Chapter 31
Researching the Practices of Policymakers in Implementing a Social Policy Intervention in Ghana

Ebenezer Owusu-Addo

31.1 Introduction

This chapter presents a case study of a research project focused upon understanding how a social policy intervention called the Livelihood Empowerment Against Poverty (LEAP) works to influence the social determinants of health (SDH) in Ghana and examining the factors that influence health sector involvement in the programme. It highlights the epistemological and ethical framework within which this health promotion research was structured. The aim of this work was to analyse the practices of policymakers and actors in the design and implementation of the LEAP programme. In doing so, the chapter examines how the practices of policy actors and policy entrepreneurs advance or fail to advance action on the SDH. It also outlines the contribution of this case study to advancing health promotion research.

Health promotion (HP) is conceived of as an action-oriented field (Lahtinen et al., 2005) and a field of social practice (Potvin et al., 2008) focused upon 'enabling people to increase control over and improve their health' (WHO, 1986). As such, one of the ontological underpinnings of HP is that the practices and actions of policymakers and other institutional actors have wider implications for health. For instance, it has been acknowledged that to reduce health inequities, there is the need to take action on the social determinants of health (SDH) through the development of culturally appropriate public policies and programmes (Marmot et al., 2012). In view of this, repeated calls have been made on the need for policymakers and other policy actors to have an SDH lens to the development and implementation of public policies.

E. Owusu-Addo (✉)
Bureau of Integrated Rural Development, Kwame Nkrumah University of Science and Technology, Kumasi, Ghana
e-mail: eowusu-addo.canr@knust.edu.gh

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As HP is grounded on humanist values such as equity, empowerment and participation (Mantoura & Potvin, 2013), a collaborative approach was used in both the design and implementation of the research to optimise HP values. The adoption of such a participatory approach to this research and the evidence that it derives, called for different epistemological attitudes to knowledge production and to reject traditional models of evidence, which considers study participants as object to be studied. Epistemologically, therefore, the evaluation research reported in this chapter hinged on the assumption that HP as a field of social practice considers both the symbolic and subjective dimensions of social practices including those of policymakers in the pursuit of valued goals. In line with this epistemic position, the realist evaluation approach (Pawson, 2013) offered the best fit for studying how and under what circumstances the LEAP programme works to influence the SDH.

31.2 Programme Under Investigation

The Commission on the Social Determinants of Health (CSDH) through its publication: *Closing the gap in a generation: health equity through action on the social determinants of health* made a passionate call for governments across the globe to design and implement policies and interventions focused upon addressing the social determinants of health (SDH) (Commission on Social Determinants of Health, 2008). A foundational element of contemporary HP, therefore, has been the central role of public policy in improving the health of populations (Marmot et al., 2012; World Health Organization, 2011). It is widely acknowledged that without appropriate social interventions that address the SDH, the health of most people, particularly in low- and middle-income countries, will continue to deteriorate (de Leeuw, 2017; Marmot et al., 2012).

31.2.1 The Livelihood Empowerment Against Poverty (LEAP) Programme

LEAP is a social cash transfer programme introduced in 2008 as the flagship program of Ghana's Social Protection Strategy. Aside from the cash payments, LEAP provides free health insurance to beneficiaries through a National Health Insurance Scheme (NHIS) (Owusu-Addo et al., 2020a). The aim of the programme is to reduce poverty by increasing consumption and promoting access to social services and opportunities among beneficiary households. The programme is implemented by the Department of Social Welfare in the Ministry of Gender, Children and Social Protection (Ministry of Gender Children and Social Protection [MoGCSP], 2020). As a cash transfer programme, LEAP combines both conditional cash transfer

