



Exemption Policy or Empty Promise? Understanding Health-Seeking Behaviour Among Older Persons in Tanzania's Lindi Region

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Abstract: Health-seeking behaviour is critical for improving health outcomes among older persons, yet limited evidence exists on how exemption policies translate into actual service utilisation in resource-constrained settings. This study examined health-seeking behaviours and perceptions of free healthcare services among older persons (≥ 60 years) in Tanzania's Lindi Region, where implementation of the 1994 exemption policy remains poorly understood despite increasing population ageing. Employing a cross-sectional mixed-methods design, the study surveyed 369 older persons through multistage sampling across Kilwa and Nachingwea districts, conducted 17 key informant interviews with health officials and social welfare officers, and facilitated focus group discussions in four villages. Quantitative data were analysed using SPSS descriptive and inferential statistics (chi-square tests), while qualitative data underwent thematic content analysis. Findings revealed that 91.7% of respondents predominantly sought care at public healthcare facilities, with 36.4% accessing free services more than five times annually, driven primarily by affordability rather than quality considerations. Chi-square analysis revealed statistically significant associations between healthcare facility choice and age group ($\chi^2=18.24$, $p=0.006$), gender ($\chi^2=9.67$, $p=0.022$), and education level ($\chi^2=24.56$, $p=0.001$), indicating that younger older adults (60-69 years) were more likely to utilise public facilities compared to those aged 80+ years. However, significant service gaps emerged: while consultation (64.3%), hospitalisation (67.8%), and diagnostic services (69.1%) were perceived as accessible, 84.6% of respondents reported chronic medication shortages, expressing deep dissatisfaction with drug availability despite policy provisions. These findings empirically contribute to health equity theory by demonstrating that removing financial barriers through exemption policies is necessary but insufficient, without addressing supply-side constraints, particularly medication availability, health-seeking behaviour remains suboptimal. The study advances policy discourse by revealing a critical implementation gap between exemption policy intentions and frontline service delivery realities, suggesting that Tanzania's pursuit of universal health coverage requires simultaneous demand-side (financial access) and supply-side (service quality and drug availability) strengthening. We recommend decentralised drug supply chain management, increased budgetary allocation for geriatric medications, streamlined exemption procedures to reduce bureaucratic delays, and community-based awareness programmes to enhance policy literacy among older persons. Without comprehensive health systems strengthening ensuring both financial and physical access to quality care, exemption policies risk becoming symbolic rather than transformative for Tanzania's rapidly growing older population.

Keywords: Health-seeking behaviour; Older persons; Exemption policy; Health equity; Universal health coverage

1.0 Background Information

Health-seeking behaviour represents a critical determinant of health outcomes among older persons, influencing disease progression, treatment adherence, and overall quality of life in later years (Bhat & Kumar, 2017; Kamarazaman & Ismail, 2024; Pirouz *et al.*, 2024; Teo *et al.*, 2022). As populations age globally, understanding how older individuals navigate

healthcare systems has become increasingly imperative for achieving universal health coverage and health equity (Carroll *et al.*, 2022; Ren *et al.*, 2023; Saka *et al.*, 2019). The importance of this topic is magnified in sub-Saharan Africa, where the population aged 60 years and older is projected to triple by 2050, reflecting major gains in survival while simultaneously exposing critical vulnerabilities in health



systems that remain oriented toward child, maternal, and acute care rather than the promotion of healthy longevity across the life course (Akinrolie *et al.*, 2024; He, 2022; Kalu *et al.*, 2021; Velkoff & Kowal, 2006). Tanzania exemplifies this demographic transition, with the number of older adults rising rapidly from 2.1 million in 2012 to 3.7 million in 2022, a figure expected to grow substantially in coming decades (National Bureau of Statistics, 2022b, 2022c). This rapid ageing, however, has not been matched by commensurate investments in preventing functional decline, frailty, and multimorbidity, leaving older adults to endure prolonged ill health in a system originally designed for younger populations (Kapologwe *et al.*, 2023; Tungu *et al.*, 2024).

The global literature has established that health-seeking behaviours among older persons are influenced by a complex interplay of factors including age, income, chronic conditions, availability of healthcare services, distance to facilities, transport accessibility, and awareness of health policies (Bhat & Kumar, 2017; Kamarazaman & Ismail, 2024; Neme, 2018; Teo *et al.*, 2022; Zeng *et al.*, 2022). To address financial barriers facing vulnerable populations, many countries have implemented exemption policies aimed at removing out-of-pocket costs for older persons. In Tanzania, the government introduced the Exemption and Waiver policy in 1994, followed by specific exemptions for elderly people aged 60 years and above in 1999, with the aim of protecting the poorest and most vulnerable population against healthcare charges (Ministry of Health, 1994; United Republic of Tanzania, 1997, 2017). This policy represents a historic commitment to health equity, building upon the post-independence Arusha Declaration of 1967 that abolished user fees and established a tax-based system for free healthcare provision (Kapologwe *et al.*, 2023; Mujinja & Kida, 2014). The policy framework established guidelines operationalising exemptions, rigorous processes for identifying eligible elderly individuals, and specific administrative structures from district to community level dealing with elderly social welfare (United Republic of Tanzania, 1997, 2003, 2007, 2017).

Previous studies in Tanzania have documented various aspects of exemption policy implementation. Tungu *et al.* (2024) identified that although designated offices exist to handle exemptions for the elderly, multiple challenges persist, including a lengthy and bureaucratic process for accessing exemptions, inadequate clarity on groups deserving exemption, poor financial mechanisms for exempted services, and insufficient information about exemption categories. Similarly, Edward and Maluka (2021) found that elderly exemption beneficiaries faced significant bureaucratic hurdles in obtaining free healthcare, while Ntanosanzwe and Rwegoshora (2021) reported that exemption measures performed poorly due to limited

geriatric services and lack of funding for free healthcare. Studies in other sub-Saharan African contexts have corroborated these findings, revealing that exemption policies often fail to translate into meaningful service access due to supply-side constraints, including insufficient drugs and laboratory tests not covered by exemptions (Alaazi *et al.*, 2022; Atakorah *et al.*, 2024; Atchessi *et al.*, 2016; Novignon *et al.*, 2021).

Despite this growing body of literature, significant knowledge gaps persist. Empirically, limited evidence exists on how exemption policies translate into actual health-seeking behaviours and service utilisation patterns among older persons in Tanzania's rural and underserved regions, particularly in areas such as Lindi Region where health workforce density is lower and infrastructure challenges are more pronounced (Ministry of Health Community Development Gender Elderly and Children, 2019; National Bureau of Statistics, 2022b). While studies have identified implementation challenges at policy and facility levels (Edward & Maluka, 2021; Magata *et al.*, 2025b; Tungu *et al.*, 2024), few have systematically examined the relationship between older persons' perceptions of service availability and their actual healthcare-seeking decisions. Furthermore, the demographic disparities in health-seeking behaviour, how factors such as age, gender, and education influence utilisation patterns, remain poorly understood in the Tanzanian context.

