Determinants of the Elderly's Social Protection Services Access in Kilimanjaro Region, Tanzania

Regina C. Malima[1], John N. Jeckoniah[2] and Zebedayo S. K. Mvena[3]

[1]Tengeru Institute of Community Development (TICD)
[2]College of Social Sciences and Humanities, Sokoine University of Agriculture;
[3]Department of Agricultural Extension and Community Development, Sokoine University of Agriculture.
Contact address: regina.malima@yahoo.co.uk

Abstract

Inaccessibility to Social Protection Services (SPSs) is a major concern for the majority of the elderly on the globe and developing countries, including Tanzania. This paper establishes the extent to which the elderly have access to SPSs and determines the factors that influence SPSs access to the elderly. A cross-sectional research design was used whereby 202 respondents aged 60 years and above were involved. Data were analysed using Ordinal Logistic Regression and content analysis for quantitative and qualitative data respectively. The indicators based on protective, preventive, promotive, and transformative dimensions were established to measure SPSs access levels among the elderly. The elderly in the study area were categorized at medium level of SPSs accessibility (87.1%). Ordinal logistic regression analysis results showed that SPSs access to the elderly's and their awareness on policy and rights, health insurance, and financial assistance were the important determinant factors that influence SPSs access to the elderly in the study area. The study recommends to the Government and Civil Society Organizations to devise intervention mechanisms for the elderly including the provision of health insurance services, cash transfers (universal pension), and enactment of law(s) that promote the elderly's welfare and eventually improve the delivery of SPSs in Tanzania.

Keywords*: Social protection, determinants, social protection services, access, dimensions*

1.0 Introduction

1.1 An Overview of the Elderly's Social Protection Services Accessibility in Tanzania

Inaccessibility to Social Protection Services (SPSs) among the elderly is a common phenomenon almost everywhere in the world. Such inaccessibility is considered as one of the critical challenges affecting the wellbeing of this category of people. According to studies (e.g. UN, 201I; Fredvang *et al.,* 2012), SPSs accessibility to the elderly is the ability of the elderly to get the required basic needs including food, health services, clothing, shelter, and income assistance from Social Institutions (SIs) as the service providers. Substantially, SPSs accessibility is a human rights issue as spelled out in various national and international policy instruments and it has become an important factor in improving the welfare of the people particularly the elderly in many developing countries (UN, 2011; Fredvang *et al*., 2012; ILO, 2014). Any person in the age of sixty years and above is considered as old and aged person who requires adequate SPSs from SIs (URT, 2003), and it is a period when their body systems start to diminish in functionality, and become no longer active and able to withstand the different challenges of life (Bookman, 2011; WHO, 2015). Furthermore, the elderly are an important component of every country's

demographic strata since they play a vital role in providing information, knowledge, and experience. They are also the custodians of customs and traditions, advisors and child carers. In this regard, they need special attention of accessing SPSs like any other insecure vulnerable groups in order to improve their welfare (Laiglesia, 2011; ILO, 2014)

The concept of SPSs, as discussed by international organizations and some development practitioners such as the World Bank (WB) and United Nations (UN), has adopted broader approaches focusing on promotive, protective, preventive, and transformative dimensions. However, there are two types of SPSs namely contributory and social assistance. Meanwhile, the provision of SPSs to the elderly in this paper is essentially advocated as a distinguished universal concern towards improving the marginalized groups including the elderly through promotive (promoting opportunities and increase in income and capabilities). Others include preventive (preventing poverty from occurring/mitigating risks in order to avoid shocks), protective (recovery from shocks), and transformative (focusing on the rights and inclusion) measures both in the developed and developing countries (Bloom, 2011; UN, 2015; Bandita, 2017). Meanwhile, this is the most relevant conceptual approach to SPSs provisions to the marginalised groups, as it encompasses the aspects of equity, empowerment, economic, social and cultural rights (Devereux and Sabates-Wheeler, 2004; Harvey, 2009; Bandita, 2017). However, one of the key challenges in addressing SPSs inaccessibility among the elderly has been the designing SPSs interventions that are supportive to sustainable elderly's wellbeing. Thus, SPSs inaccessibility concerns have frequently been voiced in order to address the basic needs of the elderly (Laiglesia, 2011; UN, 2011; ILO, 2014).