Table 31.1 Key characteristics of the LEAP Program

Program attribute	Description
Type of CT	UCT & CCT
Beneficiaries/ target groups	LEAP targets extremely poor and vulnerable households which have the following four categories of eligible members: Orphaned and vulnerable children (OVC) or, Persons with severe disability without any productive capacity and Elderly persons who are 65 years and above Extremely poor or vulnerable households with pregnant women and mothers with infants
Programme conditions	LEAP conditions for households with OVC are enrolment of children in school; school attendance; birth registration; utilisation of antenatal and post-natal services; complete immunization of babies; protection of children against child labour; and enrolment in the National Health Insurance Scheme
Programme benefits	Cash grant plus National Health Insurance
Transfer size	The amounts paid to beneficiaries have increased from GH¢ 8 -GH¢ 15 (about USD 8–15) per month in 2008 to GH¢ 64–GH¢ 106 (about USD 11–18) in 2020
Frequency of transfer	Bi-monthly
Mode of cash grant payment	Electronic payment
Coverage	LEAP covers all 216 administrative districts in Ghana with 213,044 beneficiary households, which translates to about 937,904 individuals
Program partners	World Bank, United Nations Children's Fund, World Food Program, United States Development Agency, United Nations Population Fund, European Union, and United Nations Development Program
Management structure	The LEAP management structure consists of the National Program Management Secretariat, which is responsible for overall program implementation and monitoring and evaluation; the District LEAP Implementation Committee (DLIC) led by the District Social Welfare Officers (DSWOs), responsible for program implementation at the district and community levels, and the community LEAP implementation committees (CLICs), which support program implementation at the community level

(CCT) and unconditional cash transfer (UCT). Table 31.1 summarises the programme characteristics.

With the focus of LEAP upon poverty reduction and human capital development, they constitute a healthy public policy, and have direct linkages to health and well-being by addressing the SDH (Owusu-Addo, 2016; Owusu-Addo et al., 2019a, 2020a).

31.2.2 LEAP Linkages to Health Promotion Values and Theory

The LEAP programme aligns with HP values of empowerment, participation, equity, social justice and inter-sectoral collaboration. Active community participation is at the centre of LEAP from the targeting stage to the implementation stage. The programme relies on participation and mobilisation of the community structures, and community experiences and knowledge for programme delivery. For example, as a matter of principle, community implementing committees (CLIC) must engage with community members in the selection of programme beneficiaries before forwarding eligible beneficiaries to the district programme office for onward submission to the national level. The national programme unit reviews the list from the community, check for eligibility, and then sends the list back to the community for approval before beneficiaries are finally enrolled unto the program. Community empowerment in the programme is further achieved through the recognition and use of community structures, and capacity building for community programme implementation committees.

With a focus on the poor and the vulnerable in society, LEAP works to tackle the root causes of poor health, injustice in society and the health gradient. For instance, LEAP emphasis on child education has led to improved enrolment and schooling for children (Owusu-Addo, 2016; Owusu-Addo et al., 2020a), which could potentially increase employment opportunities in adulthood, and ultimately raise socioeconomic status. This in a way would help in addressing social and health inequities to promote health across the lifespan.

Similarly, LEAP aligns with HP principle of inter-sectoral collaboration. By its nature, LEAP promotes inter-sectoral action on SDH and therefore, aligns with the concept of "health in all policies.". LEAP's cross-sectoral objectives (e.g., improving health, education, nutrition and poverty reduction) thus call for the active involvement of the health sector (Owusu-Addo et al., 2019a, 2020b).

31.3 The Research Process and Implications for Health Promotion Research

31.3.1 The Research on the LEAP Programme

31.3.1.1 Framing the Research Aims

The overall aim of the research was to understand how LEAP works to influence the SDH, and to examine the factors that influence health sector involvement in the programme. The project was informed by the fact that while LEAP could potentially influence a broad range of SDH and as result promote health equity, past evaluations of the programme have not taken an SDH lens to produce evidence that

would inform programme design and adaptation. Further, with the potential of LEAP for achieving health sector objectives, there is a growing concern that the health sector and health promoters have not been actively involved in the programme.

31.3.2 The Research Framework

HP research moves beyond the question of what works to include how and why health promotion programmes work. This research was thus underpinned by the realist evaluation approach (Pawson, 2013; Pawson et al., 1997). The choice of realist evaluation framework, which is a theory-driven approach, was informed by the aims of the study which is focused upon understanding how and why LEAP works to influence the SDH. Because of the inherent complexities within the LEAP programme (Owusu-Addo et al., 2020a) and the possibility that their operations are context dependent, it was important to identify a methodological approach that could elucidate the causal process by which changes and impacts are achieved, and to address questions relating to how and why the programme works, and the factors influencing health sector involvement in the programme, which are all of high relevance to policy and practice.