Theoretically, while Health Equity Theory provides a framework for understanding inequalities in healthcare access and utilisation, its application to exemption policy contexts has been limited (Braveman & Gruskin, 2003; Goddard & Smith, 2001). The theory's key variables, availability of services, equity in access to care, equal use for equal need, equal quality of care, and institutional influence, have not been systematically examined in relation to older persons' health-seeking behaviour under exemption policies (Carroll *et al.*, 2022; Goddard & Smith, 2001). Moreover, recent evidence suggests that the relationship between policy intentions and implementation realities is more complex than the theory accounts for, with Tungu *et al.* (2024) revealing that implementation has become controversial, burdening both the elderly and health facilities, and raising questions about whether the exemption policy achieves its initial aim of relieving the elderly from high healthcare costs. This suggests a theoretical gap in understanding how policy implementation failures, particularly in low-resource settings, mediate the relationship between exemption policies and health equity outcomes. The absence of clear financial mechanisms to compensate health facilities for free services has led to exemptions becoming a financial burden that undermines service quality and availability (Pennestri, 2025; Tungu *et al.*, 2024).



It is against this backdrop of persistent implementation challenges and theoretical gaps that this study situates itself. While exemption policies in Tanzania have been documented at national and district levels, limited evidence exists on how these policies shape health-seeking behaviours at the community level, particularly in contexts of resource scarcity where medication shortages and service quality concerns intersect with demographic vulnerabilities. The Lindi Region in southern Tanzania provides an important case study, characterised by lower density of health professionals, limited infrastructure, and significant geographical isolation, factors that may exacerbate the gap between exemption policy intentions and service delivery realities for older persons (Ministry of Health Community Development Gender Elderly and Children, 2019; National Bureau of Statistics, 2022a, 2022b).

This study, therefore, sought to understand the health-seeking behaviours of older persons who utilise free healthcare services under the exemption policy in Tanzania's Lindi Region and to explore their perceptions of the services provided at public primary healthcare facilities. Specifically, the study aimed to: examine the health-seeking patterns and facility preferences among older persons accessing free healthcare services; determine the frequency of healthcare visits and factors influencing service utilisation; and assess perceptions of the availability and quality of free healthcare services, particularly consultation, diagnosis, medication, and hospitalisation services.

As such, the study addressed the following research questions: What are the health-seeking behaviours and facility preferences among older persons utilising free healthcare services in Lindi Region? What is the frequency of healthcare visits among older persons, and what demographic factors influence their utilisation patterns? How do older persons perceive the availability of free healthcare services, including consultation, diagnosis, medication, and hospitalisation, at public primary healthcare facilities? Therefore, by addressing these questions, this study contributes to both empirical and theoretical knowledge on health-seeking behaviour among older persons in sub-Saharan Africa. Empirically, it provides primary evidence from a region where exemption policy implementation has been poorly documented, offering insights into the real-world challenges older persons face when accessing supposedly free healthcare. Theoretically, it extends Health Equity Theory by demonstrating that removing financial barriers, while necessary, is insufficient for achieving health equity; without addressing supply-side constraints, particularly medication availability, exemption policies risk becoming symbolic rather than transformative for older populations. The findings have significant policy implications for Tanzania's pursuit of universal health coverage, highlighting the need for simultaneous

strengthening of both demand-side (financial access) and supply-side (service quality and drug availability) components of the health system.

2.0 Theoretical Framework

2.1 Introduction to the Theoretical Framework

Understanding health-seeking behaviour among older persons who utilise or underutilise free healthcare services despite their availability requires a robust theoretical foundation. This study employs the Health Equity Theory as developed by Goddard and Smith (2001), which provides a comprehensive framework for examining factors influencing the availability, accessibility, and utilisation of healthcare services across population groups. The theory is particularly relevant to this study as it addresses the central question of whether exemption policies for older persons translate into equitable access to quality healthcare, or whether they remain an "empty promise" due to persistent implementation barriers.

2.2 Health Equity Theory: Conceptual Foundations

The Health Equity Theory, as articulated by Goddard and Smith (2001), assumes that all groups of people should have equal access to and utilisation of healthcare, regardless of age, gender, ethnicity, religion, social class, socioeconomic status, or socially determined circumstances. The theory primarily addresses inequalities in healthcare access and promotes universal healthcare, including for vulnerable groups such as older persons. Braveman and Gruskin (2003) argued that inequities in health tend to worsen the health of disadvantaged groups when they are unable to access healthcare, suggesting that older persons exempt from healthcare costs under exemption policies have the right to access quality healthcare without discrimination; otherwise, their health would deteriorate.

The theory identifies several key variables crucial to achieving health equity that may influence health-seeking behaviours. These include the availability of services, equity in access to care (fair financing, health insurance, and education), equal use for equal need (utilisation), equal quality of care (appropriate treatment), and institutional influence (policies and reforms). According to Goddard and Smith (2001), these variables interact to determine whether individuals with equal needs receive equal access to healthcare services. The theory helps explain why some older persons might not use free healthcare services as much as they could, even though they are available, due to factors other than cost, such as access to health facilities and socioeconomic factors, including awareness of the exemption policy.

Health equity is achieved when access to quality healthcare is accompanied by a well-distributed workforce of health



workers and fair financing. Gómez *et al.* (2021) asserted that unequal distribution of resources, wealth, power, and services in an environment shapes the social determinants of health, hence is responsible for health inequities. This suggests that healthcare facilities should have sufficient resources, such as health workers and reliable quality of care, to promote health-seeking behaviour and increase the number of healthcare visits, which are important components in access to and utilisation of free healthcare services.

2.3 Components of Health Equity Theory

Goddard and Smith (2001) articulated a comprehensive framework for examining equity of access, which is adapted for this study to understand health-seeking behaviour among older persons in Tanzania's Lindi Region. The framework comprises four interconnected components:

Availability of Services: This component examines whether certain healthcare services are available to all population groups, or whether clinicians have different propensities to offer treatment to patients with identical needs from different population groups. In the context of this study, availability refers to the presence of consultation, diagnosis, medication, hospitalisation, and other healthcare services at public primary healthcare facilities in the Lindi Region.

Quality of Services: This component addresses whether the quality of certain services offered to identical patients varies between population groups. Donabedian (1980) identified three categories of quality; structure, process, and outcome; each of which may vary systematically between population groups. Variations in staff attitude, condition of premises, waiting time, time spent with patients, and clinical outcome may create inequities in access that are not captured by simple availability measures.

Costs of Services: This component examines the financial and non-financial costs imposed by healthcare services that may vary between population groups. For older persons in Tanzania, while the exemption policy removes formal user charges, there may be considerable variations in the personal costs of using services, including transport costs, opportunity costs of time, and unofficial payments. As noted by Tungu *et al.* (2024), bureaucratic procedures for obtaining exemptions and illegal payments create hidden costs that may deter utilisation.

