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Access to Health Services among Elderly through TASAF III in Luhungo Ward, Morogoro District Council, Tanzania

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ABSTRACT

The TASAF III program is a major, effective response to improving older adults' access to healthcare services. However, data on TASAF III's contribution to older adults' access to health services in Luhungo Ward, Morogoro District Council, and the factors associated with access to health services remain scant. Thus, this study investigated the role of the Tanzania Social Action Fund (TASAF) Program in older adults' access to health services in Luhungo Ward, Morogoro District Council. The study used data from a survey of 60 older adults aged 50 and above in Luhungo Ward, Morogoro District Council. It used a mixed-methods case study, triangulating descriptive and exploratory designs to analyse the role of TASAF III programs in elders' access to health services in Luhungo Ward, Morogoro District Council. The study used descriptive analysis, content analysis, and thematic analysis of 70 interviews, along with a systematic documentary review. The research examined the availability of health facilities, transport used to reach them, travel distances, and the affordability and acceptability of services. The results indicate that most respondents went to Kilala Dispensary, usually walking. Distances varied, as some older people had to travel long distances because of how the facilities were situated. Affordability was also a concern, as some people said they had paid for the services, which in turn influenced their satisfaction. Other problems included poor facility conditions and a lack of specialised training among healthcare providers. The findings highlight that, despite TASAF's indirect role, the healthcare system is complex, with factors such as physical availability, proximity, affordability, and quality shaping elderly people's access to health services. The study concluded that improving infrastructure, affordability, and training is essential to improving healthcare access for the elderly in the area.

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INTRODUCTION

The Sustainable Development Goals (SDGs) emphasise the well-being and healthcare needs of the elderly, with Goal 3 specifically addressing these concerns (UN, 2016; Rutagumilwa, 2026). Elderly refers to “older persons or elderly population” whose biological, chronological, and social age fall within 50-55 and 60+ years (United Nations Development Programme [UNDP], 2017). This group will comprise 1.2 billion by 2031 and 2.1 billion by 2050 (World Health Organization [WHO], 2026). In 1991, the United Nations outlined core principles for older people: independence, participation, self-fulfilment, and dignity (UN Human Rights, 1991). While older adults have significantly contributed to the workforce, many remain active workers and volunteers in their fields of specialisation (WHO, 2026). However, most of them are prone to age-related health issues such as depression, impaired mobility, and frailty. These challenges require concerted global efforts to provide long-term Care (WHO, 2026). While the United Nations recognises the elderly's past contributions and future investment (UNDP, 2017; 2018), health facilities for the elderly remain inadequate (Russell et al., 2023; Magata et al., 2026). For example, WHO (2025) finds that health systems are underprepared and significantly disjointed, denying older adults access to quality health services at their homes. Ordinary health systems can barely accommodate geriatric syndromes. The peril of incapacitated health services denies access to and further exacerbates complex health conditions the elderly experience. This may be severe in underdeveloped continents like Africa.

In Sub-Saharan Africa, the WHO (2026a) estimates that the number of people aged 60 and above will increase by 67 million by 2050, growing from 100 million today to 163 million. Although the elderly population is growing quickly, they will make up only about 5% of the population in some areas by 2050. In low- and middle-income regions like Sub-Saharan Africa, older adults still face limited access to healthcare services, highlighting the need to improve healthcare facilities (WHO, 2021).The UN Madrid International Plan of Action on Ageing (MIPAA) encourages countries to include issues affecting older adults in national strategies, such as poverty-reduction policies and data harmonisation (UNDESA, UN, 2025).The African Union also creates coordinated policies for elderly care across Africa (ibid). Even with these initiatives, life expectancy in Africa continues to rise (UN, 2026). The region continues to experience infectious diseases and high risks of chronic diseases (UN, 2023). Additionally, discrimination against the elderly may result in poor access to health services and, subsequently, jeopardy and death

The current situation of the elderly in Tanzania is similar to that of many developing countries (World Bank Group, 2026). According to the Tanzania National Bureau of Statistics (NBS), the Statistics (NBS), the elderly population is estimated at 2.7 million. It will reach 7 million (8.1% of the population) by 2050 (United Republic of Tanzania [URT]Tanzania [URT], 2024). Efforts to keep pace with growing demand for quality services for older persons extend beyond ratifying global and regional conventions and national policies. Elderly accessibility to health services is highly influenced by the National Ageing Policy-2003, which addresses "welfare, health and social security of elderly" (URT, 2027); Healthcare Free Exemptions, which guide health service providers to offer services to the elderly upon proof of birth certificate or an introduction letter from the. In the island, the Zanzibar Elderly Affairs Act (Revolutionary government of Zanzibar-RGoZ, 2020) provides that the elderly aged 70+ receive monthly social pensions, are entitled to free health services, special treatment, and priority access in all public health facilities and hospitals; it also guides home-based care. The lack of documentation, coupled with limited health facilities and hospital arrangements, hinders implementation of existing policies. As a result, few formal pension schemes remain, leaving most elderly without support (URT, 2017). Earlier, the Economic and Social Research Foundation (ESRF, 2010) noted a gap in implementing policy provisions in mainland Tanzania. Failure to implement policy provisions creates systemic fissures and, eventually, detrimental outcomes.