The role of theory in HP research has been widely acknowledged (Crosby & Noar, 2010; DiClemente et al., 2002; Green, 2000). LEAP operates at the macro, meso and micro levels of a system. Therefore, to understand the programme's mechanisms of change and the context within which they operate to influence the SDH, a number of formal theories were drawn upon in this research, including Kingdon (2011) 'multiple streams' theory of policy action, partnership synergy theory (Lasker et al., 2001), Sen's capability theory (Sen, 2001), empowerment theory (Friedmann, 1992), self-determination theory (Ryan & Deci, 2000), and self-efficacy theory (Bandura, 1982).

Kingdon argues that the convergence of three streams, namely, the problem (in this case, how CTs are perceived as an action on the SDH), policy (here, the nature of government and the CT policy-making process) and politics (changes in government and public opinion), create a window of opportunity for a policy action. In Kingdon's view, prospective policies are developed from a 'primeval soup' where ideas are constantly being discussed and developed. He emphasised the importance of 'policy entrepreneurs' who make use of available windows to instigate policy change. In this research, Kingdon's framework provided a useful analytical tool for understanding the windows of opportunity that LEAP opens for health sector involvement, and the factors that may facilitate or inhibit the role of the health sector and health promoters as policy entrepreneurs in the LEAP programme. In line with critical realist thinking, the findings of this study show that CTs' cross-cutting goals (poverty reduction, health, nutrition, etc.) and a health sector mandate for health promotion constitute the key structures and powers with the potential to trigger a more substantive involvement of health sector and health promoters in the

programme. Kingdon argues that policy entrepreneurs exert influence through their advocacy efforts, which necessitates leadership and commitment to a policy agenda. The application of this framework, however, showed that while LEAP opens a window of opportunity for a more substantive role to be played by the health sector, it appears the Ministry of Health and the Ghana Health Service did not have input into the formulation and design of the LEAP policy. In the language of the participants, without these national-level actors 'showing a clear commitment to the LEAP as well as acknowledging its implications for the SDH, there will be low involvement of local health units in the programme. In the Ghanaian context, it appears that the dominance of curative health services has 'crowded' (Kingdon, 2011) the health policy agenda, leaving little room for health sector involvement in the CT policy. Factors found to influence health sector involvement in the LEAP included understanding of the SDH, legitimisation of health promotion in the health policy portfolio, national health sector commitment to SDH agenda, evidence linking the LEAP programme to SDH, intersectoral collaboration, and health promoters' knowledge of the policy-making process.

Sens' capability theory (Sen, 2001), which focuses on an agent's capability to make 'valued choices' offered a valuable explanation of the operation and impact of LEAP at the micro level. In the words of the programme beneficiary households interviewed, the LEAP gives them 'power' and makes them feel 'empowered' (both economically and psychologically), 'motivated' and that they have 'a new sense of hope' upon receipt of the cash grant (Owusu-Addo et al., 2020a). This aligns with the capability theory which acknowledges the need to focus on agency and empowerment in poverty reduction programmes. Partnership synergy theory (Lasker et al., 2001) posits that leveraging of resources and skills of various stakeholders enhances programme design, implementation processes, and realisation of outcomes. Using this theory, it was found that building partnership and collaboration for LEAP would mean the government first showing clear leadership and commitment to LEAP, providing the relevant policy frameworks and fostering intersectoral working at the ministerial level. Building partnerships also meant training key programme partners about the programme, creating a shared vision around the programme across sectors and nurturing trust and transparency amongst stakeholders to enhance their participation and embedding of LEAP activities into their work schedules. According to Kabeer (1999), empowerment theory has two inter-related dimensions, namely, resources and agency. In relation to LEAP, this highlights the resources offered by the programme to households, and how these resources enable choices and decision making (agency) under different conditions (Owusu-Addo et al., 2019b). Self-efficacy theory also posits that if the LEAP social grant serves as incentives to boost household and/or caregiver confidence, then they can trigger intrinsic motivation. Applying this theory to LEAP in this research proved very useful as it helped explore the circumstances under which LEAP promotes households' self-efficacy, and how the programme can be better designed to optimise this.