Information about Services: This component addresses whether healthcare services ensure that the availability of certain services is known with equal clarity by all population groups. Variations in awareness of exemption policies, healthcare services, and how to navigate the healthcare system may exist due to differences in education, language, or cultural factors. Edward (2021) found that literacy levels

significantly influenced elderly exemption beneficiaries' access to healthcare services in Tanzania.

2.4 Application of Health Equity Theory to the Study Context

This study adapts Goddard and Smith's (2001) Health Equity Theory to examine health-seeking behaviour among older persons in the Lindi Region. The adaptation incorporates the specific context of Tanzania's exemption policy and the challenges facing older persons in accessing free healthcare services. The theoretical framework (Figure 1) illustrates the relationships between the key components of Health Equity Theory and health-seeking behaviour among older persons.

Figure 1 presents a conceptual model adapted from Goddard and Smith's (2001) framework, demonstrating how the components of Health Equity Theory influence health-seeking behaviour among older persons. The model shows that health-seeking behaviour is shaped by the interaction of availability, quality, costs, and information, which are themselves influenced by broader contextual factors including institutional policies, socioeconomic conditions, and demographic characteristics. The framework highlights that even when exemption policies remove financial barriers, supply-side constraints, particularly medication availability, may prevent the achievement of health equity.

The conceptual model illustrated in Figure 1 demonstrates the pathways through which the components of Health Equity Theory influence health-seeking behaviour among older persons. The framework posits that:

Institutional and Policy Context: The exemption policy, health system structures, and implementation mechanisms create the institutional environment within which older persons seek healthcare. This includes the policy framework established by the Ministry of Health (1994) and the United Republic of Tanzania (1997, 2017), as well as the administrative procedures for granting exemptions.

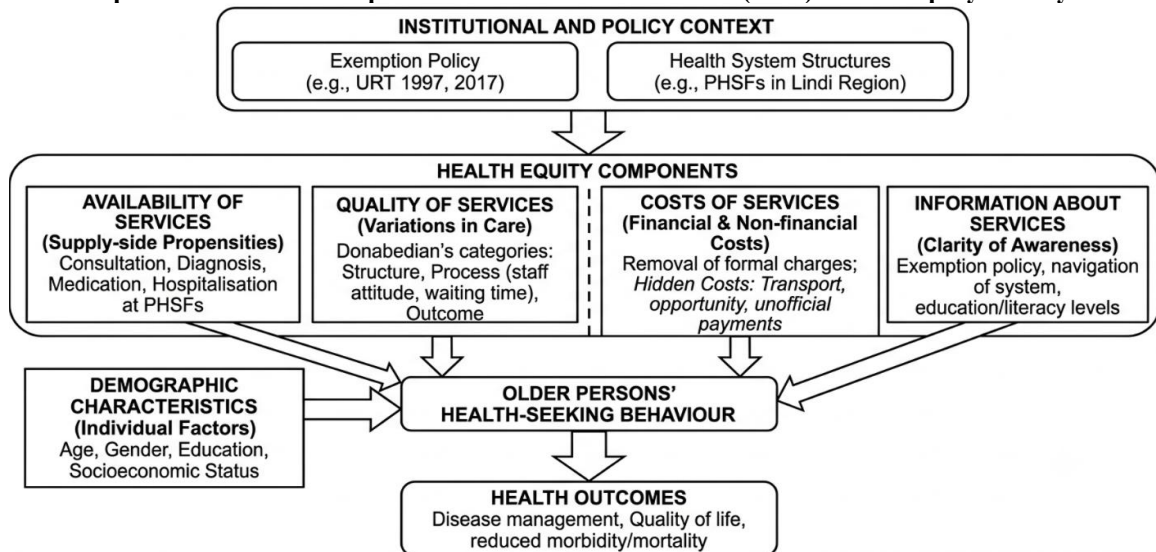
Health Equity Components: The four components, availability, quality, costs, and information, mediate the relationship between institutional context and health-seeking behaviour. When these components are adequately addressed, health equity is promoted; when they are deficient, inequities persist.

Older Persons' Health-Seeking Behaviour: This includes the actual decisions and actions taken by older persons when they experience health problems, including whether to seek care, where to seek care, and how frequently to seek care. The framework acknowledges that health-seeking behaviour is influenced not only by the health equity components but

also by individual demographic characteristics such as age, gender, education, and socioeconomic status.

persons can access healthcare services without difficulty, thereby promoting universal health coverage. By applying

Figure 1: Conceptual Framework Adapted from Goddard and Smith's (2001) Health Equity Theory



Health Outcomes: Ultimately, health-seeking behaviour influences health outcomes for older persons. When older persons are able to access quality healthcare services, they may experience better disease management, improved quality of life, and reduced morbidity and mortality.

2.5 Relevance of Health Equity Theory to the Study

Health Equity Theory is particularly relevant to this study for several reasons. First, the theory provides a comprehensive framework for examining the multiple dimensions of access to healthcare, moving beyond simple measures of availability to include quality, costs, and information. This is important because, as noted by Tungu *et al.* (2024), the implementation of exemption policies in Tanzania has been controversial, with challenges including lengthy bureaucratic procedures, inadequate clarity on groups deserving exemption, poor financial mechanisms for exempted services, and insufficient information about exemption categories.

Second, the theory enables the identification of specific barriers to health-seeking behaviour among older persons, which may differ across demographic groups. For example, Goddard and Smith (2001) noted that variations in information about available services may exist due to differences in education, language, or cultural factors. This is particularly relevant in the Lindi Region, where literacy levels among older persons may be lower than national averages (National Bureau of Statistics, 2022b).

Third, the theory aligns with the policy objectives of Tanzania's exemption policy, which aims to promote health equity by removing financial barriers for vulnerable populations. The United Republic of Tanzania (1997, 2003, 2017) established the exemption policy to ensure that older

Health Equity Theory, this study can assess whether the policy is achieving its intended objectives or whether implementation failures are undermining equity.

Fourth, Health Equity Theory has been extensively applied in various healthcare studies focusing on older persons and marginalised populations. Studies by Carroll *et al.* (2022), Catlett *et al.* (2025), Geneviève *et al.* (2024), Homan and Brown (2022), and Ren *et al.* (2023) have used health equity frameworks to examine healthcare access and outcomes among older adults. The theory's focus on enhancing healthcare access and promoting an inclusive society makes it particularly suitable for examining the health-seeking behaviour of older persons who are exempt from healthcare costs in the Lindi Region.