Among many efforts to address issues affecting the elderly, the Tanzania Productive Social Safety Net (PSSN) is a national flagship program. It implemented the Tanzania Social Action Fund (TASAF). Launched in 2000, it was a basic intervention aimed mainly at breaking the vicious cycle of poverty (Baird et al., 2012). Several TASAF Phase I (2000-2005) addressed social services delivery, capacity building and food insecurity. TASAF II (2005-2013) centered on improving social services. TASAF III reflected the success of TASAF II & III, with legacies in school enrollment and declining under-5 mortality (URT, 2012). (PSSI I) focused on nationwide conditional cash transfers, and TASAF III (PSSN II) (February -2020-September 2025) scaled up the target to TZS 1.4 million for vulnerable households nationwide. TASAF III (PSSN III) commenced in March 2026, focusing on youth and households becoming economically empowered and active (World Bank Group, 2026). Scrutiny of healthcare for the elderly in TASAF Phases I & II was mainly indirect. The focus was on healthcare

infrastructure (i.e., health facilities); the elderly worked in groups to generate income, some of which they could use for medical expenses (World Bank Group, 2017). In Phase III (PSSN III), older adults living in extreme poverty could receive regular cash stipends, with mandatory access to health checkups cascaded at the household level; the elderly could get access to health services, mainly for regular checkups (World Bank Group, 2017). The same money could be used to access other services, reduce out-of-pocket expenses, and contribute to community fund systems (Athuman & Kashaga, 2023). While the new approach improved the elderly's access to healthcare, Malichewe et al. (2026) note inadequate palliative care services at primary health facilities. In addition, Magata et al. (2026) highlight multiple encounters for the elderly, such as bureaucratic procedures before accessing free healthcare; they were supposed to receive key information, but it remained concealed. Ntibabara et al. (2026) show that excluding the elderly from obligatory health insurance increases the burden on low-income elderly, who face high out-of-pocket costs. Irrespective of the challenges, which may range from market economy and ideological points of view (Athuman & Kashaga, 2023) to the design of health facilities (Magata et al., 2026; Gordian, 2026), the elderly would not benefit from a design that provides cash and free services (Ibrahim et al., 2026).

Previous studies, including Magata et al. (2026), Athuman and Kashaga (2023), Malichewe and colleagues (2026), and Ntibabra et al. (2026), have highlighted TASAF's contribution to improving elderly access to healthcare services. Magata and colleagues found that income influences health-seeking behaviours. Malichewe and colleagues argue that street-level bureaucrats prioritise integrating palliative care services into primary healthcare facilities. Athuman and Kashaga explored the TASAF effect on beneficiaries' livelihoods and concluded that it had a positive outcome. The study implies that the elderly can access health care services because they can afford them. Although they did not study TASAF, Ntibabara and colleagues examined issues around health insurance coverage among adults in Mlimba District. They concluded that, despite being mandatory, most adults did not enrol in health insurance. Previous studies have only tangentially addressed TASAF III's influence on elderly access to health care services. Therefore, this study assessed TASAF III's effect on elderly access to health services in Luhungo Ward, Morogoro District Council. Identifying barriers to TASAF implementation is important for improving elderly access to health facilities. The findings are policy-motivated, as discrepancies between provision and implementation may require an intervention to improve the quality of elderly access to health care services in the district.

THEORETICAL PREMISES

Several theories address access. Jesse Ribot and Nancy Peluso presented theories in resource geography and political ecology (Ribot & Peluso, 2009). In 1959, Shlomo Hansen formulated a general theory of spatial access (Levinson & Wu, 2020). Penchansky and Thomas (1981) developed a theory focused on access to health care. According to Penchansky and Thomas, the intended service, satisfaction with the healthcare services accessed, and health system practices influence the elderly's access to health services. Hence, access implies a discrepancy between the expected and the actual quality of healthcare experienced.

In summary, “the better the fit, the better the access (Saurman, 2016: 1), meaning that the “degree of fit between the elderly and the health systems (Penchansky & Thomas, 1981, p. 128). The theory suits evaluating health facilities in rural and dispersed settlements where economically marginalised dwellers live, which TASAF III supported to some extent. Older adults in such areas likely face long distances to health facilities and a shortage of bureaucrats (Mattson, 2011).

