

Challenges Facing the Elderly in Accessing Health Services

A Case Study of Akheri Ward in Arumeru District, Arusha, Tanzania

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ABSTRACT

Globally, the ageing population is growing fast. Older adults face complex health needs and struggle to access appropriate care, especially in low- and middle-income countries. In Tanzania, rural elderly individuals face multiple barriers to healthcare. These include long distances to facilities, financial hardship, and a shortage of geriatric services. This study examined the challenges faced by elderly people in accessing healthcare in Akheri Ward, Arumeru District. The study employed a mixed-methods cross-sectional design involving 78 participants. The sample included elderly residents, community members, healthcare workers, and local leaders. Quantitative data came from structured questionnaires. Qualitative information was gathered through interviews, focus group discussions, and document reviews. Results showed that distance to facilities, poor transport options, and dependence on public health centers limited access. Socioeconomic barriers, including a lack of insurance, high medical costs, and low income, exacerbated the problem. Quality of care was mostly rated average. Long waits, limited explanations from providers, and a lack of geriatric specialists were common concerns. Ageism and weakening family support added further challenges. The study recommends decentralizing services, expanding mobile clinics, training more geriatric staff, improving financial protection, and reducing discrimination. These steps can help ensure that elderly people in rural Tanzania receive fair, respectful, and effective healthcare.

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Introduction

Globally, the issue of healthcare access for older adults is gaining urgency due to demographic transitions and the rising ageing population. By 2050, individuals aged 60 years and above will constitute approximately 22% of the global population, with over two-thirds living in low- and middle-income countries [20]. This shift has been accompanied by a growing burden of chronic illnesses such as cardiovascular disease, diabetes, and dementia, which disproportionately affect older adults [24]. The WHO [24] estimates that nearly 80% of older adults worldwide have at least one chronic condition. However, many healthcare systems remain underprepared to meet the complex needs of ageing populations, particularly in low-resource settings [19]

In Africa, the elderly population is expanding rapidly due to improvements in life expectancy, but healthcare systems are often focused on maternal and child health and infectious disease control, with limited attention to geriatric care [1]. The African Union [2] projects that the population aged 60 and above will triple from 64 million in 2015 to 220 million by 2050. Financial constraints, limited trained personnel, and inadequate infrastructure compound the challenge [23].

In Tanzania, the elderly population is expected to reach 5.6 million by 2050 [20]. While the National Ageing Policy [21] was an important milestone, its implementation has been hindered by limited funding, insufficient geriatric training, and weak institutional capacity [15]. Approximately 80% of older adults in Tanzania live in rural areas where poor transport infrastructure and limited health facilities are common [7]. In Arumeru District, where Akheri Ward is located, many older adults depend on family members for transportation to health facilities, with distances exceeding five kilometers in some cases [6].

This study investigated the specific challenges facing the elderly in accessing healthcare services in Akheri Ward, identifying the social, economic, and systemic factors that influence healthcare access and proposing strategies for improvement.

Literature Review

This study draws on Erikson's psychosocial theory, particularly the final stage of development, "integrity versus despair" [4]. This stage typically occurs in late adulthood, when individuals reflect on their life's accomplishments, relationships, and personal meaning. Successful navigation of this stage leads to a sense of integrity, acceptance of the life lived, and readiness to face the end of life without fear. Conversely, failure to achieve integrity results in despair characterized by regret, bitterness, and a perception that life has been wasted. Access to

adequate healthcare is a central determinant in this process, as it influences both physical functioning and the ability to maintain social participation. Poor health or limited access to care can diminish autonomy, restrict social interactions, and heighten dependency, thereby fostering despair and social isolation [8]. Health services that are responsive, respectful, and inclusive can therefore play a pivotal role in supporting elderly individuals' psychological well-being and enabling them to achieve a sense of fulfilment in later life.

From a sociological perspective, ageing is understood as a socially constructed process, shaped by societal structures, cultural norms, and economic conditions. In many African societies, including Tanzania, traditional family systems historically ensured that older adults were cared for within extended households, where they provided guidance, preserved cultural knowledge, and contributed to decision-making [1]. However, processes of modernization, economic transformation, and rural to urban migration have progressively eroded these family-based care networks [16]. Younger generations often migrate in search of education or employment, leaving older relatives in rural communities with limited daily support.