3.0 Methodology

3.1 Study Area

The study was conducted in four villages located in Kilwa and Nachingwea districts within the Lindi Region of southeastern Tanzania (Figure 1). Kilwa District lies at 5°10'0" South of the equator and 39°46'0" East of Greenwich, covering an area of approximately 15,000 km². The district has a population of 18,961 older persons, accounting for 18.5% of its total population. Nachingwea District is situated at 10°22'21" South of the equator and 38°45'45.04" East of Greenwich, with 20,821 older persons representing 20.3% of its population (National Bureau of Statistics, 2022a, 2022b).

The selection of these districts was purposive, based on several criteria. First, both districts exhibit characteristics typical of rural Tanzania, including limited healthcare infrastructure, lower health workforce density, and significant geographical isolation (Ministry of Health

Community Development Gender Elderly and Children, 2019). Second, the districts have a substantial older population, making them appropriate for studying health-seeking behaviour among older persons. Third, the districts represent different livelihood systems, Kilwa District is characterised by trade, cultural tourism, fishing, and subsistence agriculture, while Nachingwea District primarily involves petty trade and agro-pastoralism, with cashew nuts being a major cash crop grown at subsistence level. This diversity allows for comparative insights into how livelihood contexts may influence health-seeking behaviour.

Within each district, two villages were selected for the study based on accessibility, presence of public primary healthcare facilities, and willingness of local authorities to participate. In Kilwa District, the selected villages were Magengeni (in Kivinje Ward) and Mnazimmoja (in Masoko Ward). In Nachingwea District, the selected villages were Nagaga (in Naipanga Ward) and Stesheni (in Stesheni Ward). The selection of four villages ensured representation across different geographical locations and healthcare access contexts within the region.

3.2 Study Design

This study employed a cross-sectional mixed-methods design, integrating quantitative and qualitative approaches to provide a comprehensive understanding of health-seeking behaviour among older persons. The cross-sectional design was chosen because it allows data collection from the selected respondents at a single point in time, providing a snapshot of health-seeking patterns and perceptions (Creswell, 2014; Setia, 2016; Wang & Cheng, 2020). According to Verulava and Jorbenadze (2025), Yadav *et al.* (2025), and Zgambo *et al.* (2024), this design is commonly used for assessing health-seeking behaviour in populations as it is quick, cost-effective, and enables the collection of diverse data across multiple variables within a short period.

The mixed-methods approach combined quantitative surveys with qualitative interviews and focus group discussions, enabling triangulation of findings and a deeper understanding of the contextual factors influencing health-seeking behaviour (Creswell, 2014). The quantitative component provided statistical evidence on patterns, frequencies, and associations, while the qualitative

Figure 1: Map of Lindi Region Showing the Location of the Study Area

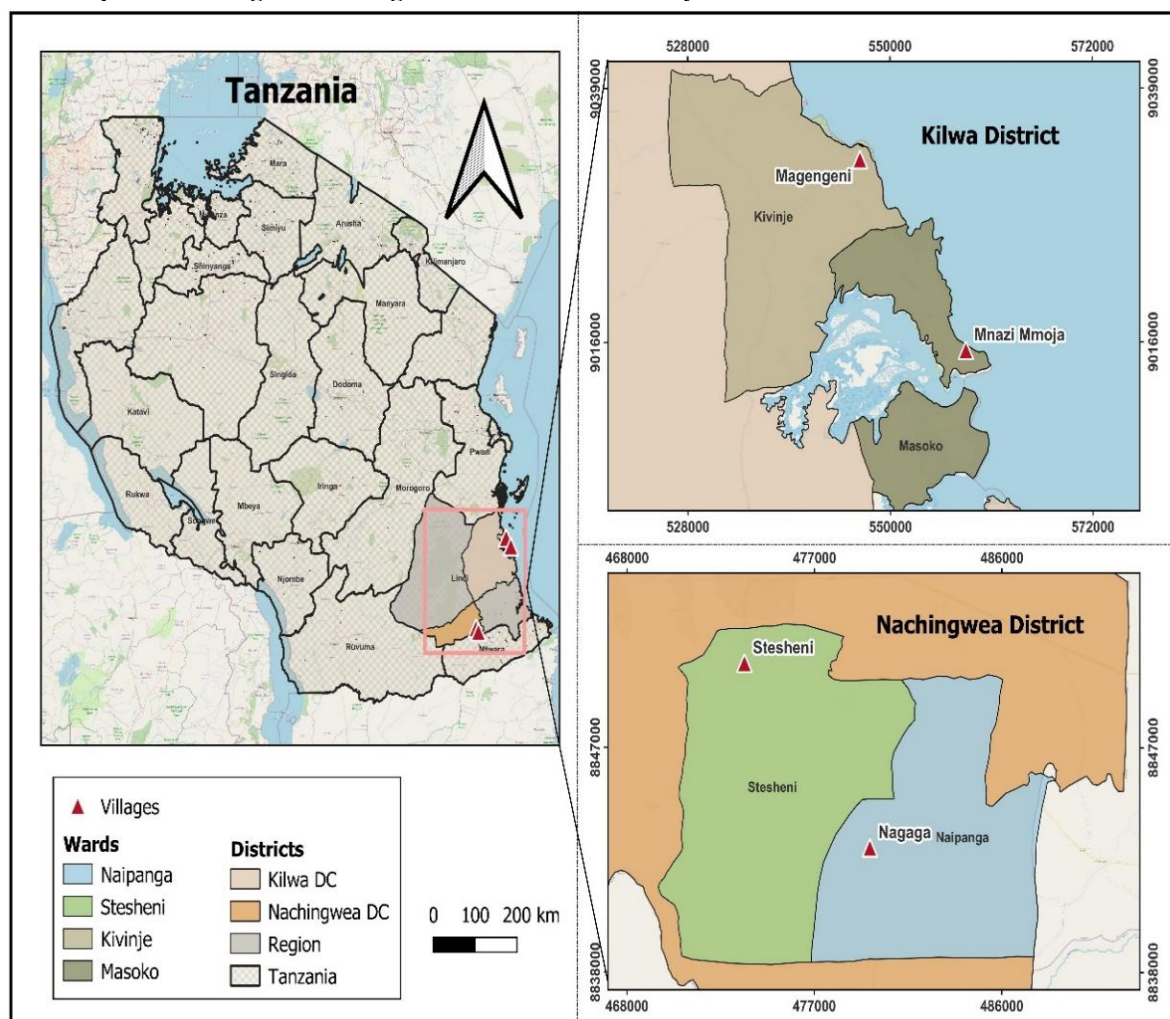


Figure 1 shows the geographical location of Kilwa and Nachingwea districts within the Lindi Region of Tanzania, highlighting the four study villages; Magengeni, Mnazimmoja, Nagaga, and Stesheni.



component offered rich contextual insights into older persons' experiences, perceptions, and the underlying reasons for their healthcare decisions.