The provision of adequate SPSs to the elderly is a shared responsibility of Social Institutions (SIs) including the family, Government and voluntary agencies (URT, 2003; Devereux and Wheeler, 2008; Bloom, 2011; Bandita, 2017). In this context, the SIs are considered as contribution based instruments that mitigate the risk for all social groups, including the elderly, by improving their welfare (Babajanian, 2013). Currently, the Tanzania Government and Non-Government institutions have made several initiatives in providing SPSs to the elderly. These foundational efforts include formulation of the 2003 National Ageing Policy (NAP), establishment of the elderly's free health services, and the establishment of the elderly's Department in the Ministry of Community Development, Gender, the Elderly, and Children. others include, elderly identification cards, fighting chronicle diseases such as Malaria through the provision of mosquito nets, food subsistence and consumption transfers, financial assistance (e.g. Tanzania Social Action Fund - TASAF), and the establishment of care centres for the elderly (URT, 2003; URT, 2005; URT, 2010).

Despite the available initiatives in improving the welfare of the elderly, SPSs inaccessibility among the elderly remains highly prevalent (Yaffe, 2012: Saunders *et al*. 2017). For example, in Tanzania, about 96 percent of the elderly aged 60 years and above are inadequately accessing SPSs such as food, health, and cash assistance (URT, 2003; ILO, 2008; Spitzer *et al*., 2009; URT and HAI, 2010; UN, 2011;;). Consequently, the majority of the elderly continue to live a risky life of abject poverty, which is devoid of SPSs. According to scholars (e.g., Spitzer *et al*., 2009; Mboghoina *et al*., 2010; Tobias, 2014; Kessy, 2014)), SPSs inaccessibility among the elderly has serious and alarming implications in terms of their healthcare, income and food welfare. These are the concerns, which need to be addressed as a matter of urgency in order to protect,

prevent, and promote the elderly's welfare (Aboderin and Gachuhi, 2007; Oduro, 2010).

Studies on elderly's accessibility to social protection services in developing countries, particularly in Tanzania are scanty. Specifically, little is known on the factors that determine SPSs access to the elderly, and the extent to which SPSs interventions in terms of protective, preventive, promotive, and transformative dimensions have enhanced the elderly's SPSs provisions in response to their basic needs against SPSs inaccessibility.

Therefore, this paper establishes the extent to which SPSs from social institutions are made accessible to the elderly in Kilimanjaro Region. Specifically, the study (i) examined the levels of SPSs access to the elderly, (ii) assessed the extent of the priority dimensions which SIs mainly use in delivering services to the elderly and (iii) analysed the determinant factors that influence the elderly access to SPSs.

1.2 Conceptual Framework

The conceptual framework of this study is adapted from Social Risk Management (SRM) by the World Bank and ILO frameworks (World Bank, 2000, ILO, Devereux and Sabates-Wheeler, 2004). The framework is essentially an analytical tool that identifies alternative strategies and arrangements of dealing with the risks for groups with security concerns in the face of vulnerabilities and contingencies by focusing on four interrelated dimensions namely, SPSs dimensions (protective, preventive, promotive and transformative), social institutions (service providers), legal frameworks and determinant factors for SPSs access. This framework is linked to the elderly as a special group that need special attention of being provided with SPSs. The attributes in the SRM are influencing one another in order to improve the welfare of the elderly including assurance of SPSs (food, health services, income etc.).

Beside this framework, the study is also aligned with the Elderly Multi- Multidimensional theory developed by Doron (2003). Doron assumes that, effectiveness of SPSs access to the elderly is based on the existing fundamental constitutional and legal principles where the rights of the elderly are defended and grounded in law. Based on these theoretical assumptions, this study assumes that the achievement of sustainable elderly's wellbeing depends on the existing SIs, SPSs dimensions, and determinant factors (awareness on policy and rights, health insurance, and financial assistance and socio-demographic variables including area of residence, literacy status, and marital status) and the nature of the legal framework. In the context of this study, SPSs access to the elderly is considered to happen when the elderly realize their legal rights through awareness rising, access to information, and the provision of health insurance and financial assistance from social institutions.

2.0 Methodology

2.1 Description of the study area

This study was conducted in Moshi District Council (MDC) and Moshi Municipality (MM), Kilimanjaro Region in Tanzania. The region was selected because it has the highest (9.7%) proportion of the elderly population compared to the national average of 5.6 percent. According to literature (i.e. URT, 2012; NBS, 2013; URT, 2014; URT, 2017), MDC has the elderly population of 28.4 percent, Rombo (15.9%), Siha (7.0%), Hai (13.0%), Mwanga (8.0%), Same

(16.4%) and MM (11.2%). Two districts (MM and MDC) were selected randomly to represent other districts in Kilimanjaro region.