As a result, the elderly are increasingly reliant on formal healthcare systems, which are frequently underfunded, understaffed, and lacking in geriatric specialization. Moreover, healthcare delivery in many rural contexts remains aligned with a "one size fits all" model that does not account for the specific medical, psychological, and social needs of older adults [25],[26]. Cultural insensitivity in health service provision, manifested in inadequate communication, ageist attitudes, or disregard for traditional beliefs, can further alienate elderly patients and discourage them from seeking care [9].

The sociological lens also highlights the role of social determinants of health, such as education, income, and community networks, in influencing healthcare access for the elderly. Older adults with low literacy levels may struggle to navigate healthcare systems or understand treatment instructions, while those with limited financial resources face barriers in affording transportation, consultations, or medication [7]. In this context, effective healthcare access for the elderly requires an integrated approach that addresses both structural barriers—such as infrastructure and workforce limitations and cultural barriers, including the need for respectful and age-sensitive care.

By integrating Erikson's psychosocial theory with sociological perspectives, this study underscores that healthcare for the elderly is not merely a medical issue, but a multidimensional challenge involving psychological well-being, cultural dynamics, and systemic capacity. Understanding these theoretical dimensions provides a foundation for interpreting the

challenges identified in Akheri Ward and developing strategies that are both contextually relevant and person-centered. Both perspectives underscore that quality elderly care depends not only on technical competence but also on interpersonal interactions, empathy, and respect from healthcare providers [9].

Material and Methods

This study adopted a mixed-methods cross-sectional design, integrating both quantitative and qualitative approaches to capture a comprehensive understanding of the challenges faced by the elderly in accessing healthcare services in Akheri Ward, Meru District, Arusha Region. The mixed methods approach was chosen to allow for triangulation of data, ensuring that numerical trends from the quantitative component were complemented by rich, contextual insights from qualitative narratives.

The study population included elderly individuals aged 57 years and above, community members, healthcare workers, and local government leaders within the ward. A total of 78 respondents participated in the study. This comprised 30 elderly individuals, 35 community members, 7 healthcare workers, and 6 government leaders. The sample size was calculated using Yamane's [27] formula to ensure statistical reliability while considering the total population of the ward. Sampling procedures were tailored to each participant category: simple random sampling was used to select elderly respondents and community members, ensuring equal representation without bias, while purposive sampling was applied for healthcare workers and government leaders, as these groups possessed specialized knowledge and experience relevant to the study objectives.

Multiple data collection methods were employed to enhance validity. Quantitative data were gathered through structured questionnaires containing both closed and open-ended questions, enabling the capture of measurable indicators while allowing for additional explanatory responses. Qualitative data were obtained through semi-structured interviews and focus group discussions (FGDs), which provided deeper insights into personal experiences, perceptions, and community-level challenges. A documentary review was also conducted to examine relevant policy documents, statistical records, and previous research reports related to elderly healthcare access in Tanzania.

Data analysis was conducted in two phases. Quantitative data were coded and entered into SPSS version 22 and Microsoft Excel for descriptive statistical analysis, generating frequencies, percentages, and cross tabulations to identify patterns and trends. Qualitative data were analyzed thematically, involving transcription, coding, and categorization of emerging

themes related to healthcare accessibility, socioeconomic barriers, and service quality. This allowed for a nuanced interpretation of the lived realities of the elderly in Akheri Ward. Ethical considerations were strictly observed throughout the research process. Permission to conduct the study was obtained from the Tengeru Institute of Community Development (TICD) and the relevant district authorities. Informed consent was sought from all participants, who were assured of their right to withdraw at any stage without penalty. Confidentiality was maintained by anonymizing all participant responses and securely storing research data to prevent unauthorized access.

Result and Discussion

The study sought to assess the challenges faced by elderly individuals in accessing healthcare services in Akheri Ward, guided by four specific objectives: (1) to analyze the availability and accessibility of healthcare facilities for the elderly, (2) to identify the socioeconomic factors affecting their access, (3) to assess the quality of healthcare services provided, and (4) to propose strategies for improvement.