31.3.3 Involvement of Research Participants in the Planning and Conduct of the Research

Stakeholder involvement has been identified as one of the critical components of HP research and evaluation planning in ensuring the uptake of findings (Fetterman et al., 2017; Owusu-Addo et al., 2015; Patton, 2011). Further, HP research is done with people and not on people (Owusu-Addo et al., 2015). In view of this, and to optimise HP value of participation, at the design stage of the research, meetings were held with LEAP policymakers and development partners who fund and support the programme to establish the aims and relevance of the research to their work. This approach was taken to ensure co-design and production of knowledge that would be useful for both HP policy and practice. This was found to be a useful strategy in getting the findings of the study to inform the practices of policymakers and other national level actors. While a participatory approach to HP research often results in the researcher relinquishing control over the research process (Woodall et al., 2018), this does not necessarily result in loss of 'scientific' rigour of HP research (Allison & Rootman, 1996).

The findings of the research were shared with key stakeholders involved in the LEAP programme, including policymakers, development partners, national programme managers, local-level programme implementers and local health directorates. The purpose of the research dissemination was to make known to the stakeholders that while LEAP might not have been designed with an SDH lens, the programme constitutes a healthy public policy with significant impacts on the SDH and the potential to reduce health inequities. This means that to optimise LEAP impact on the SDH and reduce health inequities, health promoters and the health sector should be actively engaged in terms of the programme design, implementation and evaluation. Engagement with health promoters during data collection and in the dissemination of the findings revealed that nearly all of them had never thought of the linkages between the LEAP programme and the SDH, and thus described the sessions as an 'eye opener'. In this way, the research process became empowering and emancipatory for study participants and thus produced positive, and transformative effects.

Additionally, participants observed that LEAP policymakers' knowledge of the SDH and their appreciation of the linkages between the programme and health determinants were important in fostering collaboration with the health sector. These suggest that knowledge of the evidence linking LEAP to the SDH can be an activating factor for health sector and health promoters' involvement in the programme design and implementation. The health promoters further noted that while the need to address the SDH requires political action, politicisation of the LEAP closes the window that would have allowed policy entrepreneurs such as health promoters to contribute to the programme design and implementation. The active engagement with the policymakers and development partners revealed that while they had a common understanding of the influences of social factors upon health, there was a limited recognition and uptake of the SDH concept in LEAP design and implementation, and the need to engage with the health sector.

31.3.4 Design and Methods Used

Addressing the question of how LEAP works implies making an inquiry into the mechanisms by which change is produced by the programme. This makes the realist framework appropriate for researching the LEAP programme, which is inherently complex. Realist research and evaluation is method neutral (Pawson et al., 1997). This research thus followed four sequential phases, as outlined in Fig. 31.1. In phase 1, rather than starting with a middle-range theory about programme mechanisms, the study commenced with identifying the programme's patterns of outcomes through a systematic review (Owusu-Addo et al., 2018b) and looked for the contexts and mechanisms that might explain them. The systematic review was complemented by a methodological review to further establish the applicability and relevance of a realist approach to this research (Owusu-Addo et al., 2018a).

To make sense of the linkages between LEAP and the SDH, in Phase 2, a conceptual framework was developed conceptualising the potential linkages between cash transfer programmes, SDH and health equity (Owusu-Addo et al., 2019a). The framework aided the design of the empirical phase of the study, including the identification of relevant key stakeholders for initial programme theory development. Phase 3 had two components. The first was a realist qualitative study to develop initial hypotheses regarding how the LEAP programme was expected to influence the SDH (Owusu-Addo et al., 2019b). The theories were then tested and refined using a realist qualitative case study design (methods included interviews, focus groups and observations) (Owusu-Addo et al., 2020a). As the health sector has been called upon to take leadership role in actions on the SDH, Phase 4 of the study entailed an exploration of the factors affecting health sector involvement in the LEAP using a critical realist case study design (methods included interviews and document analysis) (Owusu-Addo et al., 2020b).

31.3.4.1 Study Participants and Sampling

This research studied the practices of development partners (i.e., The World Bank, Department for International Development and United Nations Children's Fund), policymakers and programme managers in relation to the design and implementation of the LEAP programme and the programme's impact on the beneficiaries. A maximum variation purposive sampling technique (Patton, 2015) was used to select information-rich cases across a broad range of programme stakeholders who have had lived experiences of the programme. Program stakeholders were drawn across the policy, management, implementation and community levels of the programme.