2.2 Research design

In order to collect multiple cases in a single point of time the study employed a cross-sectional research design. The design is considered as appropriate as it is useful for description purposes and for the determination of the relationship between variables. Further, the design allows the collection of both qualitative and quantitative data for two or more variables, which are then examined to detect patterns of associations (Bryman, 2004; Rwegoshora, 2006). Four wards and eight villages were selected for the study. Two wards and four villages were selected purposely from each district based on the list of the elderly provided by the District Government Officials in the respective study areas (Table 1).

Table 1: Distribution of the villages/streets selected for the study

District	Division	Wards	Villages/Streets	NES
Moshi Municipality (MM)	Moshi Mashariki	Kiusa	Kiusa Line	24
			Kiusa Sokoni	24
		Bomambuzi	Kanisani	24
			Kilimani	26
Sub Total (MM)				98
Moshi District Council(MDC)	Vunjo Mashariki	Mwika Kusini	Mawanjeni	26
			Kiruweni	26
		Marangu	Samanga	26
			Rauya	26
Sub Total (MDC)				104
GRAND TOTAL				**202**

Note: NES= Number of elderly selected

2.3 Sample size determination

The sampling unit for this study was the elderly aged 60 years and above with different marital statuses. The elderly men and women were the respondents because SPSs provision is a non-gender biased issue. Thus, SPSs inaccessibility is likely to affect both the elderly men and women if not addressed by SIs. For the purpose of this study, all elderly respondents were regarded as SPSs beneficiaries regardless of their gender, marital status, education, and occupation. The sampling frame was a list of names of all the elderly registered in the respective districts. Simple random sampling technique using lottery method was used to obtain sample size of 202 respondents where 98 and 104 were obtained from Moshi Municipality and Moshi District Council respectively.

2.4 Data Collection

Qualitative and quantitative methods were employed to collect data. The combination was useful as it provides triangulation of information (Creswell, 2013). A structured questionnaire with close and open-ended questions was used to collect quantitative data. The tool was self-administered to the elderly since they were the target or primary group who had information on social protection services. The most important information collected through the questionnaire was the social demographic characteristics and the social dimensions. An interview guide was used to gather information on the services provided and the mechanisms used. Data were collected from 36 key informants including 10 representatives from the elderly's households, 4 religious leaders, 2 Tanzania Social Action Fund (TASAF) officers, 4 District Community

Development Officers, 4 elderly's council leaders, 4 Ward Executive Officers, and 8 Village Executive Officers/Street leaders). These are social protection service providers. A focus group interview guide was used to gather information from eight (8) FGDs, which involved 6 to 12 people (6 men and 6 women respectively) per group for qualitative data collection. FGD, KII and in-depth discussion helped the researcher to explore practical experience of the elderly's SPSs accessibility status.

2.5 Data Analysis

Qualitative data were analysed using content analysis whereby SPSs access to the elderly, their levels and factors that influence SPSs access to the elderly were transcribed and categorised based on the study objectives. Statistical Package for the Social Sciences (SPSS) was used to analyse data. Quantitative data were analysed descriptively and inferentially. Descriptive statistics such as frequencies, percentages, averages, and standard deviations were used to describe socio-economic characteristics of the elderly. Ordinal logistic regression model was used to determine the factors that influence SPSs access to the elderly. SPSs accessibility to the elderly was established based on protective, preventive, promotive, and transformative dimensions as the potential benchmark for social protection phenomenon (Doron, 2003; Devereux *et al*., 2004). Furthermore, the indicators for each dimension were set and agreed upon during FGDs as adopted from the 2003 Tanzania National Ageing Policy to reflect the context of SPSs accessibility to the elderly in the study area.