We need tangible evidence of health facility use, as the most important thing is using the available services. In the subsequent access analysis, those who need the most medical care and elderly support would benefit from available health facilities and support. The elderly would then access health services if they can reasonably make the time and distance between home and the facilities. Hence, accessibility means health services are within a reasonable travel time for the elderly. However, availability matters when health facilities match the number of older adults and the services they need, which shapes satisfaction levels. Health systems and support must match the elderly's needs and preferences (Tesha et al., 2026). Healthcare services should also be designed to let older adults choose medical practitioners/doctors, schedule convenient appointments, and access cost waivers (Ibrahim et al., 2026). All these factors contribute to the acceptability dimension.

Affordability will attract access to health facilities only when the elderly can afford healthcare costs. If service providers cannot design healthcare services that match the elderly's ability to pay, they cannot access such facilities. That is why Tanzania, through TASAF III, introduced direct costs to help low-income families with elderly members access healthcare services. However, when the elderly are required to pay for healthcare services, it jeopardises equitable access to quality health services (Simagolwa & Sundewall, 2025). Most elderly in low-income families can be deprived of significant health support and subsequently die or suffer severe pain for a long time. This contrasts with efforts to sustain the health sector population (Shevelkova et al., 2023).

Access to health services depends on accessibility, availability, acceptability, and affordability, but accommodation also improves elderly access to health services (Penchansky and Thomas, 198). The elderly can access health care services when health systems are designed to provide adequate services. Hence, health systems should be organised to match the elderly's characteristics. Elderly outpatients may need health services beyond the normal outpatient schedule and require wheelchairs, appropriate facility structures, and referral systems (Malichewe et al., 2026). Hence, a health facility that offers services suited to the elderly enhances their access to health services.

While Penchansky and Thomas (1981) assume health facilities are created with all 5As (i.e., accessibility, availability, acceptability, affordability, and accommodation/adequacy), Saurma (2016) critiques this, arguing that health systems with these features are still inadequate for elderly access without *awareness*. She argues that creating quality health facilities unknown to the community undermines their operations before they even become operational (Makwana, 2022). In this context, the elderly and service providers should understand the features of the best health services (Saurma, 2018). Health services are effective only if they fit the situation and people are aware of them (Saurma, 2016). Awareness involves using a range of strategies and communication methods to help people understand what services are available and how to access them (Edward, 2021; Iman et al., 2026). It means there should be proper communication between the service providers and the elderly to cover all information such as policies, rules and regulations, procedures, types of services, costs and modes of payment, and locations of health facilities to enhance elderly access to healthcare (Snider, 1980; Madondo et al., 2026). Even the support TASAF III provides should be known to the community. Effective information and communication strategies must also include input from patients, clinicians, and the community (Sourma, 2016; Madondo, 2026). Although some people have criticised it, access theory remains a useful analytical framework. It offers a valuable way to improve health services for older people, a group that often faces mobility challenges, chronic illness, and special care needs. It encourages health providers to adjust their services accordingly. By focusing on affordability, acceptability, accommodation, and availability, the framework supports more responsive and comprehensive care for older people.

METHODS AND MATERIALS

Data for this study were obtained from a survey conducted between 12 August 2022 and 24 September 2022 in Luhungo Ward, Morogoro District Council. The survey was carried out in Luhungo Ward because geographical challenges and respondents' diverse cultural, social, and economic characteristics limit most older adults' access to health services. The survey uses a case study design that triangulates descriptive and exploratory designs to understand access to health services in Luhungo Ward, Morogoro District Council.

Sample size and sampling techniques

The study sample size is seventy (70) respondents. This comprised the District Executive Director (DED), TASAF Project Officer, District Medical Doctor (DMD), Ward Medical Doctor (MD), Nurse, Ward Executive Officer (WEO), Village Executive Officer (VEO), Elderly Chairman and Elderly, which form the total sample size of seventy-five people (75); however, five (5) questionnaires were disqualified, as were those not duly filled. Therefore, only 60 questionnaires were included in this study, as illustrated in Table 1 below. The number of respondents was chosen to enable the researchers to gather sufficient information about access to health services for the elderly. Seventy people were sufficient to provide the representation needed for a case study.

Table: 1 Sample compositions

Type of Respondent	Sample size
District Executive Director (DED)	1
TASAF Project Officer	1
District Medical Doctor (DMD)	1
Ward Medical Doctor (MD)	1
Ward Nurse	1
Ward Executive Officer (WEO)	1
Village Executive Officer (VEO)	3
Elderly Chairman	1
Elderly	60
TOTAL	**70**

Source: Researchers' construct (2022)

Sampling techniques

Many procedures can be used to select a unit for study. However, their applicability depends on research demands and resource availability (Hayes, 2000). In this study, the researchers used snowball and purposive sampling techniques to select respondents in the study area. The researchers identified a few older adults who met the inclusion criteria and asked them to recommend others they knew who also met the selection criteria. The researchers used snowball sampling because the study involves a group of people with similar behaviours, and the researchers may find it difficult to locate or access them due to the topography; in this case, the elderly were involved.