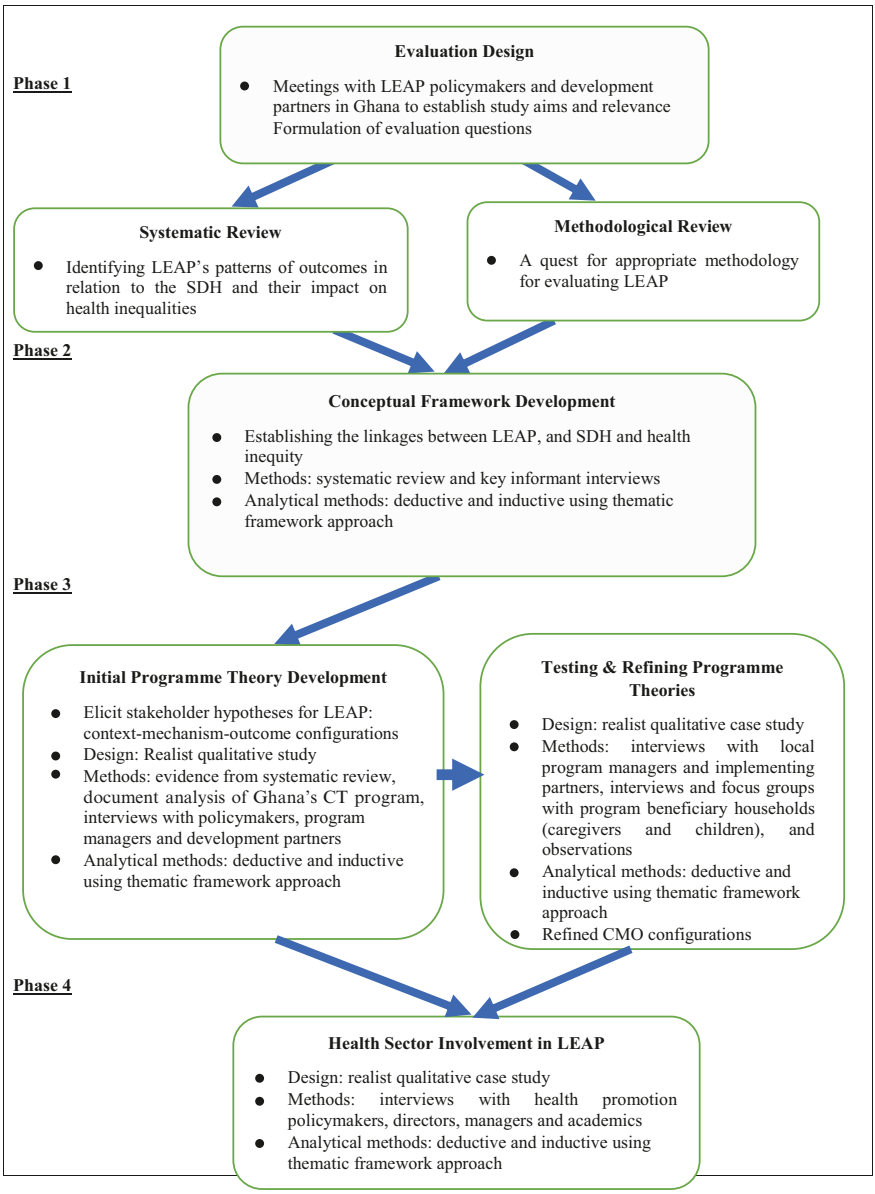

Fig. 31.1 Research process flow chart

31.3.4.2 Data Collection and Analysis

Data collection entailed in-depth interviews with policy-, management- and implementation-level stakeholders and programme beneficiaries, and focus groups with programme beneficiaries and field observations. The use of method triangulation (interviews, focus groups, observations and document analysis), and data triangulation (collecting data from various stakeholders) strengthened the dependability and credibility of the findings (Hesse-Biber, 2011; Liamputtong, 2013; Patton, 2015).