The established indicators in the protective domain were food, shelter, healthcare, bed and mattress, mosquito net, clothes, and care/respect. In the preventive domain, the indicators were health insurance, consultation and medication, health check-ups, and transport to the hospital. The promotive indicators included cash transfer, financial services, entrepreneurship knowledge, and knowledge on the rights of the elderly. Transformative indicators included awareness on policy and the rights of the elderly, representation in decision-making organs, participation, respect, and access to information (URT, 2003). Each response to a given indicator was assigned a score of either zero (0) for "do not have access" or 1 for "having access". The sub-total score values for indicators obtained from the four dimensions were summed up to get the grand total scores for each respondent. Finally, the grand total scores were categorized into three levels score namely; 0 = Low; 1 = Moderate and, 2 = High. This classification of measuring and establishing accessibility levels among the elderly is well documented in many literature sources including Meena *et al*., (2012) and Nzali (2016) as follows:
Low (Below Mean-Standard Deviation (SD); Medium (Mean – SD to Mean + SD); and High (Above Mean + SD). The categories for the elderly status were summarized as Low = 0 – 3, Moderate = 4 - 10; and High = 11 - Above. These categories were established to measure the extent of accessibility to SPSs by the elderly as a dependent variable. The normality test was conducted to determine whether the dependent variable was normally distributed. The results on Shapiro-Wilk Test showed that there was a significant difference at $p < 0.05$. This implies that the dependent variable was not normally distributed. Thus, the model fell under logistic non-linear function.

The determinant factors that influence SPSs access to the elderly were established using ordinal logistic regression model. The model was relevant because the dependent variable (Y) was classified in terms of ordered access to social protection services levels (low, medium, and high)

which assisted to establish the relationship between the dependent and independent variables, which are the determinants of the SPSs access to the elderly. Ordinal logistic regression is appropriate when the outcome is at ordinal level with more than two categories (Agresti and Finlay, 2009). The ordinal logistic regression equation according to Agresti and Finlay (2009) is expressed as:

$$Logit[p(x)] = Y = \log\left[\frac{p(x)}{1-p(x)}\right] = a + \beta_1\chi_1 + \beta_2\chi_2 + ... + \beta_n\chi_n + \varepsilon \ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots (1)$$

Where:

Y= Access to social protection services: 0 = Low access, 1 = Moderate access, 2 = High access.

This model was used to estimate the influence of the hypothesized explanatory variables on the chances the elderly were highly accessing social protection services. The independent variables (X_is) were thirteen as shown in Table 2. The independent variables included dummy and continuous variables. The dependent variable (Y = 0, 1, or 2) for low, moderate and high access respectively was regressed on the independent variables to examine the influence of each independent variable termed as factors determining access to social protection services by the elderly.

Table 2: Definition of the independent variables of the model

	Explanatory variables	Definition	Expected signs
X_1	Residence of the elderly	1= residing in rural area; 0 = reside in urban area	+
X_2	Age of the elderly in years	Years of living	+
X_3	Sex of the elderly	Gender: 1 = Male; 0 = Female	+
X_4	Literacy status	1= able to read/write; 0= unable to read/write	+
X_5	Marital status	1= married; 0 = otherwise	+
X_6	Size of the household	Total number of people residing in the household	+
X_7	Income from agricultural produces	1= access; 0 = otherwise	+
X_8	Income from selling h/h items	1= access; 0 = otherwise	+
X_9	Remittance from children/ relatives	1= access; 0 = otherwise	+
X_{10}	Health Insurance	1= access; 0 = otherwise	+
X_{11}	Awareness on elderly rights	1= Aware; 0 = not aware	+
X_{12}	Access to information	1= access; 0 = otherwise	
X_{13}	Cash transfer from TASAF	1= access; 0 = otherwise	+

3.0 Results and Discussion

3.1 Descriptive statistics

Descriptive statistics of independent variables showed that the age of the elderly ranged from 61 to 105 years; the total number of people residing in the household ranged from 1 to 12 implying that some households had family members who could provide care for the elderly (Table 3). It is evident that, the higher the number of people in the household the higher the reliability of the care to the elderly. This is because members can collectively contribute to income raising, ranging from agriculture to sales of household items. The income of the elderly from agricultural sales was between 0 and 1 000 000.00 TZS; remittance from children/relatives was between 10 000.00 and 500 000.00 TZS. Cash transfer from TASAF was between 0 and 1 000 000.00 TZS and income from selling personal household assets and goods such as land, clothing, furnishing and furniture was between 0 and 8 000 000.00.

