare seeking for the elderly are dwarfed by the costs involved.

“They see that the person has already grown old and ignore his suffering. There is little that can be done to improve the health of the old man and yet a lot of money has to be spent. Sometimes that money has to be borrowed or children will withdraw from school” (FGD, Men Manhica, Mozambique).

Various additional factors were described as combining and interlinking to affect the health status of older men and women. The vulnerabilities and how older people cope, as well as the poor or limited access to health services, all form a web of disadvantage that undermines the health of older people in the community. Narrative evidence from FGDs and in-depth interviews show that across the four countries, vulnerabilities of all people include limited access to income and livelihood opportunities, cash and food, labour insufficiency, limited participation in community activities/ isolation, poor housing, and limited access to healthcare. Specific barriers to accessing health services and the limitation of these services are discussed in more depth in the section below on health services.

What are older people’s recognized social protection entitlements what evidence is there on older people’s actual access to cash transfer?

Faith, 76, Svishavane, Zimbabwe Faith lives in Svishavane district, with her daughter and four grandchildren. Faith receives a cash transfer. In the beginning this was from HelpAge Zimbabwe but now it is from the Government. She receives \$50 every two month (\$25 per month) because her household is made up of more than 4 persons.

Faith and her family members make a big effort to save some of the cash transfer money. From the savings, Faith bought goats. She plans to increase the number of animals they have so that she can sell them in times of need or hardship. Faith says, “Our biggest challenge is to get food for the family. The grandchildren are in school, so they should eat healthily and have enough food to perform well. But that has not been easy, due to lack of money. Reduced rainfall has prevented us from growing vegetables, which we normally do to complement our food basket and get some extra money through selling. If things do not change, I’ll have to sell a goat to get money for buying the necessary food”.

The table below illustrates the numbers of FGDs’ participants who were receiving a cash transfer, the type of cash transfer and the amount they received. Below this, information collected on the cash transfers and other social protection entitlements is presented. Detail additional to the key research question is also included for context. Where this is the case, no reference to the literature is made as this was beyond the scope of the research.

Location	M	F	Type of cash transfer	Amount	Total # of recipients
Ethiopia – Bahrtseba (rural)	8/10	5/10	Had received the UNICEF, HelpAge, Government cash transfer as part of a 5-year programme. This has now ended and some recipients have reportedly been transferred onto the Government’s PSNP cash transfer.	ETB 155 per month (US\$6.9)	13/20
Ethiopia – Addis Ababa (urban)	4/8	*	Receiving a monthly cash transfer provided by the St George Welfare Association (see below).	Was 155 ETB (US\$ 6.9per) month. Now 100 ETB (US \$4.4)	4/8
Mozambique – Manhica (rural)	1/9	8/11	Government PSSB cash transfer.	310 Mts (US\$4.3)	9/20
Mozambique – Maputo (urban)	3/6	4/6	Government PSSB cash transfer	310 Mts (US\$4.3)	7/12
Tanzania – Mbarali, Mbeya (rural)	9/10	8/10	Government TSAF cash transfer	Reportedly ranges from TZS 10,000-50,000 per month depending on h/h no. (US\$ 4.5 -US\$ 22.9) per month	17/20
Tanzania – Ubaruku (urban)	6/10	9/10	Government TSAF – PSSN cash transfer	Reportedly ranges from TZS 10,000-50,000 (US\$ 4.5 - US\$ 22.9) depending on h/h no.	15/20
Zimbabwe – Goromonzi (rural)	0/5	0/8	No participants were receiving a cash transfer.	No participants were receiving a cash transfer.	0/13
Zimbabwe – Svishavane (urban)	3/7	6/14	Government public assistance programme cash transfer.	\$10-\$25 per month (US\$50 every two months) depending on h/h no.	9/21

Coverage and type of cash transfer

74 / 134 (55%) older people who participated in the FGDs were receiving or had recently received a cash transfer. In Mozambique, Tanzania and Zimbabwe, the cash transfers which were being received were all part of national government programmes that were reported in the Literature Review, including the PSSB cash transfer in Mozambique, the TSAF – PSSN cash transfer in Tanzania and the Public Assistance Programme (Harmonized Cash Transfer Programme) in Zimbabwe. However, it was reported by a key informant that the Harmonised Cash Transfer programme in Zimbabwe had ceased operating in March 2016 causing significant hardship amongst those who had received it. It will apparently resume in October 2017 in some places but not in full, as the government has reportedly failed to commit enough support to the programme to satisfy UNICEF and the World Bank who are the main funders and so it will be reduced to 8 districts from its current 19.

In Ethiopia, the Tigray cash transfer programme that participants had received ran between 2011-2015 and was a joint initiative between UNICEF, HelpAge International and the regional government. This programme reportedly reached 3,767 (2825 female headed) households (6,716 beneficiaries), of which around 40% had children under 18 and 75% were female-headed.¹⁶⁵

The St George Welfare Association cash transfer that men in Addis Ababa received was an independent programme run by the organisation and initiated by the Support to Urban Older People Project funded by HelpAge International, the International Organisation for Migration and United Nations Office for the Coordination of Humanitarian Affairs (UN OCHA). Through the St George Welfare Association, the programme reportedly provided cash transfer to 100 beneficiaries in Addis Ababa (25 men and 74 women).

Neither of these cash transfers were reported in the initial Literature Review.

In Mozambique, we heard both from older people and KIIs that the PSSP had limited coverage. HelpAge Mozambique stated that national data from the shows that 390,000 households are currently receiving the PSSB social cash transfer and that about 94% are older households, while around 4% are people with disabilities and less than 1% are people with chronic illness. In Manhica, 4032 are reportedly receiving the PSSB social cash transfer, including people with disability and chronic illness. The large majority of these people are reportedly women. In Moatize district, 2015 data states that there are 1462 beneficiaries of the (PSSB) (516 male and 946 female).

In Zimbabwe, it was reported that the donor-funded cash transfer programme is functioning in 19 districts covering some 18% of the poorest households, benefiting approximately 55,000 people, around 61% of whom are older people according to UNICEF. This is to be reduced to 8 districts, as described above. There is no information available on the number of older people covered by the running programme.

Eligibility and conditionality

The cash transfers that were reported in Ethiopia, Mozambique and Zimbabwe were all unconditional, as reported in the literature, while the PSSB in Tanzania was conditional a family's participation in education and health related services, and community sessions on health, nutrition and sanitation every two months. In Ethiopia in Tigray, however, health and welfare services were present at the pay points on days when the cash transfer was paid, increasing people's access to these services.

In addition, in all countries, none of the cash transfers were universal and a number of issues were raised in regard to eligibility by both FGD participants and key informants. The eligibility criteria were determined at either local or national

level and even where national criteria exist, inconsistencies or a lack of clarity in the criteria were reported by key informants and FGD participants. This was particularly the case in Zimbabwe. Generally, criteria nearly always appeared to include at least vulnerability/poverty and in the Ethiopian and Zimbabwe cash transfers, age was also a criteria. One stakeholder in Zimbabwe said that "The eligibility criteria seemed not to take into consideration the vulnerability of older people". In all the systems except in the case of the St George's Welfare Association in Addis Ababa, Ethiopia, the amount that people received depended on household numbers and how many dependents there were.

In Zimbabwe, eligibility was reported as a divisive issue. Men who participated in the FGD in Goromonzi, none of whom were receiving the cash transfer, said that "people in the community do not disclose if they receive cash transfer" and anger was expressed in other FGDs in Zimbabwe about some receiving the cash transfer and others not. In addition, in Tanzania people also felt there was inequality in the provision of the cash transfer. Men in Umbaruku, Tanzania, said "it's unfair because the remaining elderly are equally vulnerable". In Mozambique, there were multiple reports of people being registered and accepted onto the programme but not receiving any money as the government was not in a financial position to extend the benefit.

Modality of access

The cash transfers received by FGD participants were paid in cash or electronically and all of them were paid at a specific location and in-person even if this was an electronic payment. The pay points were reportedly in the middle of towns in all cases and the distance that some had to travelled varied, reaching as far as 25 kilometres, though for most it was between 1-3 kilometres. FGD participants were generally content with the operation of the cash transfers, though experiences of irregular payments were recounted in multiple countries, particularly in Zimbabwe, where KIs said that since May 2016 payments have been done very irregularly. A key informant said, "Beneficiaries go for long periods without receiving the amount they are entitled to, due to the disturbances to the programme", as discussed above.

Value and use

The amount that the cash transfers provide varied between countries, as detailed in the table above. In Zimbabwe, where the cash transfer was reported to pay the most amount (between \$10-\$25 per month based on dependents) this was an increase on its initial amount when it was introduced in 2012. All other cash transfers delivered a minimum of between US\$4,00-US\$7.00 per month. In Mozambique, where the cash transfer was lowest, upgrades in line with inflation were apparently in the regulation but had not been able to take place in the last two years due to the economic climate.

In Mozambique, the devaluing of the cash transfer as a result of inflation had had a significant impact. In one FGD in Manhica, a man said:

"It would have been better to receive a food basket, as those who receive a food basket are still getting the same amount in weight. With the money the cash transfer gives, I can only afford half what I could get with the same amount a year ago".

Others said they spent it only on food. One man said he worked hard to put some money aside from it each month, so that he could use the money for emergencies. He said:

"You have to have your head in order. You need to put some aside and make sure you save it for when you're sick. If you don't save it, it doesn't provide enough".

Most people in Manhica and Maputo said they spend the cash transfer on food, salt and soap. Some women in Maputo said they try to use it for income generation activities, such as selling vegetables or fruit. Everyone stressed it was not enough to cover their basic needs. Despite this, it was reported as the main source of income for many, in line with the evidence found in the Literature Review.¹⁶⁶

In Addis Ababa, Ethiopia, men said they spent the cash transfer they received on food, soap and sometimes helping them a bit to cover their rent. Some said it helped them to cover their medical expenses. In Bahrtseba in northern Ethiopia, people said it enabled them only to buy the minimum amount of food and shelter (clothing). Meeting some health costs was also discussed. One man also noted that the cash transfer enabled him to borrow money from family and friends, as people knew that he would receive the payment each month, which acted as security for the loan. People in Bahrtseba also spoke about its impact on social networks and enabling them to participate in community obligations again. These findings correlate with evaluation of the SCTPP in Tigray which found that the cash transfer improved people's ability to meet household's basic needs, particularly in regard to food security.¹⁶⁷

In Tanzania, people spoke about the cash transfer enabling them to do a number of things with the money. This included meeting the needs of grandchildren, especially the school related needs; buying what is lacking in the household, such as food, sugar, salt and soap; meeting some health-related costs, such as medication and transport; and, if there was any remaining money, investing in income generating activities. However, people still said the money wasn't sufficient. As a man in Mbarali said,

"This money is not enough; we only buy food and uniforms and it is finished – the money cannot cover most of the other needs".

In Zimbabwe, people said they spent the cash transfer or would spend the cash transfer on buying food, investing in income generating activities, internal lending, taking care of children's well-being, health care costs, and meeting their basic needs such as soap and sanitation.

In all countries, even with the cash transfers, all older people faced significant challenges meeting their basic needs. Its impact on health-related costs specifically is discussed in depth in Question Six.

Other social protection support

The following social protection entitlements were discussed in the FGDs and KIIs. These do not include health entitlements, which are addressed in Question Three.

Ethiopia:

Informal support provided by Community Care Coalitions (see Evidence Section 1 on Literature Review and KIIs) and Idirs was also discussed by FGD participants and KIs, and support from NGOs and the Church.

PSNP Direct Cash Transfer, as reported in the Literature Review and Country Overview, above. A KII with Ministry of Labour and Social Affairs reported that the PSNP provides 'about 1.3 million' with direct support. No data on older people receiving supported is available.

For those who could work, the PSNP has a Public Works Programme, that provides a cash transfer conditional on work, as reported in the literature review.

Formal sector social insurance schemes and pensions.

Some support provided by government social welfare workers in communities.

Mozambique

Some older people reportedly receive a food basket rather than a cash transfer as part of the PSSB.

For those who could work, the Programme for Direct Social Action (PASD) was also reported to provide support conditional on work, as reported in the Literature Review.

Older people's homes were reported to exist by Ministry of Health and Ministry of Gender representatives. These were also mentioned to exist in FGDs in Maputo.

Some support provided through government social welfare departments.

Formal sector pensions and social insurance schemes.

Tanzania

Older people's homes were said to exist for destitute older people, providing for food, shelter and health needs.

Older people's associations were said to exist in some parts of the country, supported by NGOs.

Some support provided through government social welfare workers.

Formal sector pensions and social insurance schemes.

Some support from NGOs and church.

Zimbabwe

Government food assistance.

Some support provided through government social welfare workers.

Some support from NGOs and the Church.

Some support with grandchildren's school fees.

Formal sector social insurance and pension schemes.

Basic Education Assistance Model (BEAM). A government programme providing free primary school access for all children. Reportedly collapsed in 2008 and ended finally in 2014.

Drought relief programme.

Social support provided through government workers.

Summary points

Coverage of the cash transfer was severely limited in every country, even when geographical spread of programmes was broad. Government funding was named as a key reason for this in every country.

In Zimbabwe, significant problems existed with funding and eligibility criteria with confusion and irregularities reported in both KIIs and FGDs.

The cash transfer positively impacted upon people's ability to meet their basic needs and acted in some places as a way of leveraging money for income generating activities or loans. It appeared to go further in Tanzania where more areas of spending were listed in regard to the cash transfer. In Mozambique, the value of the cash transfer provided had been severely impacted by recession. This resulted in people saying they would have been better to receive food baskets.

All countries had reports of the cash transfer impacting upon access to health care. This is discussed further below.

What are older people's health services entitlements and what evidence is there of older people's actual access to health services?

Maria, 72, Maputo, Mozambique

Maria, aged 72, lives on the outskirts of Maputo. She has no children or grandchildren so she lives alone. Her biggest problem is hunger. She often doesn't have enough money to eat or to meet basic needs. She has had sight problems for two years [she is short-sighted], hypertension, arthritis, and bad pains in her legs. All these bring her headaches frequently.

When Maria is ill, she says, "I try to walk around and stretch". Sometimes she goes to the doctor, too. Once when she went about her legs, the doctor gave her a plaster to cover it. She hasn't seen the doctor about her eyes, though, because of the cost. She is entitled to free treatment as an older person, but says, "They don't show the will to help unless you give them money".

FGD participant, male, Addis Ababa, Ethiopia

"Even when you are lucky to visit a hospital, many drugs are not provided at the government health centres. You are just told to get them from private pharmacies. These pharmacies are owned by the doctors who work in the government health centres also had private pharmacies/clinics so they want to make money in their private businesses. They even discriminate against some older men whom they see as poor because of the way they are dressed. Besides, good professionals work in private clinics".

In all countries, evidence found from Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs) on government policy in relation to health entitlements correlated closely with information identified in the Literature Review.



Development Action (Camilla Williamson) Mozambique

	Access to health – Policy for OP	Health Insurance	Other provisions
Ethiopia	Indigent Fee Waiver program provides the poorest with free access to specific health services provided in government health centres and hospitals.	Community-Based Health Insurance (CBHI) provides financial protection in case of illness for informal sector employees and rural residents. Kebeles decide collectively to establish CBHI scheme, but enrolment decisions are made at household level.	
Mozambique	Older people (F over 55, M over 60) are entitled to free inpatient admittance in General and Central Public Hospitals, free outpatient services and free access to most drugs at health centres.	Health insurance but only available to those in the formal sector.	Older people are exempt from queuing at health facilities. Some homes for destitute older people
Tanzania	Free health care for older people at government facilities, when a free health card for older people is presented.	A government community-based health insurance is available, costing 10,000 TZS for five members providing coverage for one year.	Provision, through local government and voluntary agencies of institutional care to older people and others who have no one to care for. Designated rooms at health centres for older people

Zimbabwe	Government policy of free access to health care in first level government health units through the Assistant Medical Treatment Orders. Although OP have to pay for all additional services including laboratory x-ray, surgery. They also pay for medicines.	Health insurance for those in the formal sector only.	Assistance Medical Treatment Orders (AMTOs) are issued to facilitate access to health The Government provides food for those OP who have medication that requires specific food, e.g. AIDS patients services for OP Older people are exempt from queuing in public health facilities
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Actual provision of health service entitlements

In all countries, evidence of the actual provision of older people’s entitlements was mixed. In Ethiopia, in both Addis Ababa and Bahrtseba, people confirmed that very few people actually received the fee waiver, with people agreeing that around 20-30 people in each kebele (small village) received this ID for free health care. This was also confirmed by both KIIs. In regard to the community health insurance scheme, in both Bahrtseba and Addis Ababa people said very few had this. The expense and the lack of trust of the new system were both reasons given by FGD participants and key informants for the low up-take so far. Some older women were reported to receive the CHI card through women development groups in the communities in both Addis and Bahrsteba (about three per community).

In Mozambique, while there was evidence in all FGDs of older people accessing services free-of-charge, as dictated in policy, there was also significant reporting in FGDs and KIIs, of older people’s rights not being respected. Numerous incidents of older people having to pay for consultations, treatments or drugs, or pay for some of the cost, were recounted, as well as older people frequently having to queue for consultation. A woman in Manhica said,

“Health professionals don’t know older people’s rights and so they don’t always know that they are supposed to get free treatment”.

There were also reports of health professionals seeking bribes in return for treatment.

In Tanzania, nearly all older people who participated in FGDs confirmed having the free health card and this enabling them to get free consultations. In regard to the community health fund, people reported that each family is supposed to contribute money (10,000 TZS for five members) and in return receive health services for a

year. However, the community health fund is currently voluntary and so there is low coverage, as was reported in the literature. Some FGD participants said they had the CHF which helped them ensure access to health care for family members, though the number was low.