A. Demographic Profile of Respondent

A total of 78 respondents participated in the study, comprising 30 elderly individuals aged 57 years and above, 35 community members, 7 healthcare workers, and 6 local government leaders. Among the elderly respondents, women constituted a slightly higher proportion than men, reflecting the national trend of longer female life expectancy. The majority of elderly participants were aged between 60 and 70 years, with a smaller number above 75 years. Educational attainment was generally low among the elderly, with most having completed only primary education or having no formal education, a factor that has implications for navigating healthcare systems and understanding medical advice. Occupationally, many elderly respondents were subsistence farmers or informal traders, indicating limited and irregular income sources.

B. Availability and Accessibility of Healthcare Facilities

The findings revealed that public health centers were the most frequently accessed facilities (39.7%), followed by traditional healers (26.9%), with private clinics and district hospitals being less commonly used. Physical accessibility was identified as a significant barrier; 36% of elderly respondents lived more than four kilometers from the nearest healthcare facility. Transport challenges were frequently cited, as many depended on family members or neighbors for assistance. For those without reliable transport, reaching health services often involved walking long distances, which was physically demanding for elderly individuals with mobility limitations.

These findings are consistent with prior studies that have documented the critical role of geographical proximity in determining healthcare utilization among the elderly. Frumence et al. [7] observed that in rural Tanzania, long distances to health facilities discourage elderly patients from seeking timely care, often leading to delayed diagnoses and worsened health outcomes. The reliance on public health centers, as seen in this study, reflects both affordability and availability, given that public facilities are more evenly distributed than private ones in rural areas [13]. However, the reliance on traditional healers by over a quarter of respondents highlights an important cultural dimension of healthcare access; many older adults may prefer traditional care due to trust, accessibility, or the perception that biomedical services are ineffective for chronic conditions [8].

Transport-related barriers further compound the issue. Studies in other Tanzanian rural districts have shown that a lack of affordable and reliable transport can result in missed medical appointments, especially among elderly individuals with limited mobility [10]. Walking long distances to access care is not only physically strenuous but can also exacerbate existing health problems such as arthritis, cardiovascular conditions, or respiratory illnesses [25]. The dependency on family members for transportation, as identified in this study, also reflects broader sociological changes; with urban migration and shifting family structures, elderly individuals are increasingly left without consistent support for accessing health services [1].

From a policy perspective, these findings underscore the importance of decentralizing healthcare services and introducing mobile clinics or community outreach programs targeted at elderly populations in remote areas. Such interventions have been effective in increasing service uptake in other parts of sub-Saharan Africa by bringing healthcare closer to communities [11]. Without addressing these physical accessibility barriers, improvements in healthcare infrastructure and service quality will have a limited impact on elderly healthcare utilization.

C. Socioeconomic Factors Affecting Access

Socioeconomic constraints emerged as a critical barrier to healthcare access for elderly individuals in Akheri Ward. The absence of health insurance was the most frequently reported challenge, affecting 35.9% of respondents. Additionally, 28.2% identified the high cost of medication as a deterrent to seeking treatment, while 19.2% pointed to expensive transportation as a limiting factor. Social factors compounded these economic barriers; 33.3% of respondents reported experiencing some form of discrimination or negative treatment from healthcare providers due to their age or perceived low economic status. The limited financial resources of

the elderly, coupled with the erosion of traditional family support systems, meant that many relied on sporadic support from relatives or neighbors to cover medical costs.

These findings align with national and regional studies showing that poverty and lack of financial protection remain major obstacles to healthcare utilization among older adults in Tanzania [14],[22]. Health insurance coverage in Tanzania is still low, especially among rural elderly populations, largely due to limited awareness, affordability issues, and the informal nature of most rural employment [10]. Without insurance, the cost of consultations, diagnostic tests, and medication must be paid out of pocket, a burden that can discourage timely healthcare-seeking behavior and lead to untreated or advanced illnesses [26].

The high cost of medicines is a particular concern, as many elderly individuals suffer from chronic conditions such as hypertension, diabetes, and arthritis, which require long-term pharmacological management. A similar study in the Kilimanjaro Region found that the expense of medication, combined with irregular income, often forces elderly patients to reduce dosages or forego treatment altogether [5]. Expensive transportation further compounds the problem, as elderly residents living far from health facilities must choose between paying for transport or for medical services, a choice that frequently results in delayed care [13].