Table 3: Descriptive statistics of quantitative variables

Variables	Min	Max	Range	Mean	Standard deviation
Age of the elderly	61	105	44	74.57	10.29
Size of the household	1	12	11	4.31	2.21
Income from agricultural sales	0	1 000 000	100 000	26 905.94	28467.59
Remittance from children/relative	10 000	500 000	490 000	66 014.85	108299.08
Financial assistance(Cash transfer from TASAF)	0	1 000 000	1 000 000	274 504.95	330398.53
Income from selling of h/h items	0	800 000	800 000	204 673.27	247666.25

Table 4 shows the contribution of marital status, literacy, gender, and areas of residence towards accessibility of SPSs by the elderly. The findings indicate that, married couples were more secured than were the unmarried and the more literate the elderly were the more aware of their rights and privileges. On the area of residence, 104 (51.5%) of the elderly came from Moshi Rural while 98 (48.5%) of the elderly came from Moshi Municipality. On gender, 112 (55.4%) were males and 90 (44.6%) were females. The majority 114 (71.3%) of the elderly involved in the study were able to read and write while 28.7 percent were not. It was also found that 139 (68.8%) of the elderly interviewed were married while only 63 (31.2%) were not married/divorced/widows or widowers. The majority 122 (60.4%) of the elderly in the study area had health insurance cards while only 80 (39.6%) of the elderly had no cards. On awareness of policy and elderly rights, the majority 148 (73.3%) of the elderly were not aware of the elderly policies and their basic rights while very few 54 (26.7%) were aware of their basic rights.

Table 4: Descriptive statistics of the dummy variables

Variables	Frequency		Percent	
	Male/Yes/ married/Rural /able to read/write	No/otherwise/ Female/Urban/ Unable to read/write/ not married	Male/Yes/ married/Rural/ able to read/write	No/otherwise/Female/Urban/ Unable to read/write/ not married
Area of Residence	104	98	51.5	48.5
Sex of the elderly	112	90	55.4	44.6
Literacy status (ability to read and write)	144	58	71.3	28.7
Marital status	139	63	68.8	31.2
Health insurances	122	80	60.4	39.6
Awareness on policy/right	54	148	26.7	73.3
Access to information	41	161	20.3	79.7

While information is regarded to be a powerful tool for the elderly in accessing social protection services, the majority of the elderly 161 (79.7%) were not accessing basic and relevant information that could have assisted them in demanding for their rights, only 41 (20.3%) of the sampled elderly were accessing information regarding elderly issues (Table 4).

3.2 The levels of accessibility of Social Protection Services (SPSs) by the elderly

Descriptive statistics of the dependent variable, which was access to SPSs by the elderly, was carried out to determine the proportion of the elderly who had access to SPSs in the study area. The results in Table 5 indicate that the elderly who had moderate access to SPSs were 81.7 percent out of 202 total respondents interviewed. They also show that those who had low and high access to SPSs were 5.9 and 12.4 percent respectively. The differences in SPSs accessibility levels could be a result of many factors including the SPSs provided by the SIs (government, non-governmental organisations and the family) in the study area. Likewise, the region has stronger health systems and socio-economic development than the regions in western and north western Tanzania (URT, 2012; URT, 2013; Kumalija *et al*., 2015). This finding indicates that the presence of various SPSs including health systems and socio-economic strength are an important determinant of the elderly's SPSs accessibility. Thus, according to Kumalija *et al*., (2015), SPSs accessibility levels (differences) are the result of strong health systems in terms of health workforce and infrastructure and it is largely associated with higher levels of socioeconomic development in the study area.

Table 5: Categorical scores of the elderly's access to SPSs (n = 202)

Levels of SPA	SPA range score	Frequency	Percent
Low	≤ 3.0	12	5.9
Moderate	4.0 – 10.0	165	81.7
High	>11	25	12.4
Total		**202**	**100.0**

Furthermore, it is important to note that, although the elderly were found to have moderate access level to SPSs in the study area, still the general access of SPSs to the elderly at the national level is not promising only 4.5 percent of the elderly are adequately accessing SPSs from SIs (URT and HAI, 2010).

3.3 The SPSs Dimensions and service delivery accessibility among the elderly

In the course of ensuring the wellbeing of the elderly, the Social Institutions (SIs) act as the vehicle that transfer SPSs to the elderly through four roles, dimensionally they are; protective, preventive, promotive, and transformative (Doron, 2003; Deverex and Sabates- Wheeleer, 2004). These dimensions as used by SIs in delivering services to the elderly are presented in Table 6. The results indicate that SPSs accessibility to the elderly were protective (57%), transformative (34%), preventive (24%), and promotive (16%).