3.3 Study Population

The study targeted two population groups. The primary target population comprised all older persons aged 60 years and above residing in the selected villages. This age criterion aligns with Tanzania's exemption policy, which grants free healthcare services to individuals aged 60 years and above (United Republic of Tanzania, 1997, 2017). According to the 2017 National Health Policy, the National Ageing Policy (United Republic of Tanzania, 2003), and the National Population Policy (United Republic of Tanzania, 2006), this group is classified as vulnerable, poor, and lacking income to pay for healthcare, thus facing limited access to healthcare.

The secondary target population comprised key informants directly responsible for ensuring the effective implementation of exemption measures. These included: District Medical Officers (DMOs), Social Welfare Officers (SWOs), Non-Communicable Disease (NCD) coordinators, hospital heads or in-charges, representatives from the Ministry of Health, Ward Executive Officers (WEOs), and Village Executive Officers (VEOs). This group provided critical insights into the policy implementation processes, challenges, and institutional perspectives on health-seeking behaviour among older persons.

3.4 Sampling Procedures and Sample Size

3.4.1 Sample Size Determination for Older Persons

To ensure the reliability and validity of the findings, the sample size for older persons was calculated using Taro Yamane's formula, which is commonly used when the population size is known and a desired level of precision and confidence is required (Sathyanarayana *et al.*, 2024). The formula assumes a 95% confidence level and a 5% precision level, providing a margin of error of 5%.

The formula is as follows:

$$n = N / [1 + N(e)^2]$$

Where:

- n = Sample size
- N = Population size
- e = Level of precision or sampling error (5% or 0.05)

According to the Tanzanian National Census of 2022, the four selected wards; Kivinje, Masoko, Naipanga, and Stesheni; had a total of 4,808 older persons aged 60 years

and above (National Bureau of Statistics, 2022a, 2022b). The distribution was as follows: Kivinje Ward (1,836 older persons), Masoko Ward (1,193 older persons), Naipanga Ward (490 older persons), and Stesheni Ward (1,289 older persons).

Applying Yamane's formula:

$$\begin{aligned} n &= 4,808 / [1 + 4,808(0.05)^2] \\ n &= 4,808 / [1 + 4,808 \times 0.0025] \\ n &= 4,808 / [1 + 12.02] \\ n &= 4,808 / 13.02 \\ n &= 369 \end{aligned}$$

Thus, the required sample size was 369 older persons.

3.4.2 Proportional Allocation to Villages

To ensure representation from each village proportional to its population size, proportional sampling was employed using the formula:

$$n_y = (N_y / N) \times n$$

Where:

- n_y = Population sample in ward y
- N_y = Sampling frame or population size for ward y
- N = Sampling frame in all studied wards
- n = Study's sample size

To obtain the gender proportion sample for each ward, the formula $P \times n_y$ was used, where P is the gender proportion percentage.

Table 1 presents the sample size distribution across the four villages, showing the number of male and female respondents sampled from each location.

Table 1 shows that Magengeni village contributed the largest sample ($n=141$), followed by Stesheni ($n=99$), Mnazimmoja ($n=91$), and Nagaga ($n=38$). Across all villages, female respondents constituted a slightly higher proportion, reflecting the demographic composition of the older population in the study area.

Table 1: Sample Size Distribution Across Study Villages

Sample Size Distribution Across Study Villages								
District	Ward	Village	Sex	N	P = N/N _y (%)	N _y	P × n _y	n _y
Kilwa	Kivinje	Magengeni	Male	831	45.3	1,836	64	141
			Female	1,005	54.7		77	
	Masoko	Mnazimmoja	Male	537	45.0	1,193	41	91
			Female	656	55.0		50	
Nachingwea	Naipanga	Nagaga	Male	226	46.1	490	18	38
			Female	264	53.9		20	
	Stesheni	Stesheni	Male	569	44.1	1,289	43	99
			Female	720	55.9		56	
	Total			4,808	369			

Source: National Bureau of Statistics, 2022a, 2022b

3.4.3 Sampling for Key Informants

A purposive sampling strategy was employed to select seventeen (17) key informants who possessed in-depth knowledge of exemption policy implementation and healthcare service delivery for older persons. Purposive sampling was chosen because it enables the researcher to deliberately select individuals with specific characteristics, knowledge, or experience relevant to the research questions (Creswell, 2014; Patton, 2015).

The key informants comprised: two District Medical Officers (one from each district), two Social Welfare Officers (one from each district), two Non-Communicable Disease coordinators (one from each district), four hospital heads or in-charges (one from each village health facility), one representative from the Ministry of Health, three Ward Executive Officers, and three Village Executive Officers. This composition ensured representation across different levels of the health system and administrative structure, providing a comprehensive understanding of policy implementation from multiple perspectives.

3.5 Data Collection Methods

Data were collected through three primary methods: household surveys, key informant interviews, and focus group discussions, supplemented by documentary review.

3.5.1 Household Survey

Structured questionnaires were administered to the 369 older persons through face-to-face interviews. The questionnaire was developed based on the study objectives and adapted from previous studies on health-seeking behaviour among older persons (Bhat & Kumar, 2017; Teo *et al.*, 2022; Zeng *et al.*, 2022). The instrument was pretested in a non-study village in Kilwa District to ensure clarity, comprehensibility, and cultural appropriateness. Modifications were made based on the pretest findings before field deployment.

The questionnaire comprised four sections:

- Socio-demographic characteristics:* Age, sex, education level, number of children, living arrangements, and source of income

- Health-seeking behaviour:* Healthcare facility choice when sick, reasons for facility preference, and alternative healthcare sources

- Service utilisation:* Frequency of visits to public healthcare facilities in the past year

- Perceptions of service availability:* Availability of consultation, medication, hospitalisation, and diagnostic services at public primary healthcare facilities

Trained research assistants conducted the interviews in Kiswahili, the local language, after obtaining informed consent from each respondent. Each interview lasted approximately 30-40 minutes.

3.5.2 Key Informant Interviews

In-depth interviews were conducted with the 17 purposively selected key informants. Semi-structured interview guides were developed to explore: (1) understanding of the exemption policy; (2) implementation processes and challenges; (3) perceptions of health-seeking behaviour among older persons; (4) availability of free healthcare services; and (5) recommendations for policy improvement. Interviews were conducted in private settings at the informants' workplaces, with each interview lasting 45-60 minutes. Interviews were audio-recorded with consent and supplemented with note-taking.

3.5.3 Focus Group Discussions

Four focus group discussions (FGDs) were conducted, one in each study village, to supplement the information gathered from questionnaires and key informant interviews. Each FGD comprised 8-10 older persons (both male and female) who were not part of the household survey. Participants were purposively selected based on their willingness to participate and availability. The FGDs explored community perspectives on health-seeking behaviour, experiences with free healthcare services, perceptions of service availability and quality, and barriers to accessing healthcare. Each FGD lasted approximately 60-90 minutes and was conducted in Kiswahili, audio-recorded with consent, and supplemented with note-taking.