Interviews

In this study, the interview involved 7 people: the District Executive Director (DED), TASAF Project Officers, District Medical Doctor (DMD), Ward Medical Doctor (MD), Ward Nurse, Ward Executive Officer (WEO), Village Executive Officer (VEO), and Elderly Chairman were all selected because each category has one or two people concerned with the whole district and ward. They were selected through purposive sampling because their positions involve the whole district and ward socio-economic development.

Formation of Focus Group Discussions

We formed three groups based on geographical location. Each group comprised six (6) older adults, for a total of eighteen (18) participants. They also filled in the questionnaire. The inclusion and exclusion criteria were based solely on readiness to participate in this data-collection approach. Researchers believe that FGD narratives cannot be replaced by questionnaires and interviews with government officials. The Focus Group Discussions began after participants completed the questionnaire.

Data collection instruments

This study used an interview guide and an FGD guide to collect information from the respondents. The research team prepared the questions in English and translated them into Swahili. For the interviews and focus group discussions, 10 members were selected to obtain information from the District Executive Director (DED), TASAF Project Officers, District Medical Doctor (DMD), Ward Medical Doctor (MD), Ward Nurse, Ward Executive Officer (WEO), and Village Executive Officer (VEO). At the same time, questionnaires were used to obtain information from the elderly on TASAF's role in their access to healthcare. The researchers used a semi-structured interview schedule to allow flexibility in questions while keeping the discussion focused on the main theme. The researchers also used Focus Group Discussions (FGDs), which included 18 elderly participants across three (3) FGDs, to collect primary qualitative data because they provide an open, fairly unrestricted forum for individuals to discuss ideas and clarify each other's impressions and opinions.

Trustworthiness

The researchers relied on primary data sources (interviewees, respondents, and informants) to support internal validity. The study may be transferred to other contexts with similar characteristics because the data sources and triangulation provided a deep account of elderly access to healthcare services. The approach ensured dependability and conformability because all data-collection processes were recorded, reducing researchers' bias.

Data analysis

The questionnaire data were summarised in Excel, producing descriptive statistics to capture respondents' preferences regarding elderly access to health facilities. We presented all preferences as percentages, as shown in the Results and Discussion section. For the interviews, researchers began by familiarising themselves with the data by reading and re-reading the transcripts for better comprehension. Then, we identified key concepts, added a few that emerged, and created categories. We interpreted and coded the interview data. This approach helped identify recurring patterns, themes, and insights in the responses, ensuring a comprehensive understanding of elderly access to healthcare. Because the responses were rich, uncovering valuable insights required careful cross-examination across a wide range of responses within each category.

Ethical consideration

The study was conducted in agreement with ethical deliberations from its proposal through completion of writing. The pertinent authorities approved data collection. Interview participants and informants consented to participate and could withdraw at any time before publication of this manuscript. Even Presentations of data are anonymous with respect to the interviews and informants. Although we tried, the qualitative approach (i.e., interviews and FGDs) means we cannot completely hide interviewees' responses from readers.

RESULTS AND DISCUSSIONS

Under this, all key findings are discussed while making a reflection based on access theory, sources of data collection and comparison with previous findings. The discussion of demographic features identifies the specific community, after which we discuss key components of elderly access to health facilities versus TASAF interventions.

Demographic characteristics of respondents

The study examined respondents' demographic characteristics. These characteristics included age, sex, marital status, education, religious denomination, occupation, and respondents' street/village. Examining these characteristics helped identify the types of respondents who contributed to the study. Table 2 presents the information.

Table 2. Demographic characteristics of respondents

Demographic Characteristics	Frequency	Percentage
	n	%
Age		
60 - 70	34	56.67
71 - 80	18	30
81 and above	8	13.33
Total	**60**	**100**
Marital status		
Never married	4	6.67
Married	26	43.33
Divorced	8	13.33
Widowed	22	36.66
Total	**60**	**100**
Gender		
Male	17	28.33

Female	43	71.67
Total	**60**	**100**
Education		
Informal education	41	68.33
Primary school	19	31.67
Secondary school	0	0
Tertiary	0	0
Total	**60**	**100**
Economic Activities		
Peasants	39	65
Livestock keeping	8	13.33
Entrepreneur	10	16.67
None	3	5
Total	**60**	**100**

Source: Field Data (2022)

Table 2 presents key issues regarding respondents' characteristics and healthcare accessibility. The main economic activity is farming, suggesting a lower-income community with low levels of formal education. The community has diverse marital statuses: 50% are divorced, never married, or widowed. About 71.7% are elderly females. They struggle to sustain their livelihoods, let alone access health care facilities. Drawing on the theoretical framework, this group needs health services that meet their needs (Penchansky & Thomas, 1981). They also need affordable health services, whether through cash payments or insurance. Additionally, an exception for costs for the elderly when accessing health services would be a practical approach. However, this still depends on effective communication to help the elderly understand their right to access health services, and on health systems being designed to accept them (Sourma, 2016). Additionally, sufficient, specialised medical personnel for older adults would make healthcare accessible (Penchansky & Thomas, 1981). In this context, while TASAF III aims to help vulnerable older adults and families access healthcare, this is difficult in practice. Moreover, without serious intervention, the consequences could be elderly poor health status and premature deaths (i.e. 60-65 years of age) (UN, 2025).