Table 6: The elderly's response total scores in each SPSs dimension (n = 202)

Social protection dimension	Total Scores	Average scores per respondents	Total scores for indicators	Percentage	Ranking
Protective	721	4.1	7	57	1
Transformative	350	1.7	5	34	2
Preventive	213	1.0	4	25	3
Promotive	115	1.0	6	16	4

These findings imply that SPSs were highly accessible by the elderly through protective measures as opposed to other dimensions (Table 6). This is because, elderly protective services from SIs necessitates a practical multifaceted approach that incorporate very basic needs of the

elderly (health, food, shelter, income and legal matters) that cannot be addressed in isolation (Shrivastava *et al*., 2013) as opposed to other dimensions which are biased to limited elderly's services. It is important to note that, the elderly population tends to have a higher prevalence of chronic diseases, physical disabilities and other co-morbidities. Therefore, these results imply that the elderly require SIs that can be able to design harmonized social protection strategies that are protective, preventive, promotive, and transformative in nature for achieving the best outcome when addressing the elderly's challenges (Nzali, 2017; Mwakajwanga, 2011; Babajanian *et al*., 2012; World Bank, 2012; Kessy, 2014).

3.4 Factors influencing elderly's access to Social Protection Services

The ordered logistic regression analysis was estimated using maximum likelihood estimation. The iterative procedure was used whereas the model converged at iteration 6 of log–likelihood of -70.972164, which fitted the model (Table 7). The likelihood ratio chi-square was 97.05, whereas the model was statistically significant at $p<0.01$ significant level. The Mcfadden pseudo R-Squared of 40.61 percent shows a proper overall capability of the model to provide accurate predictors for the dependent variable (Table 7).

To capture the factors influencing the elderly's access to social protection, the dependent variable (Y= Access to social protection services: 0 = Low access, 1 = Medium access and 2 = High access) was regressed on independent variables. these specifically involved socio-demographic characteristics (age, marital status, literacy level, residence location, and the size of the household), socio-economic factors (selling of household items, remittance from children/family, selling of agricultural produces), and institutional factors (health insurance, awareness on elderly rights, access to information and financial assistant - cash assistance from TASAF) as depicted in Table 2.

The results of the ordered logistic regression in Table 7 show that some of the socio-demographic variables including area of residence were more likely related to the elderly's accessibility to social protection services and was significant at $p<0.05$ significance level. This finding implies that the elderly residing in rural areas were more likely to access SPSs such as food and income from their family/relatives as opposed to the elderly in urban areas. This is because there are more opportunities at family levels (secured subsistence farming) including farms, assets and livestock keeping, and nonfarm occupations among the family members in rural areas as opposed to those living in the urban areas. This information is supplemented by qualitative information, which was collected during focus group discussions, one of the elderly respondents had this to say:

> "*There is plenty of food in rural areas……as you can see… majority of us are still involved in farming and non-farm occupations such as selling of farm and livestock products. You cannot do all these if you are in urban areas and not in rural areas"* (Elderly FGD participant, Mawanjeni Village, 2016).

The above extract shows the relationship between the elderly's area of residence and accessibility to SPSs from social institutions. These study findings are supported by the findings reported in a study by other scholars (e.g. Forrester, 2000; HAI, 2008; Nkwarir, 2010) who revealed that the elderly in rural areas in many countries including Tanzania and Cameroon are

still active and are engaged in a range of economic activities at very old ages. Therefore elderly are able to obtain their basic needs such as food and health services easily.

Moreover, literacy status was also more likely related to the elderly's accessibility to social protection services and was significant at p<0.1 significance level (Table 7). These findings imply that literacy status is associated with increased probability of access to services by the elderly. Literacy here means the ability to read and write that can assist the elderly to build awareness of the rights and privileges. The findings imply further that the elderly who have better understanding of different rights pertinent to their welfare are more likely to access SPSs from social institutions than those who are illiterate. These findings are consistent with what has been reported in literature (e.g. Spitzer *et al*., 2009; Nkwarir, 2010; URT, HAI, 2010) who found that literacy status is an important factor that influences the livelihoods of the elderly as it enables them to meet their basic needs and improve their socio-economic security.