3.5.4 Documentary Review

Documentary review was conducted to complement primary data collection. Relevant documents included: the Exemption and Waiver policy guidelines (United Republic of Tanzania, 1997), the National Health Policy (United Republic of Tanzania, 2017), National Ageing Policy (United Republic of Tanzania, 2003), district health reports, and service provision records from Nachingwea District Hospital for January to December 2023. This provided quantitative data on actual service provision, complementing the survey data.

3.6 Data Management and Analysis

3.6.1 Quantitative Data Analysis

Quantitative data from the household surveys were entered into SPSS (Statistical Package for Social Sciences) Version 26.0 for analysis. Data cleaning was performed to check for completeness, outliers, and errors. Descriptive statistical methods, including frequency distributions, percentages, means, and standard deviations, were used to summarise the characteristics of the data and health-seeking behaviour patterns. These were also cross-tabulated at the village level to observe differences or similarities across locations.

Inferential statistics, specifically chi-square (χ^2) tests, were employed to examine associations between demographic characteristics (age, gender, education level, living arrangement, source of income) and healthcare facility choice, as well as perceptions of service availability. Chi-square tests were chosen because they are appropriate for analysing associations between categorical variables (Agresti, 2018; Field, 2018). Statistical significance was set at $p < 0.05$. Cross-tabulations were performed at the village level to observe differences or similarities in responses across geographical locations.

3.6.2 Qualitative Data Analysis

Qualitative data from key informant interviews and FGDs were analysed using thematic content analysis, following the steps recommended by Braun and Clarke (2006) and Creswell (2014). The process involved: (1) familiarisation with the data through repeated reading of transcripts; (2) generating initial codes; (3) searching for themes; (4) reviewing themes; (5) defining and naming themes; and (6) producing the report. Audio-recorded interviews were transcribed verbatim in Kiswahili and later translated into English for analysis. Data were coded manually using a systematic approach, with themes emerging both from the data (inductive) and from the theoretical framework (deductive). The analysis focused on identifying patterns, categories, and explanations of health-seeking behaviour and perceptions of free healthcare services.

3.6.3 Triangulation

Findings from quantitative and qualitative methods were triangulated to enhance the validity and comprehensiveness of the study findings. According to Creswell (2014), triangulation involves using multiple data sources, methods, or investigators to corroborate findings and reduce the risk of bias. In this study, quantitative survey findings were contextualised and explained using qualitative insights from key informant interviews and FGDs, while documentary review provided additional verification of service provision data.

3.7 Validity and Reliability

To ensure the validity and reliability of the research findings, several measures were undertaken. For the quantitative component, the questionnaire was pretested in a non-study village to ensure clarity and comprehensibility, and modifications were made accordingly. The sample size was calculated using a scientifically established formula to ensure representativeness. Research assistants were trained on the questionnaire administration procedures, including consistent interpretation of questions and standardised data recording.

For the qualitative component, credibility was enhanced through triangulation (multiple data sources: surveys, interviews, FGDs, documentary review), member checking (sharing findings with some participants to verify interpretations), and prolonged engagement in the study area. Transferability was enhanced through thick description of the study context, methodology, and findings. Confirmability was ensured through an audit trail documenting all research decisions and procedures.

3.8 Ethical Considerations

Ethical approval was obtained from the relevant authorities before data collection, in accordance with Tanzanian national research policies. The researcher secured permission from the Vice Chancellor through the Director of Postgraduate Studies at the University of Dodoma prior to data collection. The District Executive Directors of Nachingwea and Kilwa, along with the Lindi Regional Administrative Authority, provided authorisation for data collection in the study area.

Written informed consent was obtained from all participants before data collection. The consent form outlined the study's aims, procedures, potential risks and benefits, and voluntary participation. Respondents were informed that they could withdraw from the study at any time without penalty. For older persons, special attention was given to ensuring they understood the information provided, using plain language and allowing adequate time for decision-making.

To ensure privacy and protection from harm, confidentiality of respondents' personal details and responses was



maintained throughout the research process. Data were stored securely with access limited to the research team. All personal identifiers were removed from the data during analysis and reporting, ensuring that individual participants could not be identified.

4. Results and Discussion

This section presents the findings of the study, organised according to the research objectives, followed by a discussion that contextualises the results within the existing literature and theoretical framework. The results are presented in three subsections: socio-demographic characteristics of respondents, health-seeking behaviour and facility preferences, and perceptions of free healthcare service availability. Qualitative data from key informant interviews and focus group discussions are integrated to provide depth and context to the quantitative findings.

4.1 Socio-Demographic Characteristics of Respondents

Table 2 presents the socio-demographic profile of the 369 older persons who participated in the household survey. The findings indicate that the majority of respondents (39.84%) were aged 60-69 years, categorising them as young-old within older population groupings, followed by those aged 70-79 years (33.15%) and those aged 80 years and above (27.01%). At village-specific levels, Magengeni had the highest proportion of respondents in the 60-69 age group (45.39%), while Nagaga had the lowest (28.95%). Conversely, Nagaga had the highest proportion of respondents aged 70-79 years (44.74%), suggesting variations in age distribution across villages that may reflect different migration patterns, survival rates, or demographic histories.

Regarding gender distribution, female respondents constituted the majority (54.66%) compared to male respondents (45.34%). This gender imbalance was most pronounced in Mnazimmoja, where females represented 63.74% of respondents, and least pronounced in Nagaga, where females represented 47.37%. The predominance of female respondents is consistent with global demographic patterns showing higher life expectancy among women and is also reflected in Tanzania's national census data (National Bureau of Statistics, 2022b; Velkoff & Kowal, 2006).

Concerning education, the overall literacy level among respondents was moderate, with 37.78% having no formal education, 43.77% having primary education, 10.55% having secondary education, and 7.90% having tertiary education. Stesheni village had the highest proportion of respondents with informal education (74.7%), while Magengeni had the highest proportion with tertiary education (7.8%). The low levels of formal education, particularly in rural areas, may

affect awareness of exemption policies and ability to navigate the healthcare system effectively, as noted by Edward (2021).

In terms of household characteristics, 71.30% of respondents reported having fewer than five children, while 28.70% had five or more children. The majority lived with their children (38.25%) or with their partners (30.34%), while only 8.04% lived alone. Living arrangements have implications for health-seeking behaviour, as social support from family members may facilitate healthcare access through assistance with transportation, decision-making, and caregiving during illness (Bhat & Kumar, 2017; Teo *et al.*, 2022).

The primary source of income for most respondents (78.33%) was farming, reflecting the agrarian nature of the study area. Public assistance was the main source for only 5.5% of respondents, while remittances from family members accounted for 16.17%. The reliance on subsistence agriculture and the limited income sources underscore the economic vulnerability of older persons in the study area, making them dependent on free healthcare services provided through the exemption policy.