In Zimbabwe, the policies on older people's health were reportedly outlined in The Older People's Act 2012. However, it was stated that the Regulations of the Law have not yet been approved so in a number of cases older people are not benefiting from the Act. In particular, we heard that the AMTOs were no longer valid, since the Government is not able to pay the (private) providers. However, FGD participants confirmed that consultations are free. In regard to health insurance, only one medical health insurance was discussed, which most older people said they could not afford.

Health service provision

In regard to service provision, in all countries, older people spoke most frequently of a government health unit or health centre being the first point of contact older people had with the health system, as described in the Literature. In some areas, for example, Maputo, the first available health facility was a hospital. For other older people in FGDs, a government hospital was identified as the second point of contact.

All countries reported that the government health facilities focused mostly on curative treatment with limited prevention work taking place in health facilities. In both Mozambique and Ethiopia, health extension workers (HEW) were also discussed. Their primary focus is reportedly on health education and prevention work. However, the numbers of these compared to the population are very low and in all locations in these countries, HEWs reportedly focused on child and maternal health. As one KI in Bahrsteba, Ethiopia, said, "Health posts and health extension workers are more focused on child and maternal health".

In Manhica, Maputo, mobile health units were reported by both key informants and FGD participants where they said they come once a month and focus on prevention. Evidence of the existence of health posts and health centres, community health agents, and elementary agents was also found, though again, people reported that these often focussed on child and maternal health. In Tanzania, village health workers and community care givers (CCGs) were reported by a KI to exist in every village, focusing on treating minor illnesses. However, another KI reported that this programme had ended as it was externally driven.

In Zimbabwe, a government medical officer at Svishavane District Hospital in Zimbabwe stated that:

"Preventive health services are very much limited in rural areas where people have less access to radio and television; health messages do not easily reach the rural population".

However, the hospital did reportedly take part in campaigns directed at raising awareness of specific illnesses, such as the cancer awareness campaign. Additional services discussed in FGDs and KIIs included the presence of Community Care workers in some areas and Goromonzi District Department of Social Services also detailed a range of social services they provide, including: Older people's Homes and support programmes for destitute people.

All FGDs and KII participants across the four target countries reported that no older person specific treatment was available in government health facilities. In Mozambique, the Ministry of Health said that there are "no specialist services for older people and geriatricians are few and are all foreign". However, in Mozambique there is a new curriculum which includes a package addressing older people's needs and the PES:15 Health Strategic Plan which also addresses older people's needs specifically. In Zimbabwe, there is reportedly no specialised

geriatric care and KIIs informed us that even the training of doctors and nurses does not include a subject on geriatrics.

Health service utilization

In regard to evidence of actual access to health services, both older men and older women in all countries and in both rural and urban areas reported visiting government health centres most commonly. A health worker in Bahrtseba, Ethiopia said, "most older people in this area are highly motivated to come to the health centre".

For cases that could not be treated at health centres, people said that they might be given a referral to the hospital. Going to the hospital was more common in Addis Ababa where the hospital was significantly more accessible than in Bahrtseba which is a very remote, rural area. Here many people also said they did not go to the hospital as they could not afford the treatments or services.

In Mozambique, both men and women said they go to the hospital for all health problems and to get medicine and that this was common. This was the same in Tanzania and Zimbabwe.

Evidence was found, however, of older people not always seeking health services or seeking health services when they were very ill rather than seeking early intervention or prevention. In Bahrtseba, Ethiopia, a health professional said "the oldest old don't seek treatment. They just accept their state of health and receive care at home from family". This was also reported in the FGDs in places.

Quality of health services

Despite accessing health services, in all countries numerous issues were raised regarding the quality of service provision at the health centres, particularly in regard to the availability of medicine. In Tanzania, people said "almost all the drugs are not available but particularly for NCDs". In Tanzania, another KI said,

"We have the policy for 'free medical access to health care for older persons' but the health system has a lot of challenges, e.g. sometimes no medicines – so even if services are free – if there are no medicines, there are no services".

Problems were also reported with staff levels, lack of specialists, inadequate/ill equipped facilities and general service delivery. Women in Bahrtseba, Ethiopia said:

"There is no equipment at health services and there is inadequate personnel. The health facility is just a symbol, there are no regular and sufficient health services".

One KI in Bahrtseba also said there is also no access to clean water at the health facility.

In Tanzania, older people said there is "No diagnostic equipment and there is no electricity at dispensaries. It is only clinical diagnosis, there are no laboratory services". This corresponds with what is reported in the literature review where it was found that health systems were challenged by severe shortages in human resources and drugs at public health facilities. Another KII in Tanzania reported,

"Staffing is the biggest problem. Shortage is about 52-57% in the health care system. In the hospital we need 200 but we have 158 but the ratio is not equal to the need; e.g. we need twelve medical doctors but we have only 2. Other posts are covered by those with no qualifications". (KII Local Leader, Tanzania)

The issue of cost of medicines is discussed further below.

Despite these issues, it is important to state that many older people in all FGDs across countries, across urban/rural environments and in both male and female FGDs, also reported having receiving good quality care when they were seen by health professionals, despite lack of medicine and inappropriate infrastructure. Quality of health facilities was most commonly rated as 'Fair' in all FGDs across countries and gender, with some ranked as 'good' and 'very good'. Although the academic lit shows that user satisfaction measurements almost always have a strong positive bias and so should be taken with caution¹⁶⁸.

Traditional and alternative health services

The scarcity of drugs and inadequate services were reported to force many older people to alternative services if they were available and if older people could afford them, as was reported in the literature. In all countries, people were forced to turn to private pharmacies to access medication, if these were affordable, which they were often not. In Tanzania, a number of other alternatives to government health facilities were also listed, including traditional medicine, private facilities, drug shops, and mission health centres, where drugs, diagnostic equipment and health workers were available. People in Ubaruku said the mission health centre provided the best health services. People also discussed going to church and praying for healing.

In Mozambique, FGD participants discussed relying on herbs or plants often, but said that they were increasingly turning away from traditional medicine as it was more expensive than government health facilities and did not work any longer. As one woman in Manhica said, "Traditional medicine used to be used but now it's now working. Traditional medicines have no power anymore". This was a view that was echoed by all participants in the FGDs in Mozambique, in both rural and urban settings.

In Zimbabwe, multiple alternatives to the government health facilities were discussed. Many KII and FGD participants talked about older people turning to traditional healers, herbs and plants, though, as in Mozambique, people said, "traditional healers charge high prices and prophets are expensive". The church was also spoken about significantly in terms of health service provision in Zimbabwe.

Churches providing health services were not reported at all in Mozambique or Tanzania. In Ethiopia, however, the St George Welfare Association provided health services to the FGD participants in Addis. Older people in both Addis and Bahrtseba were more included to use traditional medicines than in other countries and "indigenous knowledge". Women in Bahrtseba said, "we prefer traditional medicine because of the low cost and some traditional healers do it for free". Others in Addis also said they practice spiritual activity such as drinking 'holy water'.

Summary points

Evidence from FGDs and KIIs suggests the provision of health service entitlements is limited across all countries, as a result of lack of government funding, lack of money of older people and reported corruption.

Evidence from FGDs and KIIs suggests health service provision in all countries does not meet older people's need, particularly in regard to the accessibility and availability of service provision, the provision of appropriate and affordable medicine, and the provision of health care staff trained in older people's needs and public health programmes focused on prevention.

This confirms evidence found in the literature review which identified significant difficulties in accessing health care for people of all ages; under-funded health services; high out-of-pocket health care costs; poor provision of essential and age-specific medication; lack of policy on older people's health; critical shortages of health care workforce; and lack of trained geriatricians and public health programmes.

Despite this, older people in all settings reported attending available government health facilities, even if they do not receive the adequate care, treatment or medication. Little information was found in the literature on this, though in Ethiopia, some data found that out of 795 people over age 60, 460 (72.3%) reported that they had visited a health facility during their last episode of illness, which broadly correlates with general responses in the FGDs, though specific data was not collected.

Older people in all settings were found to access multiple alternative services, including traditional medication (though in many places this appears in decline and has a high cost), private pharmacies to access medication where this is affordable; and church and NGO provided health care.

What are the direct and indirect costs of accessing health services for older people? What are the barriers to accessing health services?

As discussed in Question Three, above, observations and experiences shared by study participants indicated that even though there is policy of free access to health care in many countries, access to those services and, in particular, the quality of services present significant costs for older men and women. This is particularly true for the most vulnerable older people, those with limited mobility, those with less family and community support and with no sources of regular income, while the less vulnerable find it relatively easier to mobilise resources to meet the costs of accessing health services.

Evidence emerged in all four countries of the direct costs of accessing health services and, especially, the cost of accessing medication, as well as the indirect costs of accessing health services, in particular transport costs and the costs associated with carer support. The costs of transport were especially large for persons residing in rural communities where there have to endure long distances to the nearest health facilities. This was a particularly significant challenge in regard to referrals to hospitals, which involved high transport costs which older people and their carers could not afford.

In some countries, like Tanzania, although health services are free (no user fees for older people) at the dispensaries and hospitals the appropriate services for older people are not usually available at health centres. The best that older people could get are consultations and prescriptions to purchase medicines from private clinics and pharmacies. Similarly, in Ethiopia many cases older people said they could not be treated at health centres but are instead referred to hospital. However, the participants noted that many people who are referred could not go to the hospital since they could not afford transport and payment for the treatment and/or prescriptions.

In Mozambique, long distances and unaffordability of prescriptions were reported as a major challenge. In Zimbabwe, apart from the lack of essential commodities and health supplies and lack of money, a general breakdown in health services were described. Some health units were said to have been closed since the financial crisis due to lack of personnel.

Other barriers discussed by participants include: treatment by health workers (unfriendly attitudes/lack of sensitivity required in geriatric care) and competing domestic needs like school fees for children (mostly grandchildren) and food effecting money available for accessing care. The poor quality of the health service

described here and in Question Three, can also appear to act as a deterrent to access and there is evidence that some older people do not visit the health services because of the staff's limited knowledge of older people's health and the lack of equipment and medications.

Distance to health facilities

Long distances to health services were said to be a significant barrier to access for participants across the countries, particularly as a result of the costs involved. In some cases, older people said they wait longer to decide whether to seek care as a result of the distance. When they finally decide that the disease or ailment will not go away, they are either too sick or unable to travel by themselves, thus increasing the cost of transport or they have already utilised the small resources they had on self-treatment care at home.

"We get free health services but it has to be at the health centre where one is registered. Sometimes, you can find you are registered at a more distant health centre even when there is a nearer one. Some of us have to travel long distances which not only increases the costs of transport but can often motivate us to delay the decision to travel in the first place. For some of us the distance is about 4km, but for others it can even be 7-10 km to the health centres where we are registered. At this age, that is a long distance". (FGD Men, Mbarali district Tanzania)

Transport

Across the countries, transport costs were described as a leading barrier to accessing health services for poor and marginalised older people.

"It is good to go for check-ups and treatment, but we cannot afford the transport costs. This makes it difficult. Sometimes we get a card which entitles us to free transport but the bus conductor will tell you 'no, this is not your age' and he demands you pay 280 MTS [3.5 USD]" (FGD Mozambique)

Costs of transport were also reported to hinder older people from following through the required referral pathways, having implications for the adequacy and quality of health care they receive.

Cost of medicines

One of the direct challenges to access to healthcare across the four countries is the cost of medicines. Often, people reported receiving a diagnosis and prescription but not being able to access medicines because they might not be available or not freely available at health facilities, as described in Question Three.

"We are told to go and buy medicines outside – we are told services are free yet when we go there, all they do is write the medicines and ask you to go and buy them from other health facilities. It defeats the logic of saying that the services is free because even the transport to come is already got from scratching everywhere. If the medicines are not there, we go back home with the hands on the head [disappointed] and resort to traditional medicine which we were leaving behind in the first place". (FGD Men Tanzania)

Sometimes, this lack of medicine from free health care centres was said to affect the willingness of older people to seek care in case of a recurrent problem or even another ailment. This was the case in Mozambique where a participant narrated her predicament:

“Whenever I go to the doctor about any other issue, the doctor gives me a prescription and tells me to go and buy the medicine. Only paracetamol is given for free and the rest I have to buy. That is why I find it boring to go back to the doctor. I just remain home and buy the paracetamol from here because even when I go to the doctor, it is the only one I am going to get. Why would I go all the way to pick-up paracetamol?” (In-depth interview/ Case study, Female, Mozambique)

Cost of registration for health cards

Across the countries, schemes where vulnerable populations are entitled to free medical care were found, as identified above. However, as discussed, the administration of the free health care can still prove a barrier to health service access.

“As the elderly, we have cards to access free health services. But if you lose a card, you pay 10,000 TNZ for replacement because you have to register again. Even for children, there is a CHF card, but in order to get one, each child has to pay 10,000TNZ. Only a few of us can afford that money. So you have to sit and wait for the time when you shall have the money even if you or the child are sick”. (FGD, Women, Mbarali district Tanzania)

Carer support

Across the four countries, it was observed that access to health services involved extra costs of a carer, especially for the more elderly members of the communities. Progression in age and particular ailments like eye problems, arthritis and other mobility problems were said to make it complicated for the very elderly to move from home to healthcare centres without a carer. The cost of transport and of maintaining the carer and the older patient when receiving treatment inevitably increases the cost of seeking care. Such costs could not be captured numerically because they vary according to the distance to and from the health facility, length of stay if receiving treatment and the mode of transport that is to be used. In some cases, older people were said to be too frail to use public transportation.

Treatment and discrimination

Some older people reported being ignored at the health centre because of their age. This is obviously counter-intuitive, especially since it goes against the goal of providing them with ‘free treatment’. That their health complaints are explained away as ‘just old age’ may have a lasting influence on whether or when older persons seek care. This was particularly pronounced in Tanzania, although it was reported in other countries too. It should be noted however, that this might be exacerbated by a misunderstanding and lack of good communication and feedback between the older people and the health workers. In a KII with a medical officer in Tanzania, she explained that sometimes health workers have to respond to emergencies and thus the older people think they are being discriminated against.

“They (older people) have poor health but when they go to the health centres, even where there are older person’s windows, priority is given depending on each one’s appearance. Those who do not look good or rich are discriminated against. Priority is given to older people with better socio-economic status”. (FGD-Older Women Mbarali District Mbeya Tanzania)

“Sometimes they say that you are suffering from old age, ‘when you get older, you are expected to have that disease’, so they say. So

the older people are mostly ignored in the hospitals/health centres. We think we get these disturbances because we get free treatment. The service is not bad, and it is not good - just fair". (FGD-Older Men, Mbarali-Mbeya, Tanzania)

Competing needs

Older people who participated in the FDGs described various needs in their day-to-day lives, all of which they must respond to - sometimes at the same time. However, the resources they have are too limited meaning health seeking for oneself may not be a priority. As one participant in Tanzania said:

"It depends on the money [resources] that one has. Sometimes you have no food and also the children have no uniform to go to school. You use the little to buy the food and uniform and it is finished. There are many needs all relying on the same meagre resources. So you have to prioritise the most pressing need, even if it means sleeping in darkness or enduring some pain untreated" (FGD, Men, Mbarali district Tanzania).

In addition, older people's burden of care has financial implications and reduces older people's availability of funds for their own health needs. They look after many grandchildren who have health needs that require money. In Tanzania, older people noted that they have to buy CHF cards and this reduces the funds available for their own health care. However, even when they spend on these cards, they rarely find medicines available at health facilities. They therefore have to spend more money to buy medicines from private pharmacies.

"When we get sick, we go to hospital, but for our grandchildren we ensure that we get CHF cards to reduce the cost of health care...It is challenging to get 10,000TNZ to get CHF cards but we have no option, we must make sure that we acquire CHF cards for our grandchildren to access health services. Although we get CHF cards, we go to hospital to get check-ups but there is no medicine. We need to buy medicine - our grandchildren are at the risk of dying. Sometimes we get medicine but sometimes we do not get it" (FGD female participant, Tanzania).

"The situation is difficult in this community for older persons. The little money they have has many needs especially if they take care of children who go to school. They do not eat well because they no longer have sufficient energy to go to gardens and plant the crops they need". (FGD Older Women, Mbarali District, Mbeya, Tanzania).

Selling off of assets and acquisition of loans

In order to cope with the costs, some households with older persons said they are forced to sell off their assets in order to access much needed care. This not only increases their vulnerability but also compromises their resilience. This was said to be more so because with age, the problems for which people seek health care may not go away after a few visits. Problems tend to be chronic or, at least, long-term.

"Selling assets like land and property to survive and go to hospital is happening. They are also taking loans, mortgaging their assets and houses and they fail to pay the loans and houses are taken and family members complain" (KII, Tanzania)

After disposing off assets in the first episodes of an ailment, older people can be left even more vulnerable to another episode of the same ailment or even another disease. This can mean that seeking health services will not be possible especially if they still have to incur some costs.

Lack of equipment

Some of the barriers discussed by older people and KIIs were related to systemic inefficiencies. As described in Question 3, above, all the countries in this study have problems of equipment in public health facilities.

“Generally, our health care system at the lower level is not well equipped to diagnose and treat problems of older persons. So may be older people do not get proper medication and diagnosis. If we can equip our dispensaries and health centres, maybe the problem of going to traditional healers will be reduced”. (KII Local Government, Tanzania)

In addition, it was reported that most of the problems that older persons present to health workers are not primary health care issues which have been a pre-occupation in the health sector of the poor communities for some time. They require specialised equipment and rare medicines which all increase the cost of care, both to the system and the patients.