Table 7: Factors Influencing Elderly's Access to Social Protection Services (N = 202)

Explanatory Variables	**Coefficients**	**Std. Error**	**Z-Score**
Residence location	1.943582	0.668	2.91**
Age of the elderly	-0.038500	0.024	-1.59
Sex of the elderly	-1.075976	0.520	-2.07**
Literacy status (Ability to read)	1.013962	0.575	1.76 *
Marital status	0.089718	0.516	0.17
Size of household	0.060840	0.100	0.60
Health Insurance	1.515142	0.582	2.60 **
Awareness on elderly's policy/right	2.149573	0.635	3.38 **
Access to elderly's information	1.003763	0.630	1.59
Selling of h/h items	-0.027117	0.522	-0.05
Remittances from children/family	0.420996	0.487	0.86
Selling of agricultural produces (by household/elderly)	-1.17361	1.494	-0.79
Financial assistance (e.g. TASAF cash transfer)	2.302986	0.695	3.31**
Threshold Parameters			
/ cut1 | -4.846489	2.640444	10.02166	0.3286858
/cut2 | 3.107304	2.631761	-2.050853	8.265461

Number of observations = 202, LR chi2 (13) = 97.05, Prob > chi2 =0.000, Log likelihood = -70.972164, Pseudo R^2 = 0.4061, **statistically significant at P < 0.05, * statistically significant at P < 0.1

However, sex of the elderly was less likely related and statistically significant at p<0.05 to the elderly's SPSs accessibility (Table 7). This finding also implies that sex is associated with decreased probability of accessing SPSs by the elderly. In this study, sex was associated with SPSs and that males had decreased access to SPPs as opposed to females among the elderly. This is because, naturally, elderly male are superior to elderly female. They are always bold enough and not in a position of exposing their difficulties unlike females. Nevertheless, according to UN (2015), sex should not be an element that hinders the elderly from accessing SPSs. At old age, both men and women have an equal chance of accessing SPSs, thus in providing SPSs, sexual category is a factor that ought to be taken into consideration when addressing specific gender basic needs.

Three variables namely awareness on the elderly's policy and rights, financial assistance/cash transfer from Tanzania Social Action Fund (TASAF), and health insurance as an institutional factors were more likely related to the elderly's accessibility to social protection services and were statistically significant at p<0.05 significance level (Table 7). This finding implies that

awareness among the elderly on their rights is associated with increased probability of getting access to social protection services. As awareness of information on the elderly rights increases, the probability of the elderly to access SPSs also increases and thereby enabling them to meet their basic needs which are among the dimension of SPSs. The importance for social institutions in creating awareness on policy and rights among the elderly was further affirmed by the qualitative data collected from focus group discussions as the extract below indicates:

> "*We know nothing about the elderly's rights. That's why we do not know where to start when it comes to demanding our rights"* (Elderly FGD Participant, Kiusa Sokoni Street, 2016).

These study findings are similar to the reported by Vellakkal (2017) that awareness generation among the elderly has a great influence on access to the institutional care and services that promote the uptake of institutional service delivery to the elderly.

Likewise, the study results (Table 7) show that health insurance among the elderly was more likely related to the elderly's access to SPSs and was statistically significant at $p<0.05$ significance level. These findings suggest that the elderly with insurance cards from the National Health Insurance Fund (NHIF) and Community Health Fund (CHF) obtained through their family members were likely to access health services. Therefore, health insurance is very important in improving the health status of the elderly. This finding was also confirmed by the elderly in the FGDs in Samanga village who pointed out that:

> *".....health service for the elderly is a challenge.... if one doesn't have an NHIF card; it is not easy to access health services from government or private hospitals*" (Elderly FGD participant, Samanga Street, 2016).

This finding is consistent with what has been reported in literature (WHO, 2008; Nkwarir, 2010) that elderly's access to health insurance is a vital factor and a social determinant of their health status.

Financial assistance (e.g. TASAF cash transfer) was also more likely related to the elderly's access to SPSs and was significant at $p<0.05$ significance level (Table 7). This implies that cash transfer is associated with increased probability of accessing SPSs by the elderly. This suggests that, if the elderly are receiving cash transfer from SIs such as those from TASAF and pension money from state funds for those who are eligible, are likely to increase the elderly's level of income and hence improve their well-being more than those without cash transfers. This finding underlines the importance of cash transfer from SIs in improving the welfare of the elderly. The findings correspond with what is reported in literature (Mathiu & Mathiu, 2012; Kessy, 2014; Nangia, 2015) that inclusion of the elderly in some financial security interventions may promote the elderly's access to health care, food, and shelter and hence improve their welfare.