Access to Health Services

This section aimed to identify the availability and accessibility of health services for the elderly. The intention was to identify the place where the elderly get treatment, the means of transport the elderly used to reach the health facility, the distance travelled from the elderly's households to the health facility, infrastructure facilities for the elderly's access to health services, and diseases that older adults face in the researched areas.

Place of getting health services

The researchers wanted to identify the health facilities in the ward that respondents use when they are sick. The findings were presented in Table 3.

Table 3*:* Place where the elderly accessed health services

Health facilities	Frequence	Percent
Morogoro Regional Hospital	1	1.66
Mzinga Hospital	4	6.67
Sabasaba Hospital	3	5
Upendo Health Center	4	6.67
Baraka Health Center	2	3.33
Kilala Dispensary	32	53.33
Mkoya Dispensary	10	16.67
None	4	6.67
Total	**60**	**100**

Source: Field Data (2022)

Table 3 shows the frequencies and the health facilities they likely accessed for health services. Proximity partly explains this preference, with Kilala Health Center and Mkoya Dispensary being preferred. However, Mzimnga Referral Hospital and Morogoro Regional Hospital were preferred for referral cases. Therefore, the frequencies of attendance at the available health facilities were determined by a mix of reasons that amount to reasonable access to healthcare services for the elderly, as it was further confirmed by one of the interviewees as follows;

> Most older adults prefer to be treated at our ward dispensary, one of which is located on Kilala Street and another on Mkoya Street, which was built through citizens' efforts and with government support (Interviewee 7, 5 August, 2022).

Figure 1: Appearance of Mkoya dispensary

Source: Researchers, 2022

The findings reveal diverse patterns of healthcare facility attendance among respondents, showing a range of preferences for different health centers. Respondents' reported tendency not to attend any facility also suggests potential barriers related to affordability or acceptability, which may be influenced by factors such as financial constraints or perceived quality of care. These findings align with Van Der Wielen et al. (2018), who noted that many older adults are socioeconomically disadvantaged and live in rural areas with poor health service infrastructure. The findings also align with access theory, as proposed by Penchansky and Thomas (1981), by revealing the multidimensional nature of access and illustrating how availability, accommodation, and acceptability influence healthcare choices. The varied distribution also reflects spatial accessibility, underscoring the importance of proximity to healthcare services. Moreover, different facility types, from local dispensaries to regional hospitals, highlight accommodation by offering a range of options to meet varying healthcare needs (Sakala et al., 2026). However, studies such as Sakala et al. (2026), Mandomo et al. (2026), Ntibabara et al. (2026), and Malichwe et al. (2026) find that most facilities are not yet designed to provide high-quality healthcare services for older adults. For example, the 2003 policy of free health services for the elderly has not yet been implemented. Some elderly are not even aware of the right to be attended to free of charge (Saurman, 2016). Adegbola (2026) argues that when other alternatives do not respond quickly, families continue to care for the elderly because of strong socio-cultural ties in Africa.

Means of Transport and Distance to Health Facilities

Respondents were asked to indicate the means of transport they used to reach the nearest health facility for health services. The findings were presented in Table 4.

Table 4: Means of transport used by the elderly

Mode of Transport	Elderly	Percent
On foot	44	73.33
By bicycle	3	5
By motorcycle	13	21.67
Total	**60**	**100**

Source: Field Data (2022)

Table 5: Distance Elderly encounter to the health facility

Distance (km)	Elderly	Percent
<2	23	38.33
2 - 5	12	20
>5	25	41.67
Total	**60**	**100**

Source: Field Data (2022).

Table 4 showed that most (44, 73.33%) walked to reach the health facility; 13 (21.67%) used a motorcycle; and the remaining 3 (5%) used a bicycle. Table 5 shows that walking more than 5 kms to access health facilities is a serious barrier for the elderly. Additionally, the distance itself may not be the major cause of delay in reaching the health facility; rather, the quality of the roads themselves as figure 2 shows,

Figure 2: Elderly Crossing a River

Source: Photo adapted by researchers, 2022

Reflecting on the distances and the qualities of the road elderly encounters as one of the FGDs asserted the following:

> We spend a long time walking to get treatment at our dispensary, which is located on Kilala Street, because the roads on Mfine Street are not suitable for any transport other than walking (FGD1, 1 August 2, 2022).