Staffing issues at health facilities

As identified under Question Three above the lack of specialised care and, in particular, the lack of knowledge on health issues related to older men and women in the health centre, constitutes another major barrier to older people accessing health care.

Overall, in trying to access health care, older persons and their households said they incur several direct and indirect costs that exacerbate their impoverishment and affect their livelihoods. Depending on the level of vulnerability some may cope by selling their assets or losing their dignity through begging others to meet their costs. The high out of pocket expenditures in the context of poor livelihoods and fragile income sources make access to health services a challenge. This has pushed older people to use services of traditional healers or homemade remedies that may not have proven efficacy, as outlined above and discussed further below. This situation is made worse by the reality that the health care systems and service provision have many challenges, including little or no expertise in efficient and effective geriatric care, inadequate numbers and cadre of human resources required (low staffing levels), and lack of essential medicines and health supplies, particularly for the NCDs and other health conditions that affect older persons.

Summary points

- Out of pocket expenditures – including transport; costs of medicine; costs of registration are still a great barrier to health seeking. While there is no easy and immediate solution, one of the easier solutions would be to make sure that older persons are registered to receive care from health facilities nearest to them.
- Competing needs within households crowd out the resources for healthcare seeking. Health is a broad concept and cannot be detached from other survival needs of the community. There is a need for a holistic approach to older people’s needs like food and clothing and the needs of their grandchildren under their care.
- Negative coping strategies, e.g. sale of assets, makes the poor older people more vulnerable and less resilient.
- Health system challenges and poor quality of health care for older people affects older people’s access to health service and willingness to attend. This needs to be addressed from the supply side. There is a need to develop training and provide equipment that meets the needs of older people.

How do older men and women pay for the costs of accessing health services?

Paulina, 74, Manhica, Mozambique

Paulina is 74 years old and is a widow. She lives in a small brick and thatched hut in a rural area about 2 kilometres from the nearest village. Paulina's life is very difficult. She lost two sons a few years ago and was left looking after their wives and their children. Shortly after this, the wives met new men and moved away, abandoning their children. Paulina is now solely responsible for her six grandchildren all of whom are of secondary school age. This responsibility causes Paulina great worry and she struggles to provide enough for them to live on and to pay for costs associated with their education.

Recent drought has added to these worries, as she cannot currently produce enough from her small plot of land to feed her and her grandchildren. Paulina says there used to be some sweet potatoes which would feed them or which she could sell, but now there's nothing due to drought: "Every day I go to check if anything is growing but there's nothing".

Sometimes Paulina receives a bit of support from other sons she has who live in the city, but she does not like to bother them and knows that they cannot afford to help her and her grandchildren in addition to supporting their own families. She asks, "What salary is enough to support all of us? There is no salary enough".

Paulina receives no support from the government. She applied for the PSSB cash transfer five years ago but she was told sometime after this that her papers were lost and officials came to conduct another assessment last year but so far she has not heard anything more from them.

In addition to financial worries, Paulina also suffers from high blood pressure. She says when it's bad this causes her veins to swell, causing her a great deal of pain, particularly in her legs. During these times, she can't go about her daily activities and she has to rely on her grandchildren to help her.

Paulina says she went to the hospital some time ago to see a doctor and was given paracetamol to help with the pain. Reflecting on this, she feels the treatment she received was good and confirmed that said she did not have to pay for the treatment, though she did have to pay for the ticket at the hospital, the medicine, and the cost of the transport there and back. She used money she had received at the time from selling some sweet potatoes to meet these costs.

FGDs and Key Informant Interviews (KIIs) across all countries identified significant challenges in meeting direct and indirect health care costs. A range of ways in which older people meet these challenges were identified in FGDs and KIIs. This section focuses on sources of income or support other than cash transfers, which is the specific focus of Question Six.

Sources of income

In discussing paying for the costs associated with accessing health care, many older people spoke about their general income sources, as outlined in the Introduction, above.

In Mozambique, people spoke about the trying to find day-work at farms, though this was reportedly rare currently due to drought. People said they also try getting money in advance for the promise of work when there is some to be done. In Tanzania, where older people have I.D. cards entitling them to free health services and, for some, the community health fund (CHF), the costs of accessing health services appeared to be less. However, other income sources were also relied upon for transport or for accessing medicine. Casual labour was discussed here, though people also said, as discussed above, that if they can't afford medicines they also go home. As one man in Mbarali, Tanzania, said, "If you have money you go and buy medicine – if you don't have it, you just leave and go back home".

Women in Umbaruku also discussed casual labour and other sources of income, including begging for the most vulnerable. Others said when they are ill they sometimes sell their assets like chicken or ducks in order to raise money to pay for medical expenses. One said,

"If you do not have any asset to sell, it is a challenge. Now no one will want to loan money if you do not have a CHF card you stay home until you get the money".

In Zimbabwe, few strategies for meeting health care costs were identified. As women in Goromonzi said, "We do not have many strategies for overcoming these challenges". Several stories were told about older people who died after not being able to get medicine. When discussed further, however, people did talk of small income generating activities, piecework or selling livestock. A representative from the Older Person's Board also identified these coping strategies.

Family and community support

In Ethiopia, FGD participants reported that some support was available through Community Care Organisations (described in the Ethiopia Country Overview). However, this was for the very needy of all ages and few people were able to benefit. Similar support was reportedly available in Addis Ababa from 'Idirs' which exist in some communities. These organisations operate like CCCs and they help with certain costs, including health costs, but again this is only for the most-needy people. For women, we heard that women's development groups which are reportedly in every village sometimes help pay for the new health insurance which has been brought in, particularly for the elderly. These groups have about 30 members, out of whom three older persons are covered for free insurance.

In Addis Ababa and Bahrtseba, FGD participants also discussed borrowing or being lent money by family and/or friends in the community. They said that the cash transfer had been important for enabling them to access this kind of money as the guaranteed income acted as a security for their loan as discussed in Question Six, below.

In Maputo, Mozambique, older people said that they received some money from charity or some handouts from people – the "goodwill of others" – like in Ethiopia. A woman in Maputo said, "we sometimes get support from the community, but it depends on the relationship with neighbours, or family and friends". This corresponds with information identified in the literature review which found that older people rely on a small set of actors with whom they interact and who they rely upon in times of difficulties. In contrast, however, in Manhica, FGD participants reported that they did not receive anything from their families or communities as others were in the same financial difficulties. One woman spoke for many when she said, "Nothing can be done". Another said, "children can't offer support as they don't have the money and don't care".

In Tanzania, limited support from the family and community was discussed. Women in Mbarali said, "some of the Chairpersons mobilise some money from the community to contribute to welfare of elderly who are sick", but added, "the community only assists when the disease is very severe". Women in Ubaruku said,

there's been "Disintegration of the social network – communal support has declined – this is not how it used to be". In Tanzania, people also spoke about prioritisation of the needs of grandchildren, particularly in regard to school, as discussed in section above.

In Zimbabwe, one KI reported that some older people support from family, including receiving remittance from children and other relatives living and working abroad. However, this was not reported as common in FGDs. In Goromonzi, both men and women, said it was only the least vulnerable people who could rely on assistance from children, but that these were few. Women said, "family and neighbour support is very weak".

Health insurance

In regard to health insurance, as discussed in Question Three, few people were found to have access. In Ethiopia, the government community health insurance had not yet been taken up by many, as there was said to be a lack of trust in the system and people could not afford the cost. In Tanzania, the free health care covered most older people's access to government services, though a couple of FGD participants also had health insurance as a result of them being included on their children's policy. In Zimbabwe, there was very limited access to health insurance. It was only discussed by a health professional at the district hospital in Svishavane who said, as in Tanzania, that "very few older people have a medical insurance of their own. If they do benefit from medical aid, they do so because one of their children has insurance and is willing and able to include parents in the scheme", as discussed in Question Three. FGD participants in Mozambique reported no access to health insurance.

NGOs and the church

NGO and church support were identified in all countries, though the extent of this varied widely. In Ethiopia, in both rural and urban areas, people discussed support they received from the church. One man in Bahrtseba said, he gets support from the church and from some community events whilst women said that the most vulnerable have to rely on begging at the church.

Despite the literature identifying church organizations and community based organisations providing a supporting role for older people in Mozambique, this was not discussed in any FGDs or KIIs. People in Maputo said, "We receive nothing from the church. We have to give the church money". Women in Manhica said they sometimes go to church when they are ill, but only "to pray or to receive a blessing".

In Tanzania, some people also said they received some support from the church or mosques, but admitted that "even churches are these days less helpful". They also discussed going to church to receive some health care as in Zimbabwe and discussed above. Women in Umbaruku, also reported receiving some support from NGOs, such as KIWAUTA which worked in partnership with the local government to provide CHF cards to older persons and their families.

In Zimbabwe, older people in both Goromonzi and Svishavane discussed donor assistance through charities or the church, though again, this was reportedly limited and support usually was given in kind.

Conclusions

These findings broadly correlate with information identified in the literature for Ethiopia that found that half (50%) of older persons use their own savings for paying for health care; 36% rely on family support; 8% have to borrow money from someone whenever they fall ill; and 4.2% said they found money from other

sources, including begging. However, savings were not directly spoken about in FGD interviews nor KIIs. Generally, older people's economic condition appeared not to allow for saving. In Mozambique, the literature emphasised the reliance of older people on family and neighbours, church organisations and community based organisations, though it found that these had patchy coverage. The findings here suggest that these support bases are insecure and that few older people were able to rely on these sources of support, often having to manage on their own or simply not access health care.

No data on how older people pay for health care costs in Tanzania and Zimbabwe was found in the literature review. However, the findings from the FGDs and KIIs correlate with information on high out-of-pocket health expenditure and general information on sources of income and, in Zimbabwe, the role of community support.¹⁶⁹¹⁷⁰

The evidence gathered in FGDs and KIIs does not suggest any clear differences between men and women or between different ages of older people in regard to paying for health care costs apart from ability to work, though, as discussed, differences were identified in relation to people's level of vulnerability. This was particularly the case in regard to people's ability to depend on family or the wider community (only those who were less vulnerable were able to rely on this support) and in people's reliance on charity or begging (the more vulnerable someone is, the more they were said to rely on these coping mechanisms).

In the face of challenges in paying for health care services, older people in all the FGDs across the four target countries discussed simply not being able to access care, as the barriers were insurmountable. As people in Mozambique said, often you "just don't go. People can't afford to lend the money and older people are afraid of not being able to pay". One Ministry of Health official said, "Sometimes older people die because they don't have money for transport". Other solutions included accessing alternative types of care, discussed below.

Summary findings

- There is no one source of income that people use to pay for health care costs in any country.
- Multiple general income seeking activities and pathways to accessing money to enable health care access were discussed in all countries.
- Health insurance was non-existent among FGD participants in Mozambique, though people were often able to access free consultations here. In Zimbabwe, no health insurance schemes were said to be accessible to poor older people, and limited services were available for free. Some people were able to access schemes in Ethiopia but Community health insurance is in its infancy there and few are signed up. It was not available at all in Addis yet. However, free health care at government facilities was available if people had a fee waiver certificate, though this is very rare. In Tanzania, many benefitted from free health care, as described in Question Three, and some also benefitted from community health fund coverage under a family member's policy. No others had any form of health insurance.
- Some assistance from community organisations in paying for health care was discussed in Ethiopia, Tanzania and Zimbabwe, but not in Mozambique.
- The church was discussed in Ethiopia, Tanzania and Zimbabwe as a source of support in paying for access to health services. It was not discussed in Mozambique, despite this being identified in the literature.
- Family support was discussed in all countries. In Manhica, Mozambique, however, older people said families are no longer able to provide support, as they were in the same situation as others.

- Receiving remittances from family overseas was only discussed in Zimbabwe by a KI.
- In all countries, many older people were said to not be able to afford health care costs and so stay at home, or just see a health professional even if they couldn't pay for medicine or treatment.
- Cash transfers were discussed in relation to paying for care in all countries.
- More research on how older people pay for accessing health care would be useful, particularly considering the proportion of money made up by different sources. Interviewing/surveying older people at the point of payment may also be useful in providing more detailed information.

What is the impact of cash transfers on improving access to health services for older people?

Tewelde, 68, Bahr Tseba

Tewelde is 68 and lives in a remote, rural village of the Tigray region of Ethiopia called Bahrtseba. He lives with his wife and his children. His children are all students. Tewelde works in agricultural activities and has a small plot of land, though he says this is too small to feed his whole family. One of the biggest challenges that Tewelde and his family have faced in recent years is the drought. This has resulted in them experiencing severe poverty, unable to fulfil their basic needs, including food and shelter.

Like some others in his village, Tewelde has been receiving a HelpAge, UNICEF and government sponsored cash transfer for two years. Each month he is paid 150 Birr, which he collects in the village. Tewelde says the payment has been vital to him and his family's survival. Even the small amount it provides has meant he is better able to meet his family's basic needs, supporting him to afford food, fuel and shelter and items such as texts books for his children.

Tewelde says that the cash transfer has also had a positive impact on his and his family's health, particularly in terms of providing nutrition and warmth. The cash transfer has also had an impact upon his access to health services, sometimes helping him to meet the minimum medical costs for small treatments at the local health centre or for medicines. In terms of secondary care, though, Tewelde explained that the cash transfer does not provide nearly enough money to meet these costs. What it does help with, however, is loans, as the guaranteed regular income means people are happier to lend him money, knowing that he will be able to slowly pay it back. This money can then support in meeting further health care related costs.

Speaking about health services more generally, Tewelde says he thinks that there is a big mismatch between people's health needs, their ability to pay, and what is provided. While the health care that is provided in the community has improved in the last twenty years, Tewelde says that many people are still not able to access the services and medicines they need either because they are not available, or because they cannot afford them. This means that people often rely on traditional medicine, or are left doing nothing.

The evidence on the contribution of cash transfers to improving access to health was mixed across all the countries irrespective of whether the cash transfers were conditional or unconditional. Overall, participants felt that the cash transfer (CT) has a potential to contribute significantly to improving access to health. However, the funds are insufficient, in quite a number of cases irregular, and not all older persons have access to CTs. Despite this, the popular or general observation and experiences shared by study participants indicated that even though the amounts

of CTs are insufficient to cover their basic needs, CTs have contributed to improving access to health care in several ways, including:

- Improving self-esteem/psychological or mental health;
- Strengthening access to food and nutrition (particularly for older persons on ARVs in Ethiopia and Zimbabwe, this was critical for their adherence to the medicine regimes);
- Meeting the transport costs to hospitals or health facilities;
- Supplementing the cost of medicines;
- Enabling the older persons to support grandchildren including buy Community Health Insurance cards (CHF) for their grandchildren;
- Improving older people's ability to borrow money;
- Increasing older people's ability to invest in income generating activities to pay for health-related costs; and overall
- Strengthening their resilience.

These messages were in some cases varied with some participants, especially women, reporting that the CT had made a relatively significant contribution to access to health compared to the men. For the men, the CT had had a significant contribution to access to food for their households.

Psychological well-being

The security provided by knowing there is a guaranteed social protection was found to directly improve the health of older people and give them psychological balance to deal with other life situations. Social protection was also found to give the beneficiaries the confidence necessary to take control of their lives. It also helped older persons to reconnect with the society and foster social inclusion.

“Cash transfers also improve the psychological and self-esteem for the family and the elderly people in particular – the more they secure their livelihoods, the more they are socially included” (KII, CSO, Ethiopia)

Social cohesion matters especially for older people who are more likely to suffer isolation and may end up developing mental health problems like depression. It facilitates older people's sense of stability, belonging and trust and offers them opportunities to be in touch with social networks which is crucial to their health and livelihoods. For example, in Tanzania, where beneficiaries of CT are expected to attend health promotion sessions, this provides them with opportunities to interface with other community members. Participation in social activities including meetings, cooperatives, village savings and loans associations as a result of CT among other factors was perceived as contributing to strengthening relations of trust, reciprocity and respect between the older people and other social groups¹⁷¹.

Accessibility of health services (transport)

One of the barriers faced by most of the older people participating in the FGDs is the inaccessibility of the health services as a result of distance and mobility. Facilitating vulnerable populations with means of transport helps to overcome this barrier and many beneficiaries of the CTs spoke about the role CT played in meeting the costs of transport to access healthcare.

“I am living with HIV and I go regularly to refill my medication. However, sometimes I feel tired and sick. One month ago, I was sick and when I went to hospital, they took very good care of me and I felt well. Whenever I felt ill, I would have loved to go back but

the cost of transport is high. If it was not for CT, I would not go there. Last time I spent 150birr [USD\$7] on transport to get ARVS which are free from the hospital". (FGD Women, Ethiopia)

In Zimbabwe and Mozambique, there was a noticeable disparity in access to health services both in rural and urban areas. However, the disparity was more noted in rural areas. This could be attributable to the fact that most of the health needs of the older persons require specialised attention at higher level facilities in the decentralised health service system. Relatively longer distances become a barrier to access health services for many in the rural areas even when they benefit from CTs. If older people from rural areas were to access the appropriate health services, they would need more facilitation to be able to traverse the longer distances to reach the district and regional hospitals. For example, in regard to older people specifically, a 2013 survey of older people's rights by HelpAge International in Mozambique found that of 100 older people interviewed, 18% indicated that there was no health facility within 30 minutes travel time of their home. The proportion with no access was higher among those living in rural locations. Lack of access was higher among older people with a limiting longstanding illness or disability (LLID) and among those from the Shangaan, Tsonga and Sena ethnic groups.¹⁷² (See country overview, Mozambique).