Furthermore, other variables such as age of the respondents, marital status, and size of the household, income from selling agricultural produce, and income from selling household items were not statistically significant neither were they positively or negatively related to the SPSs

access to the elderly in Moshi Municipality and Moshi District Council, Kilimanjaro Region Tanzania (Table 7).

Moreover, since the age of the respondent had a negative statistically significant correlation at $p<0.1$ with the elderly's access to SPSs; this implies that as the elderly's age increases, SPSs for the elderly decreases. The findings in this study revealed that the elderly had low access to SPSs on promotive dimension due to their ageing status, as they are inactive and incapable of performing manual works. Therefore, some service providers may not be willing to invest in empowering the elderly through capacity building programmes. In this regard, the elderly are subjected to social exclusion and discrimination in accessing SPSs. According to World Bank, (2012) and Babajanian *et al*., (2012), inclusion of the elderly in promotive interventions such as cash transfer is significant as it may increase the elderly's financial security and enable them to access various SPSs including health care, food, and shelter.

The results in Table 7 also show that household size was not a significant predictor variable in influencing elderly's access to service delivery. According to scholars (e.g. Hyeladi, 2014; Alfred *et al*., 2017), it is obvious that such elderly's households might be more likely unable to provide high-class service delivery such as food to the elderly. Some studies (e.g. Sekhampu, 2013; Hyeladi *et al.,* 2014) have found that the larger the family size, the poorer the household. Other variables such as marital status, remittances from family members, income from selling agricultural produce, and income from selling household items were not statistically significant; neither were they positively or negatively related to the elderly's access to SPSs (Table 7). According to studies (e.g. Bookman and Kimbrel, 2011; ILO, 2014)), remittance from children/family is not a sufficient factor to influence the elderly's SPSs accessibility; this is because family members are mobile searching for jobs and business opportunities. As a result, majority of the elderly are not only abandoned, but also lose much of their family support (HAI, 2008; Bloom *et al.*, 2011).

Furthermore, marital status in this study was not a significant factor that influenced elderly's access to SPSs. Although living with a spouse or in any form of marital union is very important for the elderly survival (Spitzer *et al*., 2009; Kessy, 2014), no correlation was found between marital status and SPSs accessibility. It is important to note that SPSs accessibility is a significant factor for human survival. According to studies (i.e., Rogers *et al.,* 2000; Cattell, 2005; URT and HAI, 2010) , old age poverty for both men and women is highly related to lack of access to SPSs and not marital status, especially if one lacks adequate means of SPSs.

Finally, income from selling agricultural produce and household items such as clothing, furnishing, and furniture was not statistically significant neither was it positively or negatively related to the SPSs access to the elderly in the study area. This is because agricultural activities are characterized by subsistence harvesting for the smallholder farmers. Moreover, furniture and other household assets do not have reasonable market value that can support the elderly's survival. This means that the income derived from sales may not be sufficient to sustain their livelihood while income from selling agricultural products and household assets is not a valid means of alternative survival for the elderly's (Devereux *et al.,* 2008; Nyasha *et al.*, 2013; URT 2014).

4.0 Conclusions and Recommendations

Based on the findings and discussion from this paper it is concluded that majority of the elderly in the study area had attained medium level of SPSs access. Generally, SPSs access to the elderly's is influenced by various determinants including elderly's residence, literacy status, awareness on elderly policy and rights, financial assistance and health insurance as the reflection of the protective, preventive, promotive and transformative SPSs dimensions. This implies that, improved welfare of the elderly's necessitates a multifaceted approach when addressing their challenges. Therefore, based on conclusions of this paper it is recommended that, Social Institutions including the Ministry of Community Development, Gender, Women, Elderly and children and Civil Society Organizations must work together to improve the welfare of the elderly. This should be done by enabling SPSs to be accessible to the elderly and by considering most important determinant factors that influence SPSs accessibility levels including provision of health insurance services, cash transfers (universal pension), and awareness raising of policy/rights to the elderly in order to address their immediate needs. Finally, there is a need for the social institutions (governmental and non-governmental agencies) to introduce systems or mechanisms of SPSs that would address protective, preventive, promotive, and transformative basic needs of the elderly in Tanzania.

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