Most respondents walk to the health facility because poor road conditions make other transport options unavailable. Long travel times and difficult weather highlight the effort required to access healthcare. This can create access gaps, especially for the elderly with limited mobility. Regarding the distances elderly encounter to the health facility, one of the interviewees asserted the following;

> Most older adults in the ward walk about one to four hours to seek health services because distances vary from one street to another, with some facilities nearby. Others were too far, and some areas were mountainous and hard to access (Interviewee 7, 5 August, 2022).

These findings can be explicitly explained through Penchansky and Thomas's (1981) access theory, which highlights how structural dimensions of healthcare access shape utilisation among older adults. Regarding availability and spatial accessibility, the physical distance to widely dispersed health facilities is a primary determinant of unmet health needs (Horn et al., 2018; Carandang et al., 2019; Kamsan et al., 2020). This geographic mismatch forces elderly patients to spend one to four hours walking to seek Care (Mattson, 2011, pp. 22-30; Sakala et al., 2026), a physical strain heavily exacerbated by weather hazards, missing vehicular infrastructure like the poor roads on Mfine Street, and treacherous environmental terrain (Madondo et al., 2026). As Figure 4.2 illustrates, physical friction points—such as rivers and slippery, undulating paths on the way to Kilala dispensary—undermine the geographic accessibility of care. This structural failure directly alters the acceptability of formal medicine for a significant number of elderly patients from Kivaza Street, who opt to remain at home, resort to traditional remedies, or buy cheaper medications from private pharmacies instead of

overcoming physical hurdles. Furthermore, access is severely compromised by financial and time constraints; while alternatives like motorcycles exist, their unaffordable costs and systemic transit delays place an unbearable burden on the elderly (HelpAge International, 2015; Kullanit et al., 2018; Magata et al., 2026). Ultimately, this severe breakdown across accessibility, affordability, and availability shows that even well-intentioned outreach, TASAF III interventions, and free healthcare policies will fail to deliver their intended results if underlying structural and transportation barriers go unaddressed.

Affordability of health services to the elderly

Reaching the health facilities may be difficult or easy, but actual access is also interpreted as the capability to pay (out-of-pocket) for the health service. Table 6 presents the elderly's experiences.

Table 6: Affordability of health services to the elderly

Responses	Sample size	Percent
Often	30	50
Less often	10	16.67
Never	20	33.33
Total	**60**	**100**

Source: Field Data (2022).

The findings in Table 6 showed that 30 (50%) of the respondents showed that they often paid for the health services; 10 (16.67%) of the respondents showed that they paid less often for the health services; and 20 (33.33%) of the respondents showed that they had never paid for the health services in the health facility when they went for treatment. One of the FGD informants declared what s/he experienced as follows:

> I am suffering from heart disease, and I got treatment at the Baraka Hospital located at the Kingalu Main Market in Morogoro District. After a checkup, it was discovered that my heart has tumors at the bottom, and I was told to provide Tshs. 200,000/= for medicine, but I could not pay, so I started using natural medicines I found in natural medicine shops at a low cost (FGD1, Informant 6 August 2, 2022).

Also, a similar response was uttered by one of the interviewees as follows:

> Medical services for poorly-off older adults have been a problem because the budget available to maintain services and buy essential medicine is insufficient (FGD1, 24 September, 2022).

Th The responses above show how important access theory is for understanding healthcare use. One person said they could not afford their prescribed medication. These findings point to ongoing affordability and access challenges, especially for people making tough health decisions. This matches what Dey et al. (2012) argue: older adults often struggle to access mental health services because of limited health budgets. In Hong Kong, people also face different levels of financial hardship when trying to get basic healthcare (He & Tang, 2021). These institutional gaps mirror those seen in Tanzania's TASAF III (Productive Social Safety Net) programme. TASAF III used conditional cash transfers to help vulnerable groups. However, evaluations show it did not lead to lasting poverty reduction or better long-term healthcare access because of design and implementation problems (ESRF, 2020; Tarimo & Machibya, 2025). TASAF III mainly provided short-term support, so it did not help people build lasting financial stability. When the cash transfers stopped, many recipients soon fell back into extreme poverty and could not pay for basic healthcare or medicines (Mhango & Barongo, 2025). Overall, the Focus Group Discussions and interviews show that financial capacity and access to healthcare are closely linked. Some respondents always paid for services, while others never did. These behaviors match the financial aspects of 'accessibility' and 'affordability' described by Penchansky and Thomas (1981). For example, one older person with heart disease could not afford treatment. This shows the affordability side of access theory: when the cost of a service is more than someone can pay, access becomes a major barrier, and the service is not used.

Acceptability and adequacy of health services

The study aimed to assess the elderly's satisfaction with the health services provided at the facility. The study used open-ended questions in the focus group discussions with the respondents. Table 7 presents the findings.