Older persons in urban areas also appeared to have somewhat easier access to health facilities in terms of transport and therefore may be able to save some money to buy medicines from drug shops and pharmacies which are in the proximity.

Affordability of health service (medications)

For most of the participants who benefited from CTs, the CT was crucial in enabling them to access health care services. This was especially the case in regard to covering the costs of buying simple medicines since most of the prescriptions are not readily available at the health centres for free due to stock availability or because many medicines are not included in 'essential drugs list' and thus are not provided for free.

"Because a CT is given monthly, it is a very important resource and acts as a health insurance – you can borrow money and pay back every month using the regular CT income. It becomes collateral or security of some sort. Of course if there was no CT, we would not be able to visit health facilities because we need to pay at the hospital. The awareness training that takes place during pay days helped us to focus on using some of the money for health." (FGD, Men, Ethiopia).

One of the biggest health care challenges appeared to be timely health seeking behaviour. For most people, failure to get immediate access only exacerbates the condition of the sickness. FGD participants and KIIs reported cases of people getting life changing effects from diseases and others ending up in fatalities or death because of untimely seeking of care. With the CT, beneficiaries appreciated that they do not have to wait to see which trajectory the illness is taking before seeking care.

However, in Mozambique, older people said that what they spent the money on depended on what was going on when they actually received the cash transfer. As a woman in the FGD in Manhica, Mozambique, said, "It's only spent on health if it is coincidentally received when you are sick and so you use it for that." Another who was not receiving a cash transfer said, whether she would spend it on health would "depend on what the priority is at the time".

Support for grandchildren

Many older people have wider families to take care of. Many of these are children who are either orphans; those left behind to stay with their grandparents when their parents leave the villages to seek work in urban areas; or those who have been abandoned. Evidence from the FGDs and KIIs in Tanzania, illustrated that CTs provide the resources necessary to purchase Community Health Funds (CHF) cards, a form of health insurance that enables orphans and vulnerable children in older persons' households to access health care. In Tanzania, this has helped to reduce the overall out of pocket expenditure on orphans and vulnerable children (OVC) and helped to save resources to spend on other critical needs that boost the quality of life of older persons' households. There was also evidence of it enabling older people to take children for medical check-ups when they are ill, rather than taking them only when they are critically ill, as a result of being insured under the CHF. One of the grandparents narrated her experiences with CT and CHF:

"In health problems, when we get sick, we go to hospital, but for our grandchildren, we make sure that we get CHF cards to reduce the cost of health care. It is challenging to get 10,000 TZS to get CHF cards but we have no option we must make sure that we acquire CHF cards for our grandchildren to access health services". (FGD Women, Mbarali district, Tanzania).

"Although we get CHF cards, we go to hospital to get check-ups, but there is no medicine. We need to buy medicine; our grandchildren are at the risk of dying. Before, as citizens we only went to health facility when the children were very critical, but with CT we learnt about health, especially through WASH awareness, helping to prevent diseases. 155 Birr is OK but it is not sufficient to meet all the need of the household (H/H) but it has contributed a fair share to help us access services. For example, [my friend] is PLHIV and she gets free health services but she uses the money to pay for her children to be treated in the health centres. Therefore though not sufficient it has contributed a fair share to accessibility to health care". (FGD older women, Tigray, Mekelle, Bartseba).

It is possible that the differences in how much is spent on health from CT received may be attributed to the differences in magnitude of orphan-hood, HIV/AIDS and poverty. For example, the challenge of caring for grandchildren, either as a result of parents dying or as a result of them abandoning their children, is a significant issue facing older people in Zimbabwe, Tanzania and Ethiopia. This issue was also discussed in Mozambique but raised less in the FGDs. One KI in Zimbabwe said that according to the 2012 population census a total number of 5,787,838 orphans were registered; 2.5 Million in Tanzania (of these about 880,000 are due to HIV and AIDS)¹⁷³ and 4.5 Million in Ethiopia¹⁷⁴ and that most of these orphans are taken care of by their grandparents. Private households especially those headed by older people continue to shoulder the growing burden, but they have difficulty fulfilling the needs of the orphans and their own children. Expenditure on the welfare of OVC including education and health affects how much remains of the CT and other income sources to spend on the health of older people. This is part of the reason why older persons with more dependents tend to be included in social cash transfer programmes and why the amount given is often determined by the number of dependents in a household.

Improving hygiene and sanitation (reducing burden of disease for water borne diseases)

The economic empowerment that is achieved through CT was reported as being crucial for people to afford personal hygiene appliances and utilities. Though such transfers may not be enough to address large economic needs, they are enough, in absence of major challenges, to afford domestic necessities like detergents, and

other personal effects like toothpaste and toothbrushes. These improve personal hygiene and sanitation, which ultimately have an impact on health.

“I can say that because of the CT there has been an improvement. My home is much cleaner than when I did not have it to use. All of us at home can buy what to need to make sure our bodies and clothes and environment is clean. And in fact the sickness at home has reduced due to this hygiene.” (FGD Women, Mozambique).

“It also improves nutrition, food security, hygiene and sanitation, and therefore reduces the number of elderly falling sick and going to the health facilities.” (In-depth interview/Case study Female, Bartseba Mekele Ethiopia).

Particularly in Tanzania, Zimbabwe and Ethiopia (particularly in Bahrtseba, Tigray) which due to high prevalence of HIV have experienced a high burden of orphans, hygiene and sanitation were perceived as crucial in reducing the morbidity and fatality due to infectious diseases - particularly waterborne diseases. Apart from the children (OVC), improvements in hygiene were also reported to have reduced the morbidity among older people. It was also noted that improvements in hygiene have an effect on social inclusion. Older people who are hygienic and have better hygiene in their homes appeared more likely to feel comfortable attending social events and to be visited by neighbours, relatives and friends. This strengthens opportunity structures for social inclusion that is itself important for its contribution towards the well-being of people and a reduction in marginalization.

Enabling people to loan and invest

For households, which are not the most vulnerable, the CT can be even more liberating, going from just consuming to investing in income generation activities. This income can lead to even greater effects on household welfare. As was stated in one of the FGDs:

“Sometimes, it is not about spending the CT. When I got the money, I bought a pig and when I sold the pig, I got 85,000 TZS which I used to meet medical expenses and also to improve the sanitation of my home.” (FGD, Men, Tanzania).

CT was acknowledged in some countries to have increased older people’s mobility, choices and opportunity structures to access better health services for themselves and their families. Choices have not only been improved and expanded for health services but also for food and nutrition.

“At least, we now have options, we can go to other facilities, we can decide to go to a facility providing better services rather than being restricted to the dispensary. Through CT, I have money for transport to go and seek services from a better health facility. We used to have one or two meals but now we have three meals, we are also able to buy vegetables and onions and buy meat twice a month to change the diet. We can also buy soap to wash our clothes and utensils and wash clothes for our children and grandchildren. I feel stronger and more energetic than before when I was weak. I am sure I even look more beautiful”. (FGD, Women Mekele Ethiopia).

Food and nutrition is a very important in the welfare of older persons and their dependents. Most participants indicated that CT money was used to buy food items that are locally available in order to feed themselves and their dependants. As one KI in Tanzania said, “Everyone says that all the money from the cash transfer is used to help them meet their basic needs for food, salt and sugar”. Another said, “It also improves nutrition, food security, hygiene/ sanitation and therefore reduces the number of older elderly falling sick and going to the health facilities” (KII, Mbarali District Tanzania).

Strengthening resilience

In the short and midterm, CTs were reported to improve the resilience of households with older persons in coping with situations that increase their vulnerabilities. Improved food security and household nutrition, access to health and easier transport to health facilities, and access to school by their dependants gives families of the elderly men and women a leverage to mobilise their resources to improve their lives and withstand shocks. CTs were found to have an empowering dimension to them because they lend a hand to struggling in order to increase their resilience in facing various difficult circumstances. It was also reported to enable vulnerable people to regain respect in society and qualifies them for exchanges on trust like getting materials on credit with a hope that they will pay in the near future. The CT may therefore play a role of re-integrating vulnerable populations in the social support dynamics in the society, where they may be excluded if they are seen as not resourceful in reciprocity terms. The below narrative explains how the CT can help to incentivise and release the innate and social potential of older persons to take charge of their lives and, once again, engage in society.

“There is a difference between now and when I had no CT, now I can buy food and school materials. Occasionally when I have money, I buy chicken – I keep those, as capital: when there is someone sick in the family, I use it to meet medical expenses. But mostly I use it to buy hens and to meet scholastic materials. When am sick there is no money, but sometimes when it is there, it helps to meet transport costs to the hospital. If the CT money is there I do not beg, I just use it to go to the health facility. I started to receive the CT at the end of last year. I have received the CT four times. It is regular, I get it after every two months. CT has given me a choice in terms of spending. For example, how to spend the money: I can now buy things. I could not buy anything without access to the CT. In terms of health and wellbeing, I am now able to wash and be hygienic, I now get two meals a day instead of one meal and I have managed to pay for rent consistently”. (Case Study Older Man, Mbarali, Mbeya, Tanzania).

In observations by participants, there was concern that there are differences in health service use between men and women. “It is mostly men who come for treatment. This could be a cultural “a cultural issue”. Even among younger populations, more men come to seek healthcare than women’, that is why we have encouraged Community Health Extension Workers (CHEWs) to focus on younger women, especially child and maternal health, rather than older people’ (KII, Director, Primary Health Care, MoH, Ethiopia).

In another aspect, the asymmetrical power relations between men and women where men own and control almost all the valuable resources of the households gives them an advantage in terms of decision making on resources necessary for accessing health care. Men too, control the proceeds of production from both subsistence and small scale agriculture. This may also have an effect on women’s access to health services.

Indeed, this is not a new phenomenon in many communities of the patriarchal societies on the African continent where men’s work is in the public sphere, while women’s work is at home. This means that men can easily travel and access services. Women may not, tied down by domestic household chores, and may be allowed and or have no information. Also, mobility is associated with costs which require one to have resources. Women also need permission from their spouses and in some cases, significant others in the family to travel to seek services. This notwithstanding, it should be noted that irrespective of these disadvantages, where women had dependants like grandchildren or orphans, women were largely

more inclined to cater for their health issues (childhood illnesses, immunization etc.) and this among others gives them “an opportunity” to visit health facilities more than the men. While they are at the facility, they can use this time too to consult about their own health problems. In fact women tended to speak and express themselves more eloquently about their experiences with the health care system in terms of access, affordability and quality more than the men. Therefore the assertion of men seeking treatment more than women should be put in context. Men may have easier mobility and relatively more control over resources in patriarchal societies like Ethiopia that gives them some advantage but older women tend to have a better health seeking behaviour than men because of their gender roles related to care for children and being generally ascribed the role of being in charge of the health care for their grandchildren (and OVC). Therefore, men tend to provide resources while women engage in the actual care.¹⁷⁵ Because of their caring roles older women appeared more likely to understand the dynamics of the health care system and health seeking than their male counterparts.

Mode of delivery of cash transfers: conditionality or innovations?

In Tanzania and Ethiopia, in particular, the CTs facilitated many older persons to access healthcare **in** both urban and rural areas. Particularly for Tanzania, health interventions were an integral part of CTs and conditional on participation in health sessions and attendance of health facilities for treatment. Members of the community were registered at specific health centres where they receive healthcare. In Ethiopia on pay-days, various health interventions, especially focusing on prevention like hygiene, sanitation, immunization, and health promotion were deliberately and to some extent systematically integrated into CTs pay-days. This could have contributed to improved access to health services among older people. It is however not immediately possible to assess the impact of these innovations on health access by older persons and their households. What is clear is that these approaches provide an opportunity to deliver health education and health promotion to beneficiaries of CTs and are a promising practice in linking CT to complementary interventions. However, they require suitable health services to be within reach of the target population.

Conclusions

Overall, although CT amounts are relatively small and not sufficient to adequately cover health related costs, it is clear that they incentivise agency, creativity and resilience; widen choices; and increase mobility of older persons and their dependents to access health care. CTs appear to open opportunities that incentivises older people to creatively spend and sometimes invest the money in multiple ways that help to improve the overall health and well-being of the household. CT if increased and accompanied by other complementary programmes like free access to health care and strengthening of health systems (especially the building blocks of human resources for health, developing capacity for geriatric care and improving availability of medicines and other health commodities) have the potential to improve access to health services. CTs are also important for the mental health and psychological well-being of the older persons.

5. FINDINGS FROM SAMPLE SURVEY QUANTITATIVE DATA

Introduction

To support and integrate the data collected with the FGDs, the case studies and the key informant interviews in the four target countries, a community-based survey among 212 older persons was conducted in Mozambique. The survey was conducted in Maputo and Tete provinces in communities where BHOPA program is being implemented. The survey focused on the key research questions of the study provides relevant and valid evidence to support the findings; albeit the small size of the survey means this is not statistically significant.

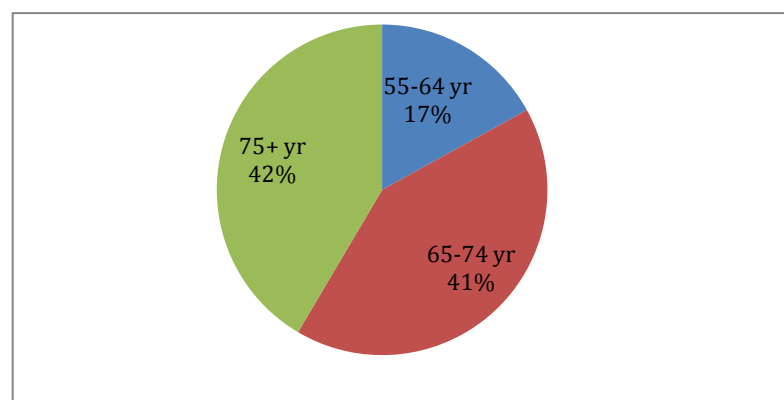
In addition, the BHOPA midterm review (MTR) data were available for Mozambique and this were used to compare supplement the results of the survey. The MTR data were collected in May 2016 through a community-based survey among 553 old persons in Maputo, Tete and Gaza provinces in BHOPA program supported communities.

Socio demographic profile

Sex and age distribution

The survey sample consisted of 212 older persons (55% women; 43% from Tete and 57% from Maputo province), majority (80%) of whom were from rural areas. The proportion of women of 55% is higher than their proportion of 52% in the general population (according to Mozambique DHS 2011). Of the 212 respondents, about 42% (44% women and 39% men) were aged 75 years and above (Figure 3.1) and 41% were aged between 70 and 74 years. The sample was stratified to ensure that sufficient data was collected on the people who were 75 and above in order to collect extensive information on their health needs and health access issue.

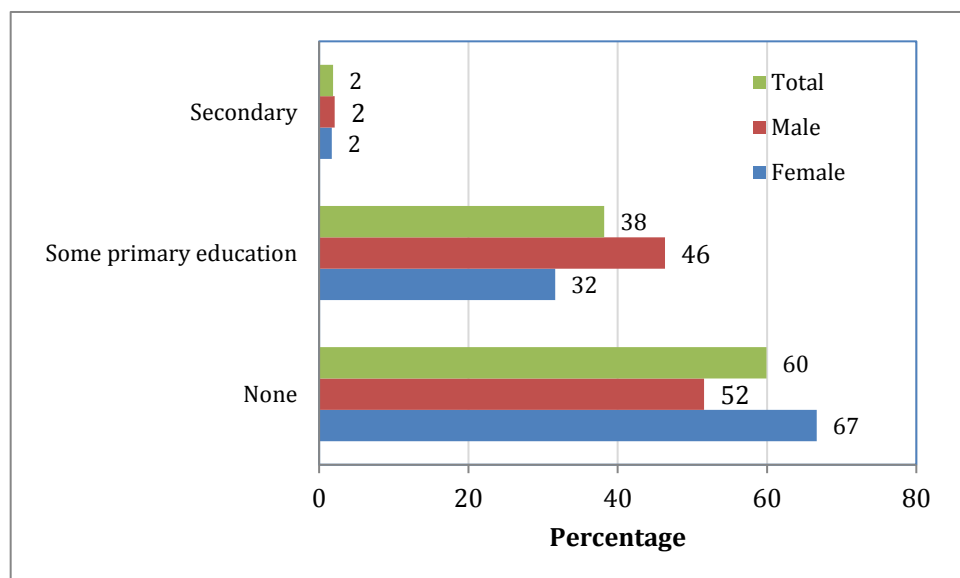
Figure 3.1: Distribution of age of the survey respondents (n=212)



Education

About 60% of the respondents (52% male; 67% female) never went to school, and among those who went to school few (2%) reached secondary school. These statistics are similar to the national level estimates reported in the DHS 2011 where 49% older men and 73% older women did not have any formal education. The fact that the majority of older people in Mozambique have no formal education means that methods of communicating with this age group cannot assume sufficient literacy to understand health related communication and entitlements.

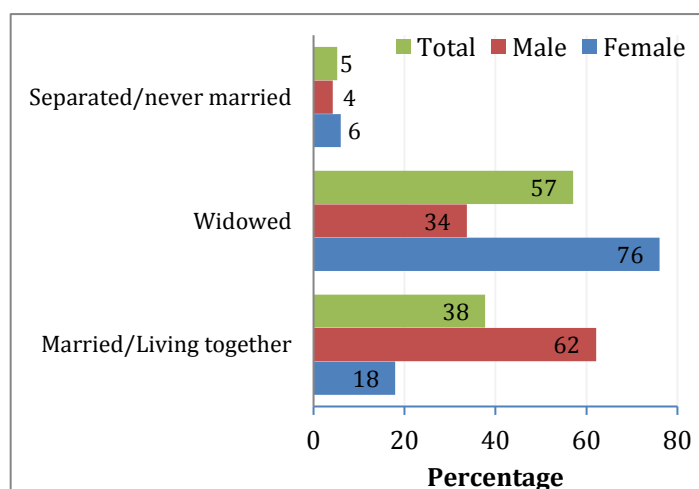
Figure 3.3: Education attainment of the survey respondents (n=212)



Marital Status

Of the 117 women interviewed, 76% were widowed which is more than twice the proportion of men who were widowed (Figure 3.4). The high proportion of widowed women is related to the empirical evidence that women live longer and, in many African settings, marry men who are older than them.