Table 2: Socio-Demographic Profile of Respondents by Village

Variable	Nachingwea		Kilwa		Average (n=369)
	Magengeni (n=141)	Mnazimmoja (n=91)	Stesheni (n=99)	Nagaga (n=38)	
Age Group (%)					
60-69 years	45.39	39.56	45.45	28.95	39.84
70-79 years	26.95	28.57	32.32	44.74	33.15
80+ years	27.66	31.87	22.22	26.32	27.01
Sex (%)					
Male	51.06	36.26	41.41	52.63	45.34
Female	48.94	63.74	58.59	47.37	54.66
Education Level (%)					
Informal	43.3	74.7	7.9	25.2	37.78
Primary	39.0	12.1	68.4	55.6	43.77
Secondary	9.9	6.6	10.5	15.2	10.55
Tertiary	7.8	6.6	13.2	4.0	7.90
Number of Children (%)					
Below 5	70.92	70.33	80.81	63.16	71.30
Above 5	29.08	29.67	19.19	36.84	28.70
Living Arrangement (%)					
Alone	8.51	15.38	3.03	5.26	8.04
With relatives	5.67	4.40	16.16	2.63	7.21
With children	29.79	38.46	50.51	34.24	38.25
With partner	40.43	23.08	26.26	31.58	30.34
With grandchild	15.60	18.68	4.04	26.32	16.16
Source of Income (%)					
Farming	78.03	80.22	91.92	63.16	78.33
Public assistance	2.84	6.50	2.02	10.52	5.50
Remittance	19.13	13.19	6.06	26.32	16.17

Source: Survey Data, 2023



4.2 Health-Seeking Behaviour and Facility Preferences

Table 3 presents the healthcare-seeking patterns of older persons in the study area when they fell sick. The findings show that the overwhelming majority of respondents (91.67%) sought care at public healthcare facilities, while only 4.95% visited private facilities, 1.93% consulted traditional herbalists, and 1.45% self-treated without seeking formal healthcare. The percentage of older persons going to public healthcare facilities when sick remained high across all villages, with rates of 88.7% in Magengeni, 100% in Mnazimmoja, 92.1% in Stesheni, and 85.9% in Nagaga.

The strong preference for public healthcare facilities is not surprising given the exemption policy that provides free healthcare services for older persons at these facilities. As noted by Tunga *et al.* (2024) and Edward and Maluka (2021), the removal of financial barriers through exemption policies is intended to increase access and utilisation of public healthcare services. This finding is consistent with studies from other sub-Saharan African countries, including Ghana, where the National Health Insurance Scheme has increased access to public healthcare over private providers and traditional herbalists, leading to better health outcomes among older persons (Darkwah, 2022; Kwasi *et al.*, 2015).

Qualitative data from the focus group discussions further illuminated the reasons for the strong preference for public facilities. In Nagaga village, one respondent stated: “*At public hospitals, we receive free healthcare, not like in the private hospital, where we cannot afford healthcare costs.*” Similarly, an older person in Mnazimmoja mentioned: “*Free healthcare services make it easier for us to go to clinics and manage non-communicable diseases.*” A health officer further explained that because of the exemption, older persons visit not only for non-communicable disease treatment but also for preventive measures, such as screening, vaccination, and management of age-related issues, including frailty.

These findings suggest that the exemption policy is achieving its intended aim of increasing access to healthcare for older persons by removing financial barriers. However, the near-universal preference for public facilities also raises concerns about the potential burden on these facilities and the quality of services provided, particularly in resource-constrained settings (Tunga *et al.*, 2024).

Table 3: Health Facility Preferences Among Older Persons When Sick

Health Facility	Nachingwea		Kilwa		Average (n=369)
	Magengen (n=141)	Mnazimmoja (n=91)	Stesheni (n=99)	Nagag (n=38)	
Private	2.8	0.0	7.9	9.1	4.95
Public	88.7	100	92.1	85.9	91.67
Self-treated	2.8	0.0	0.0	3.0	1.45
Traditional	5.7	0.0	0.0	2.0	1.93

Source: Survey Data, 2023

4.2.1 Factors Influencing Healthcare Facility Choice

Chi-square tests were conducted to examine the associations between demographic characteristics and healthcare facility choice. Table 4 presents the results of these analyses.

Age: The analysis revealed a statistically significant association between age group and healthcare facility choice ($\chi^2 = 18.24$, $df = 6$, $p = 0.006$). Younger older adults (60-69 years) were significantly more likely to utilise public healthcare facilities (94.2%) compared to those aged 70-79 years (90.6%) and those aged 80 years and above (87.5%). This age-related disparity likely reflects physical mobility challenges, transportation difficulties, and declining functional capacity among the oldest old, which may limit their ability to access public facilities even when services are financially accessible. These findings align with studies by Bhat and Kumar (2017) and Teo *et al.* (2022), who found that increasing age poses additional barriers to healthcare access beyond financial constraints.

Gender: A statistically significant association was observed between gender and healthcare facility choice ($\chi^2 = 9.67$, $df = 3$, $p = 0.022$). Female respondents demonstrated higher public facility utilisation (93.8%) compared to male respondents (89.2%). This gender difference aligns with studies showing that women, particularly in rural sub-Saharan African settings, tend to have higher healthcare utilisation rates due to reproductive health needs, caregiving responsibilities, and social norms that encourage health-seeking behaviour among women (Prasad & Sekher, 2023). However, it may also reflect that older women are more likely to be widowed and economically dependent, making them more reliant on free services at public facilities (Bhat & Kumar, 2017).

Education: A statistically significant association was found between education level and healthcare facility choice ($\chi^2 = 24.56$, $df = 6$, $p = 0.001$). Respondents with formal education, primary (92.6%), secondary (94.5%), and tertiary (93.2%), were more likely to utilise public facilities compared to those with informal education (89.3%). This suggests that education enhances awareness of exemption policies, understanding of the healthcare system, and ability to navigate bureaucratic procedures, supporting Edward's



(2021) findings on the interplay between literacy and health service access among elderly exemption beneficiaries in Tanzania.

Living Arrangement: No statistically significant association was found between living arrangement and healthcare facility choice ($\chi^2 = 8.43$, $df = 12$, $p = 0.752$). While living with family members might provide social support for healthcare access, the lack of a significant association suggests that other factors, such as age and education, may be more important determinants of facility choice.

Source of Income: No statistically significant association was found between source of income and healthcare facility choice ($\chi^2 = 6.78$, $df = 9$, $p = 0.664$). This is somewhat surprising given that income is often a key determinant of healthcare access (Saka *et al.*, 2019; Zeng *et al.*, 2022). However, the lack of association may reflect the uniformity of economic vulnerability among the study population, most of whom rely on subsistence agriculture and have limited financial resources, making them equally dependent on free public services.