Table 7: Acceptability and adequacy of health services to the elderly

Responses	Sample size	Percent
Satisfied	3	5
Neutral	10	16.67
Less satisfied	42	70
Unsatisfied	5	8.33
Total	**60**	**100**

Source: Field Data (2022)

Table 7 shows that the elderly did not appreciate the quality of health services as expected. More than 70% were less satisfied. 10 (16.7%) ranked them less than dissatisfied with the health services. Only 5 (8.3%) never appreciated the quality of service. These responses were confirmed by the third FGD observation about acceptability and adequacy, as the informants declared that:

> When we come to the dispensary for treatment, we always explain ourselves to the doctor, and we were given medicine to use. However, we have never seen laboratory tests because we always see the needles themselves being boiled in the kitchen (FGD3, 8, 8 August, 2022).

The focus group discussion provides real insight into the specific reasons for the widespread discontent. Penchansky and Thomas's Theory of Access (particularly the dimensions of adequacy and acceptability) explains this well. One elder mentioned that they had never seen any lab tests carried out at the health facility. That clearly illustrates a lack of adequacy (the degree to which the health service's administration, organisation, and technical capacity can meet patients' clinical needs). The facility has no basic diagnostic equipment and is therefore structurally incapable of providing proper or reliable medical care. The older person also reported seeing medical needles being boiled in a normal kitchen area. This is a total breach of medical standards and poses a serious risk of cross-infection. That finding will significantly affect the acceptability dimension (the patient's perception of the standards of care being provided relative to what they consider safe, respectful, and ethical care). So even where services are available and affordable, deficiencies in quality, clinical safety, and cultural acceptability can significantly affect overall satisfaction and, in turn, reduce the likelihood of future use.

In conclusion, these results show that access to healthcare is more than availability by location alone. It must also account for quality, safety, and a patient-focused approach, reflecting the inherently multidimensional nature of access. This aligns with Amporfro et al. (2021), who found that most respondents were dissatisfied with the health services offered at the health facility. Kalligirwa et al. (2026) and Adegbola (2026) both stress that health facilities must not compromise the health status of the elderly, as treatment errors harm this group and place a significant emotional and financial burden on families. Even with some of the structural flaws, there is still a segment of the elderly (40%) who are somewhat satisfied with the health services they have received (Fonta et al., 2017). The study also found that the most frequent reasons for continued dissatisfaction were long waiting times, poor cleanliness and rude staff. These indicate failures in adequacy (long waiting times and facility conditions) and acceptability (rude staff and the patient/provider relationship).

Health Workers' Training in elderly care

Elderly healthcare is required because they may need treatments that general practitioners may not offer. Hence, on-the-job training would add to their medical expertise. Through interviews, insights were gained as one of the interviewees uttered the following:

> I am a medical staff member treating patients, but *I* did not receive any training for elderly services; I use my knowledge of clinical medicine to treat elderly patients (Interviewee 4, 2 August, 2022).

In addition, one staff member from the social welfare office gave the opposite response. The officer argued that;

> Our concern is elderly health issues; we have supplied medicine, bought medical equipment, and trained medical personnel on elderly medical issues at two local dispensaries through the aid of our donors and local well-wishers (Interviewee 10, 24 September, 2022).

The responses above point to a huge variation in health service providers' preparedness. This variation may reflect inconsistent on-the-job training, which is not necessarily available to all staff. For instance, a new staff member may have received no training in elderly health services. Staff have basic medical knowledge but clearly need ongoing education to stay up to date with older adults' specific needs.

Saurman (2016) builds on Penchansky and Thomas' theory of access by adding 'awareness' as a sixth dimension. He argues that access to healthcare is not simply about physical availability but also about awareness. Access requires both providers and users to understand the health system and its protocols (Iman et al., 2026). Structured training is needed to close the knowledge gap and ensure staff are up to speed on the latest policies and procedures, which in turn improves care for older people.

The results show that limited training among health service providers is a major factor limiting older adults' access to preventive Care (Kisiwa et al., 2023; Amar et al., 2022). Socio-economic factors such as low income and rural residence also create barriers to access. Without specific training in these settings, elderly patients are far less likely to receive appropriate Care (Kaligirwa et al., 2026). Conversely, appropriately trained staff can significantly reduce medical and procedural errors when caring for elderly patients (Kaligirwa et al., 2026).

This aligns with access theory, which acknowledges older people's differing needs and expectations when accessing health care (Penchansky & Thomas, 1981). Kalula (2011) notes that limited provider knowledge and skills significantly impede preventive care delivery to older people. The WHO (2017) adds that lacking these competencies reduces the likelihood of identifying older patients who need preventive care. Providers without the requisite training are unlikely to identify necessary interventions (e.g., routine immunisations, timely screening) (Tesha et al., 2026).

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

The study on the Tanzania Social Action Fund (TASAF III) in Luhungo Ward, Morogoro District Council, provides important insights into the barriers elderly individuals face in accessing healthcare services.

A key finding is that the availability and proximity of healthcare facilities significantly influence older adults' access. Many respondents relied on Kilala Dispensary, which required long walks, particularly for those living farther away. This geographical barrier underscores the need for policymakers to improve the distribution and accessibility of healthcare facilities so older adults can seek necessary medical care without significant hardship.