Figure 3.4: Distribution of marital status of the survey respondents (n=212)



Household Composition

On average, the respondents had household sizes of 4 (range: 1-14) members. This is close to the national average of 4.5, according to DHS 2011. Since over 90% of the households are owned by the older persons, an average household size of 4 implies that other family members are staying with the old persons. These were mainly children which reflect a likelihood of high dependency ratio on the older persons, especially in the rural settings. To the other extreme, however, there were 26% older women and 17% had men living alone. This may point to social isolation from the family.

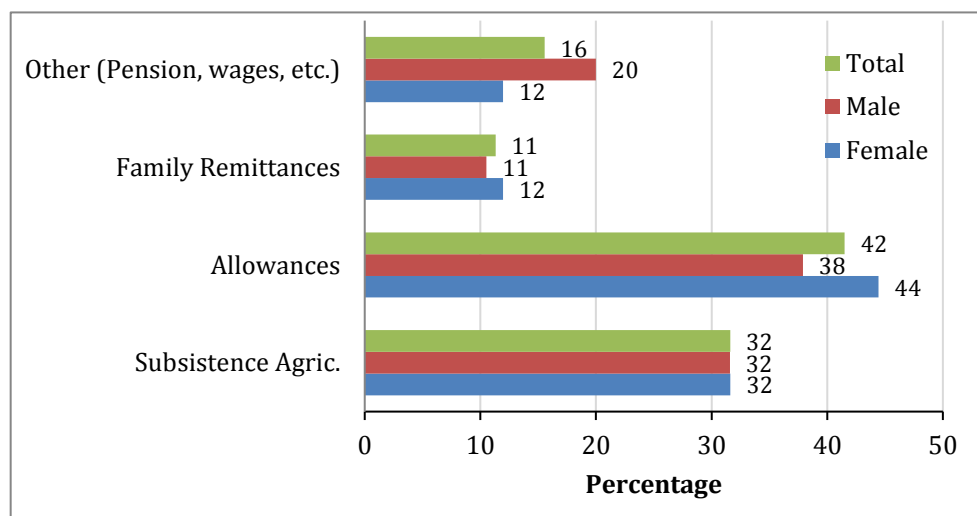
Household socio-economic status and expenditures

Of the 212 respondents, 94% (93% female; 95% male) owned or jointly owned the houses they are staying.

The most important sources of the household income within the past 12 months included government social benefits or allowances (42%) and sales from subsistence agriculture (Figure 3.5). These most important sources were equally the main sources of household income. Work-related pension and wages contributed less (16%) to household incomes.

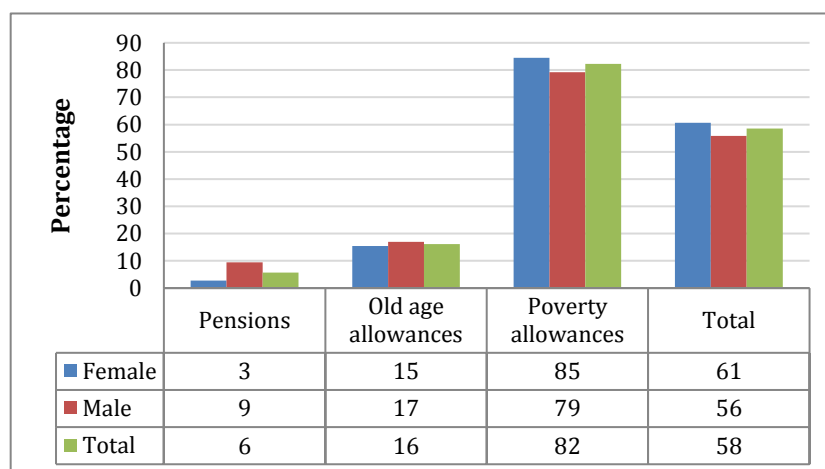
The importance of subsistence agriculture is due to the fact that 80% of the respondents are from rural areas and 60% of them have never been to school. Access to paid employment at the age of 70 year or to work related pension is therefore limited to a few. Midterm review reports similar results about main sources of income. There were no significant differentials on sources of income by gender.

Figure 3.5: Most important sources of household income in the past 12 months (n=212)



Fifty eight percent (61% women, 56% men) indicated that they are currently receiving cash transfers – pensions and/or social benefits. Of these, 94% PSSB (82% receiving poverty allowances and 16% were receiving old age allowances) and only 6% were receiving state pension (Figure 3.6).

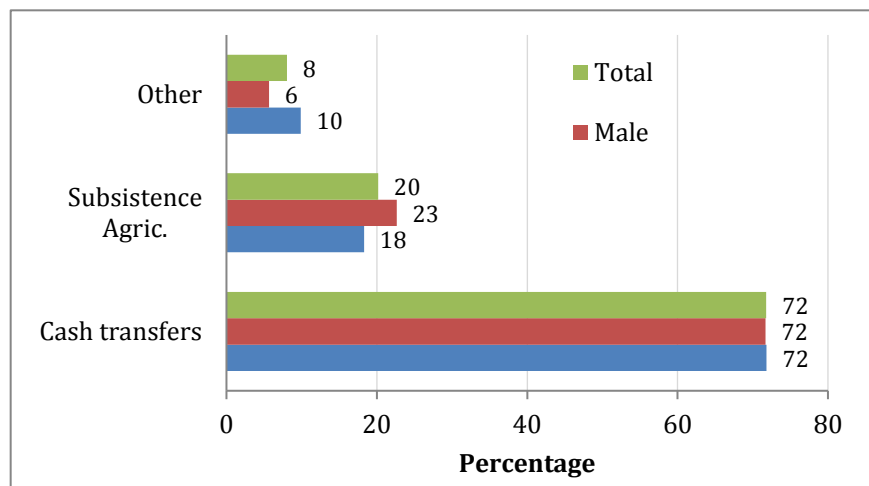
Figure 3.6: Proportion receiving various types of cash transfers (n=124)



Of note, is that of the 58% respondents receiving cash transfers, 72% cited the cash transfers as the most important and as the main source of their household income (Figure 3.7). There were no significant differentials

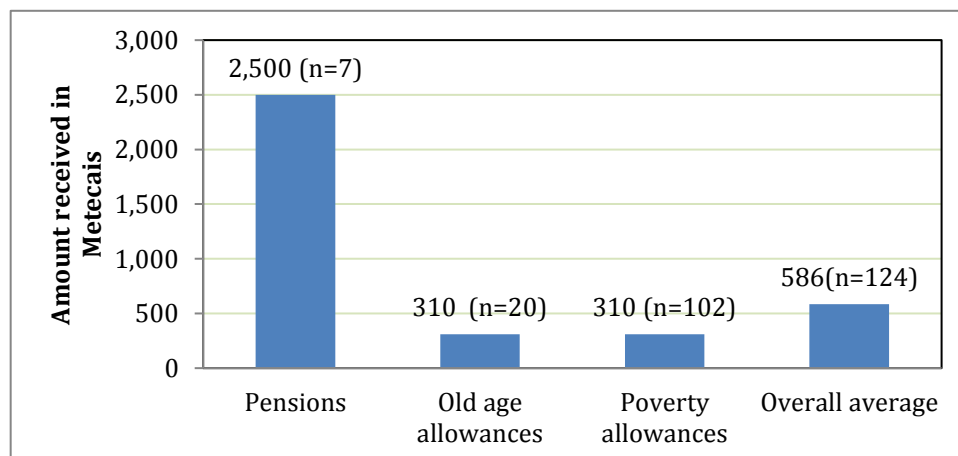
between the rural and urban areas. This might indicate that vulnerable older Mozambican receiving cash transfers might economically depend on these transfers. This finding is similar to what was reported in a 2013 survey done by HelpAge International in 8 districts in 5 provinces in Mozambique among recipients of PSSB. In that survey, findings showed that the cash transfers contributed between 76 and 100% of the income for 78% of the household who participated in the survey.

Figure 3.7: Most important sources of household income in the past 12 months among respondents receiving cash transfers (n=124)



The average amounts of cash transfers were the same between men and women; with the seven state pensioners receiving a monthly average of 2,500 Mozambican Metecais (about 35 US Dollars); while the PSSB (both poverty and old age allowances) was about 4 US Dollars per month (Figure 3.8). The difference between State Pension and Poverty allowance is significant and it is indicative of the inadequacy of the cash transfers for older people for whom this is the main source of income.

Figure 3.8: Amount of cash transfers received per month (n=124)

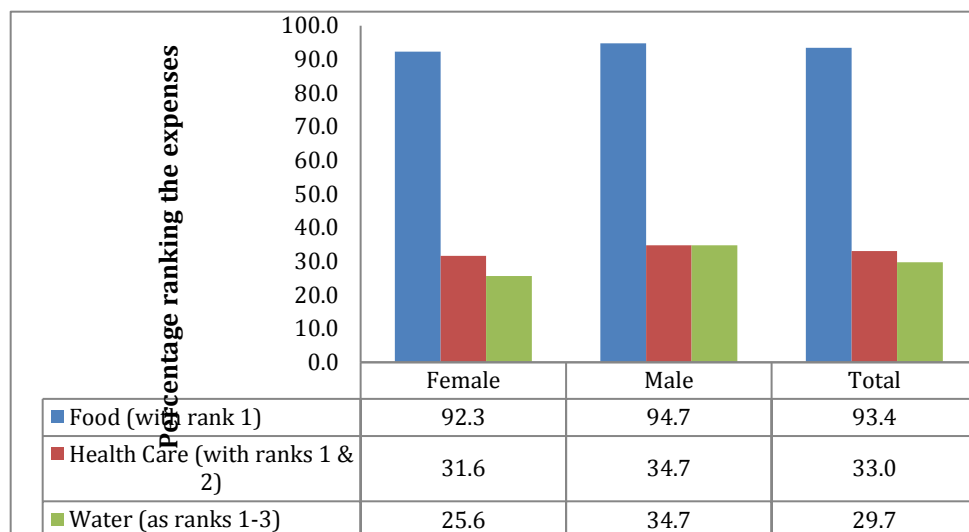


Expenses:

The three most important expenditures in any given month were on food, access to healthcare and access to water (Figure 3.9). Over 90% of the respondents ranked food as number one expenditure, while costs relating to access to healthcare and water were ranked as number one by less than 10%. However, among the respondents with at least one self-reported chronic disease, 53% ranked the healthcare costs as number one or two. More generally, reliance on agricultural sales and allowances as main sources

of income reflects instability of older people’s income and the limited resources available for spending on health care in a context where food and basic needs are scarce.

Figure 3.9: The top three household expenditures in the past six months (n=212)

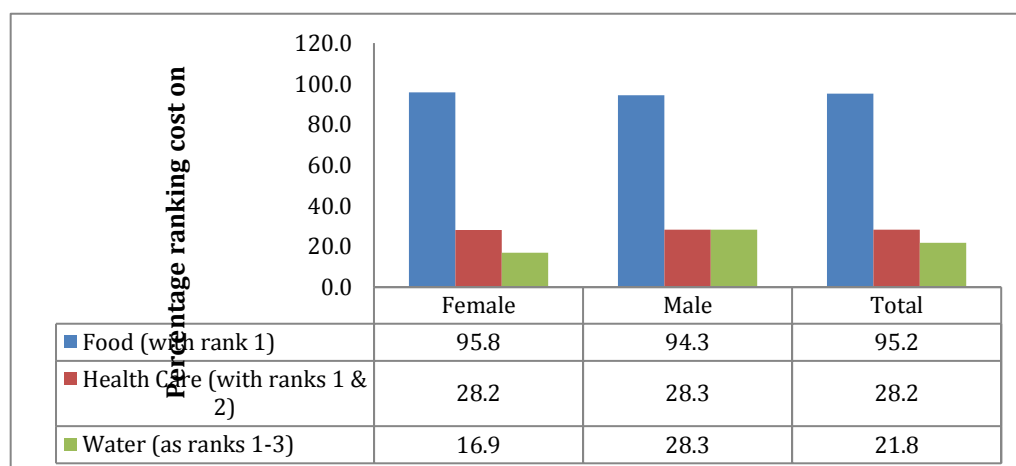


Expenditure of cash transfers:

Cash transfers, in particular the PSSB, are used for buying food by over 90% of the respondents. Second in rank for usage of cash transfers are the costs associated with access to healthcare and water. At least 35% of the respondents with chronic conditions also use cash transfers to cover the healthcare costs. Although, many of the respondents stated that this money is rarely saved to cater for healthcare related costs, it was noted that receipt of this money reduced expenditure pressure on other sources of household income, which then are used to cater for healthcare related costs where necessary. Less than 2% of older persons donate or spend cash transfers on other household members’ expenses (except covering food costs).

The fact that 65% of the older persons with chronic illnesses do not use or save cash transfers to help with healthcare costs underscores the competing needs within households, the insufficiency of PSSB and lack of alternative sources of income for older persons. It highlights the need to consider increasing the PSSB amount.

Figure 3.10: Ranks of expenses where cash transfers were used for in the last one month



Significance of cash transfers in household welfare and healthcare:

In general, respondents receiving cash transfers, in both in rural and urban areas, reported some consumption confidence and ability to pay for healthcare related costs, notably the travel costs (Table 3.1). Satisfaction with household's ability to meet costs associated with healthcare and personal needs was significantly higher among the respondents receiving some form of cash transfer as compared to those without (Table 3.1). The ability for a household's consolidated income to meet healthcare costs and personal needs increase by at least 30% when the household member receives cash transfers.

In Table 3.1, 61% of the respondents who were receiving cash transfers were satisfied with their ability of meeting the healthcare related costs as compared to only 47%, representing a 30% relative improvement. This is statistically significant with associated Z-score test p-value of less than 0.05 (p-value = 0.038). Similarly, satisfaction with ability to meet other personal needs including food and water, was significantly higher among the cash transfers recipients (61% vs. 41%, p-value 0.034).

Table 3.1: Percentage satisfied with their household's income in meeting costs associated with healthcare and personal needs,

	Households without cash transfers			Households with cash transfers			p-value
	Male	Female	Total	Male	Female	Total	
Healthcare	17 (37.0)	24 (57.1)	41 (46.6)	40 (56.3)	35 (66.0)	75 (60.5)	0.038
Personal needs	13 (28.3)	23 (54.8)	36 (40.9)	45 (63.4)	30 (56.6)	75 (60.5)	0.037
General Transportation	6 (13.0)	8 (19.0)	14 (15.9)	16 (22.5)	13 (24.5)	29 (23.4)	0.122

In conclusion, older people in the sample rely on subsistence farming; family remittances and cash transfers for survival. Only a small group of older people access work related pension or paid employment. The ability for a household's consolidated income to meet healthcare costs and personal needs increase by at least 30% fold when the household member receives cash transfers. Food costs are the most demanding costs and takes precedence over healthcare and other costs. Older people with chronic diseases and therefore higher need to access health care services are particularly dependent on cash transfer to directly, or most often indirectly, support their access to health care services. There are not significant gender differences in the access and use of cash transfers.

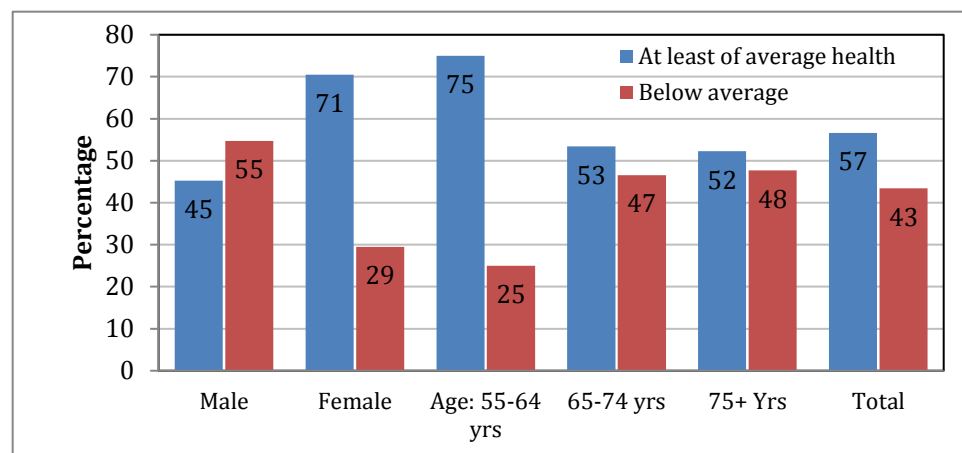
Health status

Self-rated health status and common ailments:

Generally, most of the older persons interviewed have poor health status with over 75% self-reporting at least one chronic disease (Table 3.2). By their own assessment, about 50% stated that their health status is below

average compared to the general population. The older women seem to be more positive about their current health status than older men. As would be expected, the percentage describing their health status as below average increased with age for both men and women (Figure 3.11).