Social barriers also play a significant role. Reports of discrimination by healthcare providers suggest the presence of ageism in the health system, a phenomenon documented in other Tanzanian studies where elderly patients were sometimes deprioritized or treated dismissively [17]. From a sociological perspective, these patterns reflect both structural inequalities and cultural shifts. Historically, extended families served as the primary source of care and financial support for older adults, but modernization, urban migration, and economic pressures have weakened these networks [1]. As a result, elderly individuals often find themselves without reliable financial or emotional support when seeking healthcare.

D. Availability and Accessibility of Healthcare Facilities

In terms of perceived service quality, most respondents rated the healthcare services available to them as average (43.6%), while 24.4% rated them as poor, and only a small proportion described them as good. The attitudes of healthcare providers were mixed: over half (53.8%) were described as neutral, 20.5% were perceived as rude or neglectful, and a smaller proportion were regarded as supportive and respectful. Elderly respondents frequently expressed concerns about prolonged waiting times, rushed consultations, and inadequate explanations regarding diagnoses and treatment plans. Furthermore, the absence of healthcare

workers with specialized training in geriatric care emerged as a significant limitation affecting the overall quality of services.

These findings highlight a persistent challenge in rural healthcare systems: quality of care is shaped not only by the availability of infrastructure and medical supplies but also by the competence, attitudes, and communication skills of healthcare providers [3]. The predominance of "average" service ratings suggests that while basic services are available, they often fail to meet the specific needs of elderly patients. This is consistent with research in other Tanzanian districts where rural health services were found to be functional but constrained by staff shortages, limited training opportunities, and inadequate patient-provider communication [12].

The reported negative attitudes of some healthcare providers point to underlying issues of ageism in health service delivery. Ageist attitudes can manifest as neglect, stereotyping, or deprioritization of elderly patients' needs, resulting in diminished trust and reduced healthcare-seeking behavior among older adults [18]. In rural Tanzania, studies have shown that elderly patients are sometimes perceived as "non-productive" and therefore receive less attentive care compared to younger patients [17]. These perceptions undermine the principles of equity and dignity in healthcare provision, as outlined in Tanzania's National Ageing Policy [21].

Long waiting times and rushed consultations, as reported by respondents, are symptomatic of systemic constraints such as understaffing and high patient-to-provider ratios. In many rural health facilities, a single healthcare worker may be responsible for attending to dozens of patients in a single day, limiting the time available for thorough examination and patient education [24]. The lack of detailed explanations regarding diagnoses and treatments reflects gaps in patient-centered care, an approach that is critical for ensuring adherence to treatment plans, particularly for elderly patients managing chronic conditions [25].

The absence of geriatric-trained healthcare workers is a particularly pressing concern. As Tanzania's elderly population grows, the demand for healthcare providers with expertise in age-related conditions such as dementia, osteoporosis, and cardiovascular diseases will continue to rise. Yet, as noted in prior studies, geriatric medicine is not a well-established specialty in most Tanzanian medical training institutions [10]. This skills gap limits the ability of healthcare systems to deliver tailored, comprehensive, and respectful care for older adults.

Improving the quality of healthcare services for the elderly will require a multifaceted approach. This includes investing in geriatric training programs for healthcare workers, strengthening patient-provider communication skills, reducing patient loads through task shifting or hiring additional staff, and institutionalizing quality monitoring systems. Additionally,

sensitization campaigns aimed at reducing ageist attitudes within healthcare settings could improve the interpersonal aspects of care, thereby enhancing both patient satisfaction and health outcomes.

Conclusion

Elderly residents of Akheri Ward face significant geographic, financial, and social barriers to healthcare access. While public facilities are the most used, they are often distant, under-resourced, and lacking in specialized geriatric care. Financial constraints, especially lack of insurance and high medication costs, exacerbate health inequalities. Improving elderly healthcare requires integrated strategies involving infrastructure investment, workforce training, financial protection, and community engagement. Policy implementation must be strengthened to ensure rural elderly populations benefit from national healthcare commitments.

Conflict of Interest

The authors declare no conflict of interest.

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