Affordability also emerged as a major barrier. Respondents noted that out-of-pocket healthcare expenses affected their satisfaction and willingness to seek treatment. Since many elderly individuals live on fixed or lower incomes, the financial burden can deter them from accessing vital medical interventions. Therefore, programs like TASAF III should include financial support mechanisms to reduce healthcare costs for older adults.

The study also highlighted systemic issues within healthcare facilities, such as poor conditions and inadequate specialised training for healthcare providers. Quality care is crucial for older adults who may face complex health conditions. The study found that many facilities struggled to deliver adequate care, largely because they lacked trained personnel familiar with geriatric health challenges. Therefore, training programs should include geriatric care as a core component to ensure older adults receive effective, respectful healthcare services.

Furthermore, the findings align with global trends regarding aging populations and their healthcare needs. The Sustainable Development Goals (SDGs) emphasise promoting health and well-being for older individuals, providing a framework for national programs like TASAF III. This connection highlights the need for countries to strengthen health systems at both macro and micro levels and actively involve older adults in policy development and healthcare decision-making.

In conclusion, improving healthcare access for older adults in Luhungo Ward necessitates a multifaceted approach. Effective strategies must address facility availability and service affordability and improve care quality through better

provider training. Programs like TASAF III can drive meaningful change, but success depends on adapting to the complex realities older adults face. Stakeholders must collaborate to establish inclusive healthcare policies that uphold older adults' dignity and well-being, ultimately enabling them to continue contributing positively to their communities and economies.

Policy Implications

The study's findings on access to health services among the elderly through the TASAF III program in Luhungo Ward, Morogoro District Council, align with several existing policies in Tanzania focused on healthcare and the elderly population. Some key policies that relate to the findings include:

The National Health Policy 2019 emphasises equitable access to health services for all, including vulnerable populations such as the elderly. It highlights the importance of addressing barriers to health access, which is reflected in the study's findings regarding transportation, affordability, and facility conditions. Secondly, the Tanzania National Strategy for Aging (2016-2021) specifically aims to improve the welfare of older persons in Tanzania. The findings, which point to challenges in accessing health services, underscore the need for strategies that strengthen healthcare infrastructure and services tailored to older adults.

Thirdly, Tanzania is a signatory to the SDGs, particularly Goal 3, which aims to ensure healthy lives and promote well-being for all, including older adults. The study's focus on barriers to healthcare access among the elderly aligns with this goal by highlighting the need to improve the availability and affordability of health services. The TASAF III program aimed to reduce poverty and improve service delivery for vulnerable groups, including the elderly. The findings on TASAF's role in improving access to health services directly align with the program's objectives.

Fourth, the study also addressed issues related to the Decentralized Health Services Framework. This framework focuses on improving health service delivery at the local level, allowing more tailored responses to communities' specific needs. The study's insights into local healthcare access issues underscore the importance of implementing this framework effectively. Likewise, the Health Sector Strategic Plan (HSSP) aims to strengthen service delivery, improve health systems, and enhance access to quality healthcare. The findings highlight the need to improve service quality and provider training, which aligns with the HSSP's strategic objectives.

Limitations and Areas for Further Studies

This study did not compare which access factors affect healthcare access for the elderly. Further studies could identify which factors matter most so emphasis can be directed to the most impactful variables. Second, a survey study could generate stronger evidence by using a larger, representative sample from Tanzania.

Contribution of the Study

The TASAF III study makes a major contribution to our understanding of the access challenges faced by the elderly in Luhungo Ward, Morogoro District Council. It uses a mixed-methods approach to examine how TASAF III enables the elderly to access health services and provides a rich dataset that, in turn, informs our broader understanding of access. The findings clearly highlight the range of access barriers (affordability, availability, and quality of health services) the elderly face and are highly valuable to policymakers.

This study aligns squarely with the SDGs, specifically SDG 3 on health and well-being for all ages. It underscores the importance of embedding aged care in national policy frameworks, aligned with the principles of the UN Madrid International Plan of Action on Ageing (MIPAA). It identifies the need for better access and higher-quality care and, as such, calls for better health workforce training and improved infrastructure.

The study also highlights the need for collaboration among all relevant stakeholders (government agencies, NGOs, and community-based organisations) to meet the health needs of the elderly. It is a study which, in itself, will have an impact

on policy at both local and national levels and will also be a stimulus for similar work to be undertaken in other parts of the country. It contributes to developing more equitable health systems for older people in Tanzania and elsewhere.

Authors' Contributions

Charles: collected data and transcribed FGDs and interviews, processed questionnaires and submitted the paper to the journal. Charles and Tefurukwa drafted the study, searched for reading materials, conducted the literature review and research methodology, designed tools, and wrote the paper. Tefurukwa proofread and edited the final copy.

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