Figure 3.11: Self-rated health status



The most common self-reported conditions include arthritis (75%), hypertension (40%) and eye problems (38%). This is irrespective of sex or age (Table 3.2). Midterm review also reports arthritis, hypertension and eye problem as the main ailments affecting older persons. In line with older people's perception of their health status the self-reporting of chronic diseases significantly grows after the age of 64. It is also interesting to note that the incidence of self-reported depression increases significantly with age and there is a higher percentage of women who report depression than men. However, it is important to note that a number of studies have identified significant discrepancy between the incidence of self-reported diseases and biometric data particularly with regard to hypertension which tends to be underestimated by study based uniquely on self-reporting.¹⁷⁶

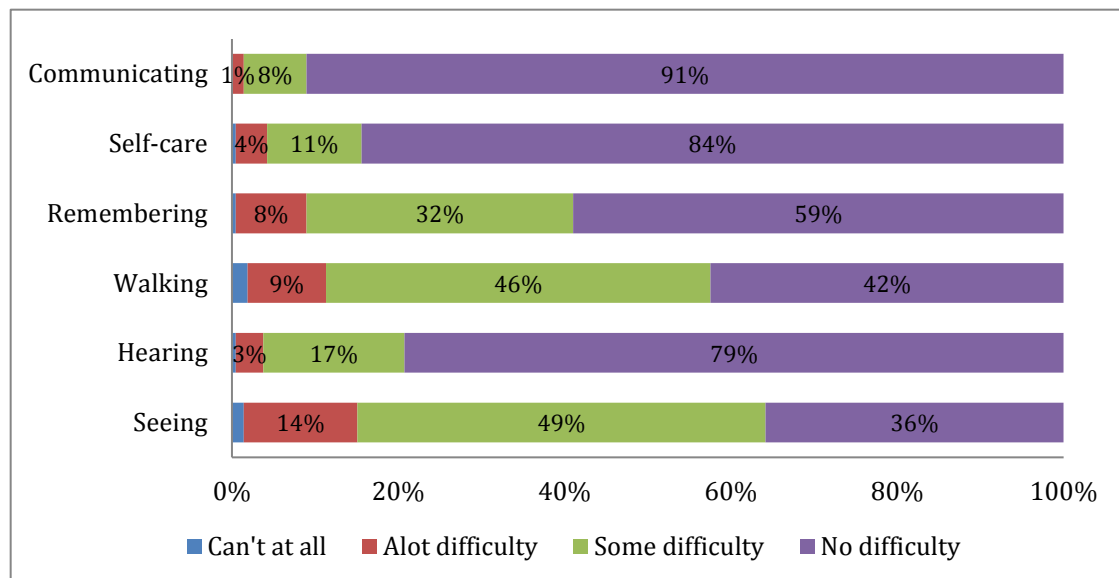
Table 3.2: Common ailments among the older persons in Mozambique

Characteristic/condition	Sex		Age			Total
	Male	Female	55-64 years	65-74 years	75+ years	Total
Arthritis	78 (75.0)	58 (75.3)	23 (76.7)	57 (77.0)	56 (72.7)	136 (75.1)
Hypertension	47 (45.2)	26 (33.8)	13 (43.3)	30 (40.5)	30 (39.0)	73 (40.3)
Eye problems	41 (39.4)	28 (36.4)	10 (33.3)	25 (33.8)	34 (44.2)	69 (38.1)
Oral Health	32 (30.8)	19 (24.7)	8 (26.7)	20 (27.0)	23 (29.9)	51 (28.2)
Angina	22 (21.2)	14 (18.2)	6 (20.0)	17 (23.0)	13 (16.9)	36 (19.9)
Depression	21 (20.2)	8 (10.4)	4 (13.3)	12 (16.2)	13 (16.9)	29 (16.0)
Asthma	17 (16.4)	5 (6.5)	3 (10.0)	10 (13.5)	9 (11.7)	22 (12.2)

The most common disabilities among the older persons were difficulty with eye sight, walking and remembering, where at least 60% of the respondents

complained of some form of difficulty (Figure 3.12). A higher proportion of women complained of some difficulty with eye problems and walking as than men (67% vs 53%).

Figure 3.12: Common disability status among older persons



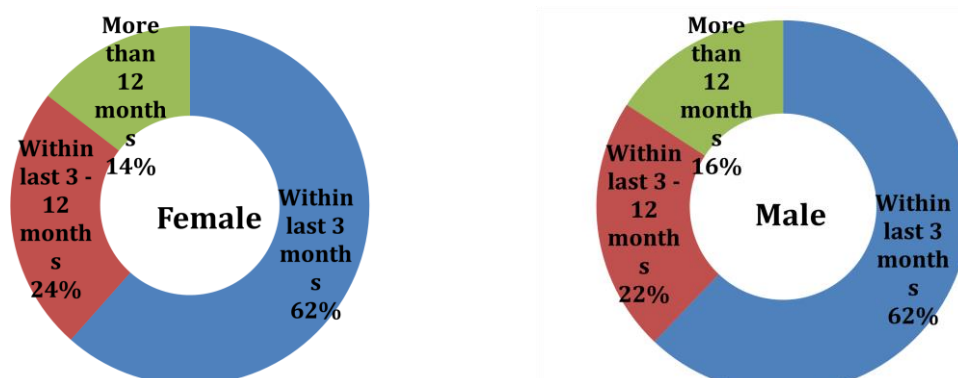
Health care utilization

We assessed different aspects associated to healthcare access and costs. These are summarized in the subsequent sections.

Time since last consultation:

Of the 212 respondents interviewed, 62% (male or female) reported to have been unwell or required a routine review within the past three months (Figure 3.13). With exception of two respondents who thought that their sickness were not serious, all the others consulted with a health professional in a public health facility/post (95%) or private health facility (5%). This is a relatively high rate of utilisation which might be related to the fact that the survey took place in communities where the Better Health Programmer of HAI had been run for three years.

Figure 3.13: Time since last healthcare consultation



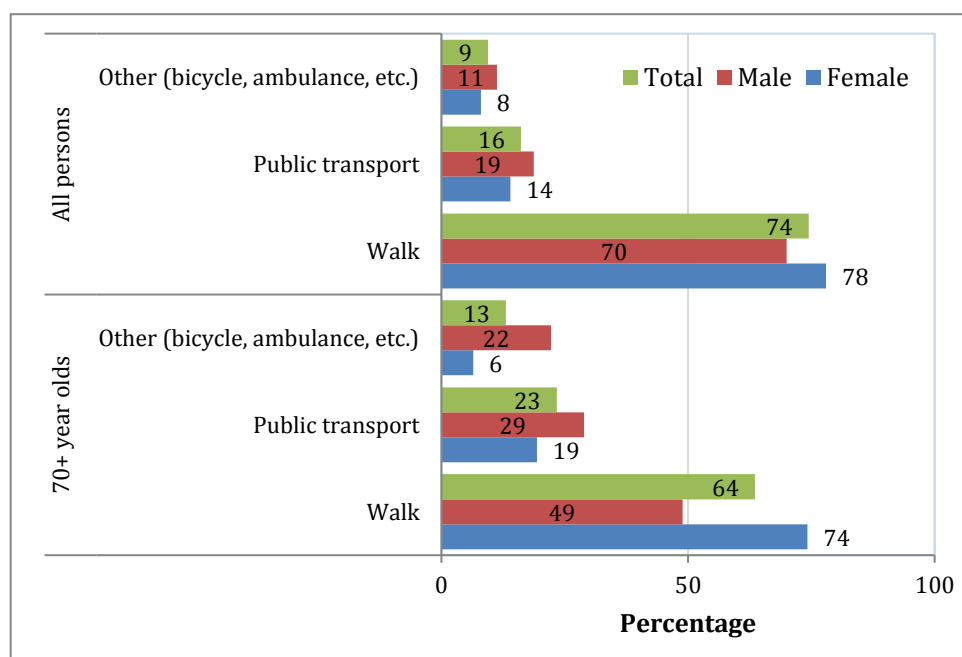
The main reasons for consultation included: review or presentation with arthritis (43%), hypertension (18%) or other chronic conditions (7%); or required treatment for cough, fever or physical injury (18%).

Payment of healthcare related costs

Transportation and associated costs:

Of the 180 respondents (100 men and 80 women) who visited the health facility, 78% walked and only 16% used public means (Figure 3.13). However, among the persons aged 70 years and above, there were more women who used public transport than men (51% vs 36%). In general, there were a significantly high proportion of the 70+ year old respondents who used public means compared to those who were below 70 years of age (23% vs 16%). In other words, the burden of travel costs to access healthcare increases with age of the older persons; as they become weaker to walk. This is particularly true for men as 49% of those over 70 years of age walked to the health service compare to 70% of those under the age of 70, whilst for women the difference is less significant (74% compare to 78%). This might be related to older women being more mobile or having greater difficulties in paying for transport. However, for both gender as the burden of chronic diseases and risk of lower mobility increases with age, so does the burden of travel costs.

Figure 3.13: Travel means used during the last visit to the health facility



Payment of healthcare related costs:

Of the 180 respondents who visited the health facility or post in the past 12 months, only 16% (29 people) ever paid any healthcare related costs (Figure 3.14) at their last visit. Most notably, all the 16% who used public means paid transport fare. Only 2% paid the healthcare provider fees or bought drugs. On average, the respondents paid 50 Metecais (\$0.7) for transport; 10 for provider fees and 34 Metecais for drugs. The overall average cost was 56 Metecais (\$0.8) per visit per person who paid any of the costs. The many sources of the funds for the payments were the family savings or remittances from children or well-wishers (Figure 3.15).

Figure 3.14: Proportion of respondents who paid healthcare related costs

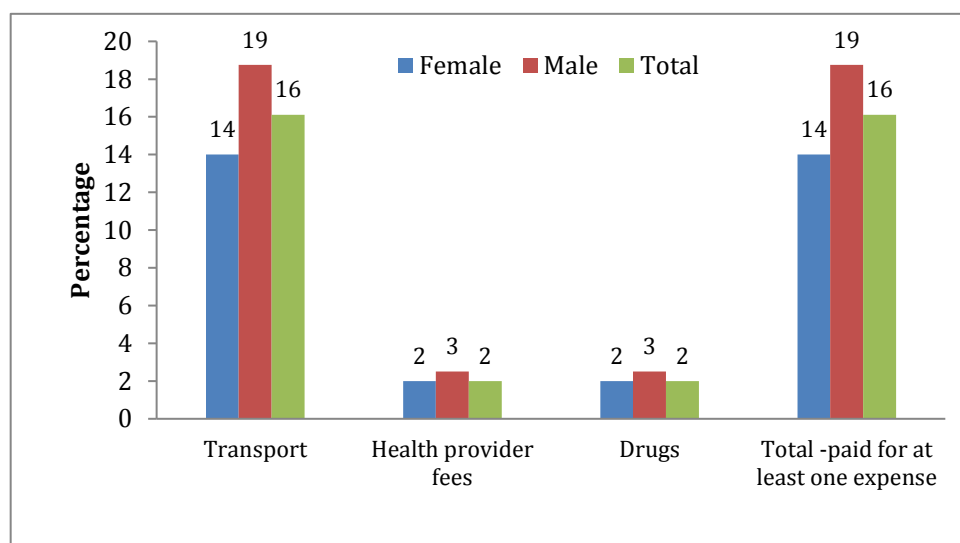
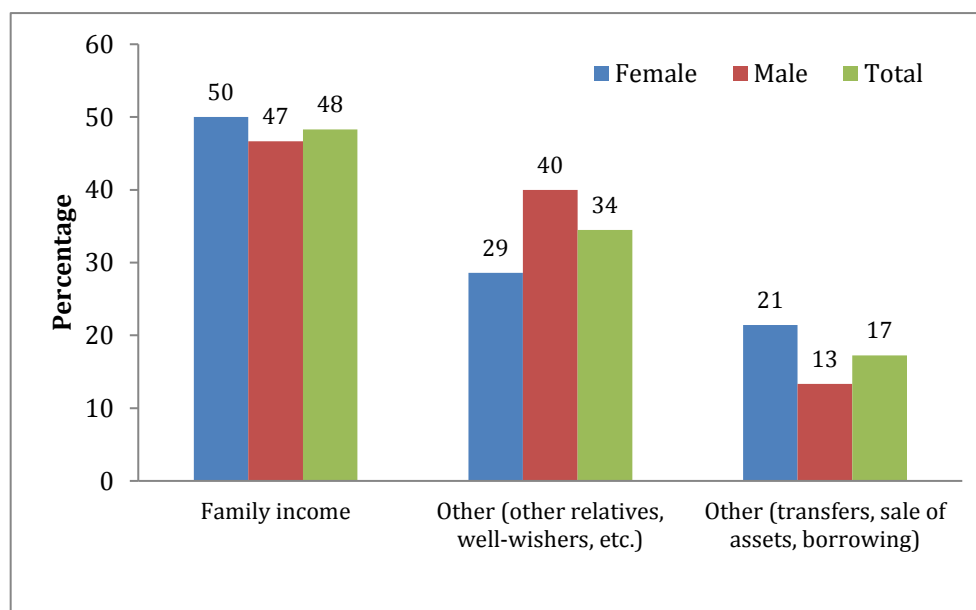


Figure 3.15: Proportion of sources for funds for healthcare related costs



Nonetheless, about 22% of the respondents noted that the healthcare related costs are a serious burden to them. This was similar between those who receive and who do not receive cash transfers.

Quality of healthcare and factors associated with healthcare utilization

Quality of healthcare services:

Of the 180 respondents who accessed healthcare, 77% (81% men and 71% women) reported satisfaction with the services they received. However, 22%

(39 respondents) reported to have either failed to get all the medication due to; (a) user fees or medication stock out at the health facility (39%); (b) unable to pay for the drugs (37%); or (c) failure to raise transport fare to collect the prescribed (especially at health post) medication at another health facility (19%).

Factors associated with healthcare utilization:

The BHOPA midterm review collected data on scores (01-100) on affordability of healthcare (including ease of access and utilisation of healthcare services) among 398 respondents. We fitted a linear regression model to these data and only the scores for the perception of quality of care (0-100) were associated with utilisation (Table 3.3). Poverty, age, sex and type of chronic disease were not significant in relation to the use of health services. Older persons were less likely to go for healthcare services at facilities they perceived to have poor quality care – including medication stock-outs, unskilled health-workers, and long waiting times. However, among the older persons aged above 70 years both the quality of care and poverty played a role in access to care ($P < 0.05$ for poverty status and t-value of 2.98). As noted before, this is likely related to the fact that the very old persons will need to pay a fare to use public transport to get to the health service or to pick up medication. Also more people over 70 suffer of chronic diseases and thus are likely to need regular access to medication they need to pay.



Photo: Development Action (CamillaWilliamson) Ethiopia

Table 3.3: Factors associated with utilization of health care services (n = 398; Midterm review data)

Variable	Coef	SE	t	P-value	95% CI	
Age						
50-59	Ref					
60-69	1.8	4.988	0.36	0.719	-8.011	11.607
70-79	3.26	4.912	0.66	0.507	-6.398	12.921
80+	-1.65	5.132	-0.32	0.748	-11.739	8.445
Gender						
Male	Ref					
Female	1.49	2.277	0.66	0.513	-2.986	5.969
Poverty						
Very poor						
Relatively better off	3.19	2.017	1.58	0.115	-0.776	7.156
Education						
No formal education	Ref					
Primary	2.49	2.226	1.12	0.265	-1.892	6.865
Primary+	10.26	11.982	0.86	0.392	-13.303	33.822
NCD						
Hypertension	Ref					
Eye disorders	4.75	7.437	0.64	0.524	-9.878	19.37
Arthritis	-1.19	4.381	-0.27	0.786	-9.806	7.424
Others	2.16	4.653	0.46	0.643	-6.994	11.306
Quality of health care						
0-49	Ref					
50-74	22.86	2.523	9.06	0.00	17.897	27.822
75-100	40.04	2.786	14.37	0.00	34.565	45.521

In conclusion, most of the older persons report poor health status with over 75% reporting at least one chronic disease. Poverty, and hence cash transfers, were not directly associated with access and utilization of healthcare services except among women and men aged above 70 years. The most important factor in relation to access to health care across the board is the perception of the quality of the health care – including skilled health-workers and availability of medications.

Focus on Ethiopia and Tanzania

For Ethiopia and Tanzania, only the midterm review data were available for re-analysis. Given the close congruence between results from mini-survey data and midterm review data for Mozambique, we believe results based on the midterm review data for Ethiopia and Tanzania give a snapshot of what have been obtained from mini-surveys had them been done in BHOPA program target communities in Ethiopia and Tanzania (The Midterm review was not conducted in Zimbabwe)

Health status and health care utilization

Self-rated health status and common ailments:

About 65% of the respondents in Ethiopia self-rated their health status to be at least average and above, with more men than women declaring a health status average or above (Figure 3.13a). However, for Tanzania, the reverse was true with 60% rating their health status as being poor also with more women than men declaring their health status below average. As would be expected, the percentage describing their health status as below average increased with age (Figure 3.13), particularly in Tanzania.