Using a realist analytical 'lens', the data generated in this research were analysed following the five steps of the thematic approach (familiarisation, identifying of a thematic framework, indexing, charting, mapping and interpretation) described by Ritchie et al. (2008). As noted by Maxwell (2012), in realist research, "data collected through qualitative means are not considered constructions. Data are instead considered evidence for real phenomena and processes (p. 103)". This aligns with the participation value of HP, which requires researchers to take a collaborative research–practice relationship in developing knowledge about HP practices by attending to and privileging stakeholders' views as the lens by which to understand and place value on policies and programmes. This implies that in HP research, participants' experiences and understandings can complement or challenge existing scientific knowledge and theory. Data analysis in this study therefore, moved from constructions to explanation of causal mechanisms.

31.3.5 Specific Challenges of Health Promotion Research Enlightened by the Programme

While the application of realist approaches seems to be well established in health services research with exemplary case studies (Marchal et al., 2012), this is not the case in the HP field. The absence of clear guidelines for using realist approaches in researching HP practices like LEAP, which are not only complex but operate in complex cultural and collectivist environments, compounded the operational challenges that were encountered in this research.

Another limitation of the realist approach in HP research is the difficulty of defining and distinguishing mechanisms from contexts. While Pawson and Manzano-Santaella (2012) argue that distinguishing between contexts, mechanisms and outcomes is determined by their explanatory role, and Dalkin et al. (2015) have developed guidelines clarifying how mechanisms can be operationalised in practice, distinguishing mechanisms from contexts in this realist evaluation was still a challenge. What proved to be helpful in this study was clarifying the outcome patterns of LEAP first through the systematic review. This clarification pointed to the mechanisms that explain how and why LEAP worked or failed to work.

31.4 Conclusions

Theoretically, using an SDH lens in studying the practices of policymakers and other institutional actors is of value. By using such a lens, this research was able to examine how LEAP works to influence the SDH and the factors affecting health sector involvement in the programme. The findings provided useful insights to policymakers, programme designers and managers, evaluators and the health sector regarding how the LEAP programme can be used as an HP strategy to tackle the SDH and contribute to reducing health inequities. In terms of HP research methods, it is clear from this study that a single qualitative research method may give limited insight, but combinations (i.e., interviews, focus groups, observations and document analysis) give a rich picture of intervention processes, impacts and conditions for improvement. What is also clear from this research is that HP research should lay emphasis on working with people collaboratively by adopting study designs that value the dignity of all participants rather than adopting an approach that detaches the researcher from the participants (i.e., the experts-know-best approach). This research has shown that both theory development and realist evaluation are feasible and valuable for advancing HP research in relation to how non-health sector interventions like LEAP work or fail to work.

Conceptually, the findings point to the need to consider an SDH perspective in LEAP policy-making, design and implementation, and to foster strong inter-sectoral collaboration and partnerships across sectors. The evidence from this research indicates that there is limited recognition, knowledge and application of the SDH concept in LEAP policy-making, implementation and evaluation. A number of factors could explain this, including the limited involvement of the health sector in the programme as well as the limited recognition of the SDH in non-health sectors (Lawless et al., 2017). Due to LEAP's cross-cutting objectives (e.g., poverty reduction, education, health and nutrition), the programme should concomitantly be underpinned by inter-sectoral collaboration among sectors, including but not limited to education, health, agriculture and social development. This calls for a participatory approach to LEAP policy formulation, design and implementation involving key programme sectors as well as ensuring policy complementarity.

This research also highlights the need to give a due recognition to the role of the health sector in taking action on the SDH, and the opportunity that social policy interventions like LEAP offer the health sector in tackling health inequities. The research suggests that national health sector leadership of the SDH and commitment to the LEAP programme are critical to health sector involvement in the programme design and implementation. This means that unless the health sector in Ghana makes addressing the SDH part of the health policy portfolio and legitimises HP, there will be minimal or no involvement of the health sector and health promoters in non-health sector programmes such as the LEAP. This would result in missing out on the opportunities that such programmes offer in addressing health inequities. The implication here is that while LEAP sits outside of the health sector, health policymakers and practitioners can still facilitate collaborative work across the

sectors to help optimise programme impacts on SDH. For this to occur, however, the health sector must first show leadership and a clear commitment to the SDH agenda to build its own legitimacy.

Lastly, for HP theory and practice to make a difference, realist approach to research and evaluation is critical. By using the realist approach, this research was able to show that LEAP can be one of the most effective means for addressing the SDH in Ghana, particularly among the poor and the vulnerable, suggesting the need to make them a formal part of public policies and health policy portfolios in the country.

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