Figure 3.13a: Self-rated health status in Ethiopia sample

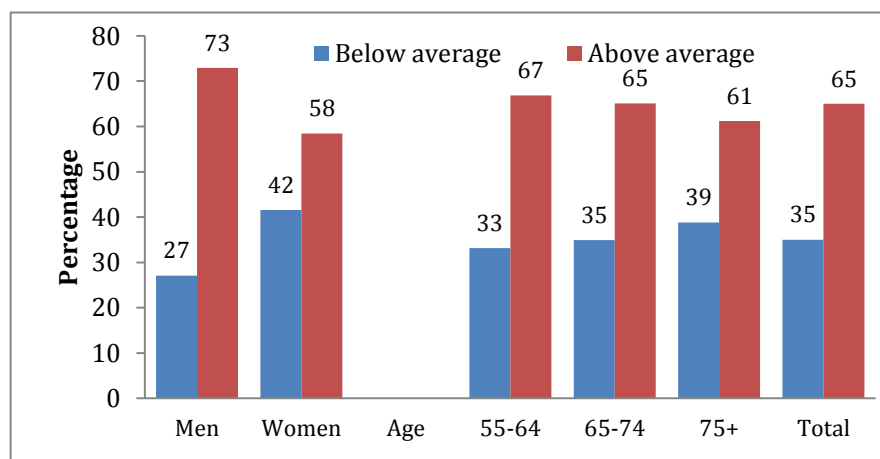
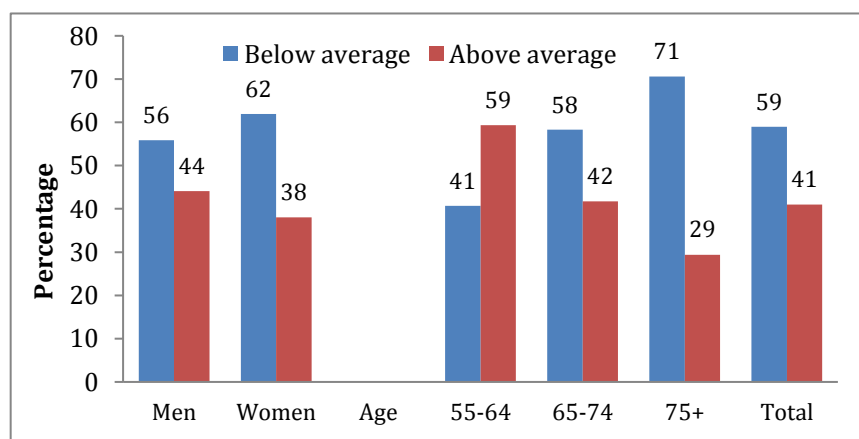


Figure 3.13b: Self-rated health status in Tanzania sample



Similar to Mozambique, the most common self-reported conditions include arthritis, followed by hypertension and eye sight problems. These were relatively more prevalent in Tanzania than in Ethiopia (Table 3.5).

Table 3.5: Common ailments

	Ethiopia			Tanzania		
	Men	Women	Total	Men	Women	Total
Arthritis	58 (32.0)	100 (45.7)	158 (39.5)	39 (26.8)	61 (39.9)	99 (33.0)
Hypertension	35 (19.3)	45 (20.5)	80 (20.0)	41 (28.4)	49 (31.7)	88 (29.4)
Eye sight	58 (32.0)	57 (26.0)	115 (28.8)	63 (43.6)	56 (36.4)	117 (39.1)
Asthma	16 (8.8)	27 (12.3)	43 (10.8)	11 (7.6)	18 (10.7)	28 (9.3)
Diabetes	26 (14.4)	13 (5.9)	39 (9.8)	21 (14.7)	11 (7.5)	30 (10.0)

Quality of healthcare and factors associated with healthcare utilization

Quality of healthcare services:

Of the respondents who accessed healthcare in the past 3 months, 50% (54% men and 44% women in Ethiopia; and 50% men and 50% women in Tanzania) reported satisfaction with the services they received.

Affordability of health care services: 67% of older people in Ethiopia and 75% in Tanzania stated that they were not able to pay for healthcare service costs on their own.

Factors associated with healthcare utilization:

Similar to Mozambique, we fitted a linear regression model to the midterm review data. In Ethiopia, poverty status, gender, nature of NCD and perceived quality of healthcare affect access and utilization of healthcare among older persons in Ethiopia. Poor older persons are least likely to access care as compared to their fairly well-off counterparts (adjusted absolute difference in proportions of 9.2%; p-value <0.01) (Table 3.6a).

Similar to Mozambique, in Tanzania, only the scores for perceived quality of care (0-100) were associated with affordability (Table 3.6b).

Table 3.6a: Factors associated with utilization of health care services in Ethiopia (n = 400; Midterm review data)

Variable	Coef	SE	t	p-value	95% CI	
Age						
50-60						
60-70	-3.97	3.017	-1.32	0.189	-9.908	1.965
70-80	0.66	3.305	0.2	0.841	-5.841	7.166
80+	-6.71	4.413	-1.52	0.13	-15.389	1.978
Gender						
Male						
Female	-5.92	2.47	-2.4	0.017	-10.78	-1.057
Poverty	9.17	2.126	4.31	0.00	4.991	13.359
Education						
No formal education						
Primary	-1.43	2.717	-0.53	0.598	-6.78	3.912
Primary+	-2.54	3.907	-0.65	0.516	-10.229	5.145
NCD						
Hypertension						
Eye disorders	10.01	4.533	2.21	0.028	1.086	18.926
Arthritis	-4.21	3.982	-1.06	0.291	-12.045	3.628
Others	0.44	4.289	0.1	0.919	-8.002	8.878
Quality of health care						
0-49						
50-74	18.1	2.723	6.65	0.00	12.746	23.462
75-100	33.6	3.107	10.81	0.00	27.485	39.712

Table 3.6b: Factors associated with utilization of health care services in Tanzania (n = 400; Midterm review data)

Variable	Coef	SE	t	p-value	95% CI	
Location						
Rural						
Urban	11.87	7.108	1.67	0.096	-2.111	25.859
Age						
50-59						
60-69	2.27	13.253	0.17	0.864	-23.808	28.34
70-79	3.98	13.347	0.3	0.766	-22.276	30.242
80+	5.21	13.465	0.39	0.699	-21.281	31.701
Gender						
Male						
Female	-0.18	2.629	-0.07	0.947	-5.349	4.997
Poverty	-0.99	2.205	-0.45	0.654	-5.33	3.348
Education						
No formal education						
Primary	1.4	3.54	0.4	0.692	-5.56	8.37
Primary+	1.12	5.031	0.22	0.824	-8.777	11.021
NCD						
Hypertension						
Eye disorders	-0.88	5.685	-0.16	0.877	-12.068	10.301
Arthritis	1.25	3.901	0.32	0.749	-6.425	8.925
Others	-4.72	4.723	-1	0.318	-14.012	4.573
Quality of health care						
0-49						
50-74	20.3	3.029	6.7	0.00	14.339	26.257
75-100	35.04	3.196	10.96	0.00	28.756	41.332

Summary of survey results in Mozambique

Of the 212 older people interviewed, majority rely on subsistence farming; family remittances and cash transfers for survival. Only a small group of older people access work related pension or paid employment. At least 58% of the respondents (61% women; 56% men) were currently receiving cash transfers – pensions and/or social benefits. Of these, 94% were PSSB (82% receiving poverty allowances and 16% were receiving old age allowances) and only 6% were receiving state pension. The PSSB was about \$4 monthly.

Generally, most of the older persons interviewed in the survey had poor health status with over 75% self-reporting at least one chronic disease. By their own assessment, about 50% stated that their health status is below average compared to the general population. As would be expected, the percentage describing their health status as below average increased with age for both men and women. Irrespective of sex and age, the most common self-reported conditions included arthritis (75%), hypertension (40%) and eye problems (38%). More generally, at least 60% respondents complained of some form of difficulty with eye sight, walking and remembering. A higher proportion of women complained of some difficulty with eye problems and walking as compared to men (67% vs 53%).

At least 80% of the older persons visited a health care facility for their most recent episode of ailment. Only 2% of the respondents reported to have paid healthcare provider fees but 16% had to pay transport fares. Proportion paying transport fare increased with age as walking to the health post becomes more difficult.

Of these respondents who visited the health care facility, 77% (81% men and 71% women) reported satisfaction with the services they received. However, 22% (39 respondents) reported to have either failed to get all the medication due to; (a) user fees or medication stock out at the health facility (39%); (b) unable to pay for the drugs (37%); or (c) failure to raise transport fare to collect the prescribed medication at another health facility (19%). Further, about 22% of the respondents noted that the healthcare related costs are a serious burden to them. This was similar between those who receive and who do not receive cash transfers.

These findings seem to indicate that a significant proportion of older people interviewed, and especially the older group suffering from chronic condition, find the cost of accessing health services and especially pay for transport and medications a serious financial burden.

Cash transfers can ease this burden and indeed respondents considered that the ability for a household's consolidated income to meet healthcare costs and personal needs increase by at least 30% when the household member receives cash transfers.

However, given the prioritization of basic needs and the competition for resources within the household, cash transfers are spent first on meeting food needs. This can have a positive impact on members' health outcomes as a result of improved nutrition. Further, the allocation of cash transfer to older people's health expenditure is dependent on a number of factors including the perceived quality of the health services provided, linked especially to accessibility of medication, and the needs of other vulnerable groups, especially grandchildren in the care of grandparents. This limited use of cash transfers to pay for the costs of accessing health service is reflected also in the findings that 65% of older people with a chronic condition do not use cash transfer to access health services. These findings highlight the particular vulnerability of the oldest old who have higher needs of the health services, higher costs to access them (especially transport) higher dependency on cash transfers as a main source of income and have to compete with the needs of all members of the household. There were not significant gender differences in the access and use of cash transfers.

6. DISCUSSION

The context of health care access

The present research focuses upon the impact of cash transfers on access to health services; it has not sought to evaluate the adequacy of health care systems objectively. However, in order to understand the health access context that cash transfers operate within, data was collected on the health status of older men and women in the target countries; social protection and health entitlements of older men and women; health service provision and older people's access to services; cost barriers to access; and how older men and women meet the costs of accessing health care. The evidence collected from both the literature review and the qualitative and quantitative data on these issues is discussed briefly here, before turning to the discussion of the impact of cash transfers on older people's access to health services in the four target countries.

Older people's health status

In regard to older people's health conditions, the findings of the qualitative research show a high incidence of self-reported non-communicable diseases (NCDs), including; hypertension; cardiovascular diseases; diabetes; cancer; general body pains, especially around joints (arthritis); urine and faecal incontinence; and eye and hearing problems. A range of mental health issues were also reported, especially dementia and depression. In regards to infectious diseases, respiratory tract infections and throat illnesses were discussed in the FGDs and with the KIs. Typhoid and diarrhoea were identified as common illnesses among older men and women. HIV/AIDS, which most of the people who are infected do not want to reveal because of fear of stigma, was also reported.

The survey data collected in Mozambique found that the majority of respondents (75%) reported at least one chronic disease, with the most common conditions including arthritis (75%), hypertension (40%) and eye problems (38%). No gender differences were noted, though the survey found that the prevalence of self-reported chronic diseases significantly increased after the age of 64, as did self-reported depression. The BHOPA midterm review data from Tanzania and Ethiopia also reports arthritis, hypertension and eye problems as the main ailments affecting older persons.

These findings correlate broadly with the limited country-level data available on older people's health, including evidence on the conditions that are most common and the prevalence of NCDs as shown in Section 3.

Older people's social protection and health entitlements

In all countries, FGD participants and KIIs reported the existence of social protection mechanisms that had been identified by the literature review. However, in all settings these were significantly limited in terms of coverage and level of protection. In Mozambique, Tanzania and Zimbabwe, some form of national cash transfer scheme existed that was aimed at or included vulnerable older people. In Ethiopia, the sampling criteria for the FGDs targeted those who were beneficiaries of location-specific cash transfer programmes, both initiated by NGOs, though in Tigray, this was implemented with government support. Even where the cash transfers were nation-wide in scope, however, coverage was reported to be extremely limited. In addition, the level of cash transfer in each country was low and was mostly spent on meeting basic needs; though it was frequently stated that it did not enable older people to meet them all. Despite this, FGD participants who were in receipt of the cash transfers still reported that they were an important or the most important source of income. This was also reflected in the

Mozambique survey, where 72% of those receiving cash transfers said this was the most important source of their income.

These findings add to the limited country-level data on the income sources of older people discussed in the literature review, which also found that cash transfers are a key income source for those older people receiving them. The research also provides some evidence of the impact of cash transfers on older people.

The survey and interviews show that older people in the target countries are aware of their entitlements for health care and cash transfers. In regard to health service entitlements, Mozambique, Tanzania and Zimbabwe were found to have specific entitlements to health services for older people. However, the implementation of these entitlements was reported by FGD participants and KIs to be patchy and limited, largely as a result of a lack of government funding, lack of policy, and/or reported corruption. In Ethiopia, no specific health entitlements for older people were reported in the FGDs or by the KIs; a National Action Plan of the Elderly and the National Action Plan of Persons with Disabilities exist but these have not been implemented.

Health service provision and older people's actual access to services

Data collected in the FGDs and KIIs illustrate that health service provision and older people's actual access to health services is significantly impacted by both supply-side and demand-side factors.

Evidence from the FGDs and the KIIs suggests the provision of health services is very inadequate across all countries, as a result of limited and/or poorly implemented entitlements to health and social protection; a lack of government funding; poor infrastructure; distance to health facilities; inadequate provision of treatments, equipment and medicines; staffing shortages; and lack of older person's specific knowledge and skills and age-friendly services. Out-of-pocket costs for accessing health services were found to be high in all countries, though to a varying degree. The findings of the qualitative research here are in-line with the literature which highlights, in particular, limited health service coverage for all age-groups in the target countries, inaccessibility of services; the paucity of the healthcare workforce; inadequate funding; insufficient or no policy on older people's health; and high out-of-pocket costs for the general population.

In regard to older people's health care specifically, the qualitative research collected in FGDs and KIIs suggests that health systems are unable to meet these needs, either because a lack of medicine, a lack of knowledge and skills, and/or as a result of the health system's focus on curative conditions as well as on child and maternal health.

The FGDs also identify access barriers related to demand. In the context of insecure income and difficulty in meeting basic needs, prioritisation of health care access is challenging and appears to depend on both household need and internal household dynamics. This was found to be particularly the case where grandparents are responsible for orphaned and vulnerable children. Both the qualitative data collected and the survey responses in Mozambique show that competing needs within households often crowd out the resources for healthcare seeking and, specifically, older people's health seeking or access to health care. Health-seeking behaviour also needs to be considered in regard to health status more broadly and the impact on this of insecure access to adequate food, water and basic needs upon this.

Overall, in both the qualitative and quantitative data, the users' satisfaction with health services was rated as broadly positive. This is in line with findings that confirm that service users tend to rate the health services positively and not challenge health professionals. Older men and women in all settings were found to attend government health services if they could afford to get there and pay

consultation costs where they occur. In the quantitative survey in Mozambique, all the participants, with the exception of two respondents who thought that their illness was not serious, consulted with a health professional in a public health facility/post (95%) or private health facility (5%) when they had been unwell or required a routine review within the past three months. Some correlation between likelihood of attending and age was found, with the older old less likely to access health facilities.

Nevertheless, the results from the FGDs showed that a perception of the quality of the health services has a bearing on the participants' access to health services. Evidence of this was found in the qualitative data where some older women and men said they do not get the necessary treatment or cannot access the required medicine and so do not attend health facilities. In both the survey carried out in Mozambique and in the mid-term review data from the BHOPA, a perception of quality of services is also linked to older people's access to health care. While there is a strong body of research which finds that people's perception of quality is a poor measure of actual standards of health services, this study appears to confirm that if people think that the services are poor then they are less likely to make use of those services.

When older people could not access health care due to costs or due to inadequate access to appropriate services and medicine, FGD participants in all countries reported turning to a range of alternative services, including traditional medication (though in many places this appears in decline due to perception of impact and the a high cost), private pharmacies to access medication where this is affordable; church and NGO provider of health care, especially in Zimbabwe; and the use of herbs and prayer.

The data provides some insight into the health services available to the older people who participated in FGDs and, through the literature review and the KIIs, older people more broadly. In Mozambique, the survey also gives some information on the health services being used by respondents. However, as the research was not focused on assessing the health services available to older people per se, only a limited understanding can be gained from this data. More research specifically focused on the health services available to older people and their access is necessary in each country.

Costs associated with health care access and additional barriers

Numerous expenses were discussed in the research findings and the burden of out-of-pocket expenditure appeared high, in line with available data. In the qualitative research, older people spoke about the high cost of health care and their inability to meet it. Analysis of the BHOPA mid-term review in Tanzania and Ethiopia found that 67% of older people interviewed in Ethiopia and 75% of those interviewed in Tanzania stated that they were not able to pay for healthcare service costs on their own. However, in the Mozambique survey, only 22% of the 180 respondents who had visited a health facility or post in the past 12 months, noted that the healthcare related costs are a serious burden to them, while of those who had accessed health care in the last six months, only 16% (29 people) ever paid any healthcare related costs at their last visit. Of those who accessed services, 22% (39 respondents) reported having either failed to get all the medication due to: (a) user fees or insufficient medication stock out at the health facility (39%); (b) an inability to pay for the drugs (37%); or (c) failure to raise transport fare to collect the prescribed medication at another health facility (19%). Part of the difference in the rating of the burden of health care costs between countries could be due to the fact that Mozambique has a policy of free health care for older people. The results might also have been different if all respondents were asked about the burden of health care costs, as those for whom a greater burden exists are likely to be the ones who had not accessed health services in the last 12 months, which may be due to cost barriers.

The types of costs associated with health care access and which were reported in the qualitative data were similar to those listed in the quantitative response given above, including: payments associated with direct access, consultation costs (in both countries that had a policy of free care and, more so, in countries that did not); access to medicines; and indirect costs of accessing health care. Transport was reported as a leading cost in all countries, and was particularly great for those in rural areas. In the survey in Mozambique, the burden of travel costs was found to increase with the age of respondents, most likely attributable to people becoming weaker in older ages and the increased burden of chronic diseases. This corresponds with the international literature, which finds financial barriers to accessing health facilities increase with age – particularly those associated with the costs of transport.

Meeting the costs of health care

In regard to meeting these costs, besides the cash transfer, which is discussed below, the quantitative data identified a range of funding sources, including general income seeking activities, assistance from community organisations and the church in some countries, and family support – though findings were mixed in terms of ability to depend on family and the community. Access to health insurance was found to be extremely limited in all settings, even in those countries that have community health insurance schemes, in line with evidence found in the literature review.

In the quantitative survey in Mozambique, the main sources of the funds for meeting health related costs were also identified as general / 'family' income sources (48%), Women respondents tended to report more support from family and others in paying for health care costs than male respondents, who generally reported a higher rate of reliance on general / 'family' income sources in paying for care.

Impact of cash transfers on older people's access to health services

In both the quantitative and qualitative data collected, evidence was found of the impact that cash transfers may have on older people's access to health services. However, even where this was the case, the evidence of its impact was mixed. A number of variables appear to affect the positive impact of the cash transfers on access to health care, including both those directly related to the cash transfer and those related to the wider context of health care access. These issues are discussed below.

The positive impact of cash transfers was found in all FGD and KIIs to a varying degree, while the quantitative survey in Mozambique found that cash transfers, in particular the PSSB, were used for meeting costs associated with access to healthcare. In the Mozambique survey, 28% of both male and female respondents who were receiving a cash transfer said they used it to cover health care costs. In addition, the quantitative survey in Mozambique found that satisfaction with household's ability to meet costs associated with healthcare and personal needs was significantly higher among the respondents receiving some form of cash transfer as compared to those without, with the perceived ability for a household to meet healthcare costs and personal needs increasing by at least 30% when the household member receives a cash transfer. In the FGD and KII multiple examples were given of older people using the cash transfer directly and indirectly to access health services. In particular, the following pathways were identified:

- Meeting the transport costs to hospitals or health facilities;
- Supplementing the cost of medicines or cost of consultation and treatment;

- Enabling the older persons to support grandchildren's access to health services, including by purchasing community health insurance cards for grandchildren;
- Improving older people's ability to borrow money which could then be spent on health care related costs;
- Increasing older people's ability to invest in income generating activities, money from which could be used to pay for health-related costs; and
- Strengthening their resilience and improving consumption confidence enabling them to pay for healthcare related costs.

Reports of using the cash transfer to meet transport, consultation and medicine costs, as well as the costs of grandchildren's health care were particularly common, though in no country were the cash transfers reported to cover all these costs, as the level of cash transfer in all settings was too low. The use of the cash transfer in income generating activities, which could have an impact on health access, was also discussed in all settings, though fewer incidents of people using the cash transfer to borrow money, which indirectly impacted upon access to health care, were reported.

In addition, it is important to note the evidence from both the quantitative and qualitative data, which found that the cash transfer impacted upon research participants' households' livelihoods more generally, with many reporting the stabilising effect of the cash transfer on their income and their access to food, nutrition, sanitation and other basic needs. This led to older people reporting that the cash transfer has a positive impact upon their and their family's health status regardless of their access to health services. Mental health was also reported to have improved in the qualitative data, with the cash transfer increasing levels of self-esteem and psychological wellbeing. Mental health was not directly captured by the quantitative survey, though the positive impact of the cash transfer on a household's consumption confidence is likely to have a positive impact upon psychological wellbeing.

FGD participants also reported that cash transfers have a positive impact on social cohesion helping people to avoid isolation. This in itself is important for both supporting better health directly and in enabling older people to access community resources which indirectly impact upon their ability to access health services.

In regard to the health services that cash transfers were reported to enable older people to access, participants mainly spoke about visiting government health facilities and getting medicines that were not available at government health facilities from private pharmacies. Generally, however, private health facilities were reported to remain unaffordable to participants even with the support of the cash transfer, or were reported not to be available in communities. Traditional health services were generally said to be expensive and increasingly viewed as not working. In Ethiopia, however, more people seemed to rely on traditional medicine services, but as these were said to be low cost and often free, access did not appear to be affected by cash transfers.

In all countries, women seemed to report a slightly more beneficial effect from the cash transfer on access to health care than men in the FGDs. Despite some reporting of patriarchal systems of money management within households and one report of men being more likely to attend health services in Tigray, women in the qualitative data collection appeared more inclined to access health services, both for themselves and for their children's health issues, than men, meaning that the cash transfer had more of an opportunity to be spent on health care by women. Women also tended to speak and express themselves more eloquently about their experiences with the health care system in terms of access, affordability and quality more than the men. This may suggest that even though men have easier mobility and relatively more control over resources in places, normative gender roles in societies, wherein women oversee caring for the health and wellbeing of

household members, particularly regarding children and grandchildren, mean they have more of a grasp of health-related issues and perhaps prioritise health care more than men. However, in Mozambique, the survey found no significant gender differences in the access and use of cash transfers. Discrepancy here may be due to different country contexts in the results, as for example, in higher rates of care giving among grandmothers in some countries, or as a result of women speaking more about their health in the FGDs, in comparison with men, biasing results.

The FGDs also revealed more use of health services and the use of cash transfers in accessing health services among those with chronic or long-term conditions. This was particularly evident for older persons on ARVs in Ethiopia and Zimbabwe, where the cash transfer was found to be a critical source of income for supporting older people's adherence to the medicine regimes. This correlates with data collected in the survey in Mozambique where 35% of the respondents with chronic conditions stated they used the cash transfer to cover the healthcare costs, compared to 28% of total respondents. This is unsurprising as those with higher need are more likely to prioritise health care costs compared to those with lesser needs.

Overall, the impact of the cash transfer, as reported in the FGDs, appeared to be stronger in Ethiopia and Tanzania, where more examples were given of the ways in which the cash transfer was used to access health services directly or to help stabilise household income with a positive indirect impact on access to health services or on health status more generally. Several reasons for this difference are possible. Firstly, while the coverage of the cash transfer was severely limited in every country, even if geographical spread of the programmes was broad, in Tanzania, a higher percentage of the participants in the FGDs were receiving cash transfers, potentially biasing the results. In Ethiopia, meanwhile, health care consultations are not free meaning the cash transfer was potentially able to have a greater impact on health service access. In contrast, in Mozambique, there is a policy of free health care for older people, while the value of the cash transfer which is already the lowest of the three countries, had been severely devalued owing to recent inflation. In Zimbabwe, the general state of the health services was reported to be extremely poor, meaning that even with the cash transfers, access was potentially more difficult than in other countries studied. In addition, as in Mozambique, health services were nominally free of charge in Zimbabwe, possibly limiting the potential effect of the cash transfer.

The relatively stronger impact of the cash transfer in Tanzania and Ethiopia may also be explained by the conditionality attached to cash transfers in Tanzania, where the cash transfer was conditional on participation in health sessions and attendance of health facilities for treatment, and in Ethiopia, with the presence of health services at the pay point on days of cash transfer delivery in Tigray and the linked health services that were available at the St George Welfare Association in Addis Ababa. Awareness training was also reported to be provided in some places, encouraging older people use some of the money from the cash transfer on health which appeared to have some impact in all locations. However, the data collected on this point is insufficient to explore independently the extent of the impact upon access to health care of the money the cash transfer provided and any conditionality or service access attached to the delivery of the cash transfer. Similarly, where work on older people's empowerment, support and knowledge to access health services had taken place, or where integration of social protection delivery with health services was evidenced, FGD participants appeared to be more likely to access health services. More research is needed to explore this issue in order to understand the extent of impact and how these interventions create change. This need is in line with research gaps identified in the international literature review.

Limitations of the cash transfer's impact on access to health services

In addition to the issues affecting variation in impact between countries discussed above, more general limitations in the impact of the cash transfer on access to health care were found in all countries.

In all settings, despite differences, the cash transfer was low and coverage was patchy. This meant that its impact upon household's income was not always sufficient to meet basic needs, let alone health care costs. In nearly all FGDs across countries, settings and gender, participants reported the money from the cash transfer was principally being spent on food and meeting other basic needs, as discussed above. While this was reported to have an important impact upon health status in itself, it meant limited funds were available for spending on accessing health care. Even where the cash transfer had more impact on household income, usually where people had additional sources of income or whose livelihood was relatively more secure, health care – especially older people's health care – struggled to be prioritised. This appeared to be particularly the case where older people were caring for grandchildren. When health care was prioritised within households or by older people themselves, more frequently amongst older people with more need, the money from the cash transfer only appeared to meet some of the costs involved in accessing care – in particular those related to transport, consultation costs and medicine; it did not meet all costs.

In the Mozambique survey, the limited impact of the cash transfer in improving access to health services is illustrated by the rate of respondents who noted that the healthcare related costs are a serious burden to them, wherein there was little difference in the results between those who receive the cash transfer and those who did not. Similarly, in the FGD data from all countries, both recipients and non-recipients of the cash transfer identified the same challenges in their lives the same spending priorities were given.

In this context, the limited impact of cash transfers on older people's access to health services suggests that income and livelihood insecurity is too great and the direct and indirect costs of accessing health services too high for a low-level cash transfer to make a significant impact. However, the limitations of the cash transfer in improving older people's access to health services also draw attention to the significant challenges presented by the supply-side barriers, discussed above. Even where cash transfers were reported to help older people attend health services, low-level availability, adequacy and quality of health systems still meant that older people reported being unable to access services that meet their needs.

Literature

The findings add to the very limited country-level research on the impact of cash transfers on access to health services for older people in Ethiopia, Mozambique, Tanzania and Zimbabwe. The findings also add to the international literature that shows cash transfers and social protection programmes can have an impact on access to health services and help to illustrate the pathways older people take in using cash transfers to access health services.

Some of these findings support evidence already in the literature considering how money from cash transfers are spent to access health services. For example, a recent evaluation of the Senior Citizen Grant in Uganda which has shown that cash transfers have helped older people to be able to better afford the costs of transport to access health facilities and to purchase medicines. However, new evidence emerges here in regard to pathways to access health services which are enabled by cash transfers. The evidence also suggests, in line with international literature, that cash transfers have a positive direct and indirect effect on older people's health status, irrespective of access to health services, through their ability to improve access to food, nutrition and sanitation.

One finding from the international literature is that the cash transfers help recipients to better manage the shocks of catastrophic health expenditures, and additional research points to an increase in access to preventative health services. While examples of using the cash transfer for catastrophic health costs were given in FGDs, limited information was collected on the type or level of health care intervention sought by older people when accessing services making analysis difficult.



Photo: Development Action (CamillaWilliamson) Mozambique

7. CONCLUSIONS AND RECOMMENDATIONS

Across all the four countries, there was some evidence of the potential impacts of cash transfers in facilitating older people's access to health services and upon the health status of older people, regardless of access to health services.

However, the impact of the cash transfer was found to be limited and evidence illustrates that significant barriers to access to health services remain, including: service adequacy, high costs of transport and medicines, the high burden on the cash transfer due to other basic needs such as food and school requirements for the children under older persons' care, and generally poor quality of care at the available health facilities. It was also noted that in some situations where older persons may feel that their health access should be a priority, the decision is not in their power to make. This appeared to be the case especially for the very old and frail, whose problems are perceived (sometimes wrongly) to be chronic/incurable. The study also shows that there is a dearth of suitable health services available for older people and highlights significant issues over the perceived quality of the services which do exist. Older people's perception of the quality of services appeared to be a key issue in their decision to seek health services.

Cash transfers and their impact on health care for older persons should not be seen in isolation. They affect and are affected by structural (policy, socio-economic and socio-cultural) as well as individual dynamics, such as the agency (abilities, skills, networks, age, education and gender) of an individual. The critical building blocks of the health care system, such as sufficient skilled staff, an adequate stock of medicines and other health supplies, appropriate health infrastructure and equipment, combine with other contextual factors to affect the overall effect of cash transfers on access to health services for older persons.

Policy recommendations

Our overarching policy recommendation, grounded in our research findings, is that enhancing the health status of older people must be a multi-sectoral endeavour. Improved health services will only enhance the health of older people if financial barriers are manageable. Equally, extending cash transfer coverage will only generate limited impacts, without good health services. Consequently, we recommend a combined strategy, which gives equal priority to both areas of intervention.

5. Improve coverage and adequacy of cash transfers

This study provides evidence of the positive impact of cash transfers on access to health services, but this impact is limited by the fact that many vulnerable older people are excluded, and benefit levels are low.

- 5.1 Expand older people's access to cash transfers, preferably through the introduction of adequate social pensions.
 - **Ethiopia:** Prioritise scaling up cash transfers to older people via the direct support component of the Productive Safety Net Programme (PSNP) while working towards implementation of a non-contributory pension, in line with the Social Protection Strategy for Ethiopia published in 2016.
 - **Mozambique:** Increase coverage of the PSSB to 62 per cent of eligible older people by 2024, in line with the strategy ambitions of ENSSB II.

- **Tanzania:** Introduce a universal social pension for all older people aged 60 years and over, building on from the successful experience of the scheme in Zanzibar.³
- **Zimbabwe:** Commit government funding for an adequate cash transfer programme for all vulnerable older people.

5.2 Improve the adequacy of cash transfers to a level that allows recipients to meet their basic needs, and supports access to healthcare services. The levels should be reviewed regularly and adjusted to reflect price inflation and inter-generational transfers that could affect how money in a household is spent.

6. Ensure health entitlements and service delivery include older people

Cash transfers cannot compensate for major weaknesses in health systems that are often the main barriers for the full realisation of older people's entitlements to access quality and affordable health service delivery. Specific recommendations for improvements are:

- 6.1 Ensure entitlements to free healthcare are implemented (where they exist). This requires sufficient infrastructure, staff and medicines, but can also be supported by awareness raising programmes (for older people and health professionals) and monitoring and holding service providers to account for those policy provisions.
- **Mozambique:** Ensure that health professionals respect older people's existing health service entitlements – including access to free health services and priority care.
 - **2.1.2 Tanzania:** Establish a legal framework that guarantees sustainable provision of free health services to older people by enacting the National Ageing Policy 2013 and ensuring the Health Service Act and the National Universal Health Coverage Strategy (currently at draft stage) include health and care entitlements for older people.
 - **Zimbabwe:** Revive older people's health service entitlements, including access to free health services through the Assistance Medical Treatment Order programme.
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- 6.2 Introduce entitlements to free healthcare where they currently do not exist:
- **Ethiopia:** Introduce specific entitlements for older people's access to health services alongside the development of those that exist for poorer people, in line with the National Action Plan of the Elderly and the National Action Plan of Persons with Disabilities.⁴

³ In April 2016, Zanzibar became the first country in East Africa to introduce a social pension for all people over the age of 70

⁴ GoE (2016)

6.3 Integrate the health needs of older people more comprehensively into health strategies and programmes, including:

- Ensuring outreach and prevention services address older people’s needs specifically.
- Ensuring availability of relevant treatment (including medicine) for age-related conditions, especially NCDs.
- Incorporating older people’s health needs into training of existing and new health staff
- Mainstream ageing issues into health service policy.

Table 8 Country specific health recommendations

Ethiopia	Outreach and prevention services should address older people’s needs rather than focusing only on maternal and child health
	Older people’s health and care needs should be directly addressed in the training of health staff and in mainstream health service policy
	Greater availability of relevant treatment in the health service should be promoted
Mozambique	Community outreach and prevention services, such as those delivered by APEs, should address older people’s needs specifically
	The availability of medicines for and treatment of age-related conditions at government health centres should be addressed
	Positive developments in the training of healthcare professionals in older people’s health and care needs should continue and an ambitious target for delivery and expansion established. This should be used by advocacy groups to promote continued efforts
Tanzania	Government to set aside 6% of the total budget to buy medicines that treat diseases that affect older people
	A special window for older persons should be open in all public health facilities
	Better integration provision of health and social care
	Need to review and update the user guide for geriatric care and to consolidate efforts to integrate geriatric care training in the continuous medical education and the curriculum of all health workers’ training institutions. Efforts to strengthen geriatric healthcare training should also be extended to universities and other higher learning institutions
Zimbabwe	All stakeholders should work together to support the revival of the healthcare system in Zimbabwe. There were clear indications during this study that although services are free, the healthcare system faces immense challenges, affecting access to and uptake of health services by older persons and other population groups.
	Community outreach and prevention services should specifically address older people’s needs
	The availability of medicines for and treatment of age-related conditions at government health centres should be improved
	Systematic training of healthcare professionals in older people’s health and care needs should be implemented

7. Promote links between cash transfer programmes and other social protection and health promotion initiatives

Cash transfer programmes were found to be effective in encouraging the adoption of healthy behaviour and increased use of health services in some cases when accompanied by health promotion activities.

- 7.1 Strengthen awareness of cash transfer programmes as a means of supporting healthy behaviours in conjunction with health promotion activities
- 7.2 Coordinate cash transfer with other social protection programmes to optimise capacity and generate synergies.

8. Ensure age-disaggregated data and evidence on older age, social protection and health at all ages is available

The study helped to highlight that the evidence base on older age, and specifically social protection and health status and health needs, is very limited. Some specific suggestions to improve this include:

- 8.1 Improve national statistical systems to build a clearer picture of the situation of older people, and their health needs, including:
 - Expanding Demographic and Health Surveys to include questions relating to people above the age of 49 – the current cut-off point in most countries.
 - Presenting age-disaggregated data in regular national surveys (such as household surveys and Labour Force Surveys).
- 4.3 Integrate the collection of age-disaggregated data into the implementation of cash transfer programmes.



Photo: Development Action (CamillaWilliamson) Mozambique

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