Table 4: Chi-Square Analysis of Factors Associated with Healthcare Facility Choice

Variable	χ^2 Value	df	p-value	Significance
Age group	18.24	6	0.006	Significant
Gender	9.67	3	0.022	Significant
Education level	24.56	6	0.001	Significant
Living arrangement	8.43	12	0.752	Not significant
Source of income	6.78	9	0.664	Not significant

Source: Survey Data, 2023

4.2.2 Frequency of Healthcare Visits

Table 5 shows the frequency of visits to public healthcare facilities by older persons in the study area. On average, 36.40% of respondents sought free healthcare at public facilities more than five times annually, 31.00% visited five times, 29.50% visited four times, 1.80% visited thrice, and 0.65% visited twice or once. There were notable variations across villages: Mnazimmoja had the highest proportion of older persons visiting more than five times (50.6%), while Magengeni had the lowest (29.0%).

The relatively high frequency of visits, with more than one-third of respondents visiting more than five times annually, suggests that the exemption policy encourages regular utilisation of public healthcare services. This finding is consistent with studies by Chowdhury and Chakraborty (2017) and Kim *et al.* (2018), who found that free healthcare for older persons at public facilities increases service utilisation and encourages more frequent visits.

However, the frequency of visits may also reflect the high burden of chronic non-communicable diseases among older persons, which require ongoing management and follow-up care (Yadav *et al.*, 2025; Zeng *et al.*, 2022). The variations across villages may reflect differences in disease prevalence, distance to facilities, or perceived quality of care. For instance, the high utilisation in Mnazimmoja may reflect better access to facilities or greater awareness of exemption policies, while the lower utilisation in Magengeni may be due to greater distances or medication shortages that discourage visits.

Qualitative data from the FGDs provided additional context. One health officer noted: “Because of the exemption, older persons visit not only for non-communicable disease treatment but also for preventive measures, such as screening, vaccination, and management of age-related issues, including frailty.” However, a respondent in Nagaga expressed a different perspective: “I was received well by the doctor, but in the end, I only received some medication.” This suggests that while exemption policies encourage visits, the quality and completeness of services received may not always meet expectations, potentially affecting future healthcare-seeking behaviour.

Table 5: Annual Number of Visits to Public Healthcare Facilities

Visits per Year	Nachingwea		Kilwa		Average (n=369)
	Magengeni (n=141)	Mnazimmoja (n=91)	Stesheni (n=99)	Nagaga (n=38)	
Once	0.0	0.0	2.6	0.0	0.65
Twice	0.0	0.0	2.6	0.0	0.65
Thrice	1.4	1.1	2.6	2.0	1.80
Four times	32.0	24.1	31.6	30.3	29.50
Five times	34.0	24.2	31.6	34.3	31.00
Five times +	32.6	50.6	29.0	33.4	36.40

Source: Survey Data, 2023

4.3 Perceptions of Free Healthcare Service Availability

Table 6 presents older persons’ perceptions of the availability of specific free healthcare services at public primary healthcare facilities in the study area.

4.3.1 Consultation Services

More than 64.30% of respondents believed that consultation services were accessible and available at public facilities. However, there was considerable variation across villages. In Mnazimmoja, all respondents (100%) reported that consultation services were provided, while in Stesheni, only 36.85% reported that the service was adequately provided, with 57.89% reporting that it was fairly provided. The high availability of consultation services is consistent with the policy framework that provides for free consultation as a core component of the exemption package (United Republic



of Tanzania, 1997, 2017). However, the variations across villages suggest that the quality and consistency of consultation services may differ, potentially affecting patient satisfaction and health-seeking behaviour.

4.3.2 Medication Services

The most concerning finding relates to medication services: 84.6% of respondents reported that medication services were inadequately available in the study area. The situation was particularly dire in Nagaga, where 95.96% reported medication unavailability, and Mnazimmoja, where 100% of respondents reported that medication was not available. Only 5.50% of respondents overall reported that medication services were adequately provided.

This finding represents the most significant implementation gap in the exemption policy. While the policy provides for free medication for older persons, the chronic shortages documented in this study suggest that the supply chain for medications is severely compromised. This is consistent with findings by Tungu *et al.* (2024), who identified poor financial mechanisms for exempted services and insufficient information about exemption categories as major challenges. Similarly, Alaaazi *et al.* (2022) and Atakorah *et al.* (2024) found that exemption policies in other sub-Saharan African countries often fail to translate into meaningful service access due to supply-side constraints, including insufficient drugs.

Qualitative data highlighted the frustration caused by medication shortages. During a FGD in Nagaga, one older person stated: “*I was received well by the doctor, but in the end, I only received some medication.*” Another respondent in Mnazimmoja expressed similar dissatisfaction: “*We come to the hospital for treatment, but often we are told there are no medicines. We then have to buy them ourselves from private pharmacies, which defeats the purpose of the exemption.*”

4.3.3 Hospitalisation Services

Hospitalisation services were perceived as accessible by 67.8% of respondents overall. Magengeni had the highest proportion of respondents reporting that hospitalisation services were provided (83.69%), while Stesheni had the lowest (34.24%). The relatively favourable perception of hospitalisation services may reflect the availability of inpatient facilities at district hospitals, though the low proportion in Stesheni suggests variations in access to hospitalisation across villages.

4.3.4 Diagnostic Services

Diagnostic services were perceived as accessible by 69.14% of respondents overall. Stesheni had the highest proportion (81.58%), followed by Nagaga (75.76%), while

Mnazimmoja had the lowest (58.24%). The availability of diagnostic services is critical for appropriate disease identification and treatment, particularly for chronic conditions common among older persons (Yadav *et al.*, 2025). However, the perceived inadequacy in some villages raises concerns about the completeness of care provided under the exemption policy.

Table 6: Perceptions of Free Healthcare Service Availability at Public Primary Healthcare Facilities

Healthcare Service	Nachingwea		Kilwa		Average
	Magengen (n=141)	Mnazimmoj (n=91)	Stesheni (n=99)	Nagaga (n=38)	(n=369)
Consultation					
Not provided	12.05	0.0	5.26	9.09	6.60
Fairly provided	2.84	0.0	57.89	55.56	29.10
Provided	85.11	100	36.85	35.35	64.30
Medication					
Not provided	68.79	100	73.68	95.96	84.60
Fairly provided	9.22	0.0	26.32	4.04	9.90
Provided	21.99	0.0	0.0	0.0	5.50
Hospitalisation					
Not provided	11.35	1.10	60.53	39.39	28.10
Fairly provided	4.96	2.20	5.26	4.04	4.10
Provided	83.69	96.70	34.24	56.57	67.80
Diagnosis					
Not provided	12.06	3.30	10.53	14.14	10.01
Fairly provided	26.95	38.46	7.89	10.10	20.85
Provided	60.99	58.24	81.58	75.76	69.14

Source: Survey Data, 2023

4.3.5 Factors Associated with Perceptions of Medication Availability

Given the critical importance of medication availability for health-seeking behaviour and health outcomes, chi-square tests were conducted to examine factors associated with perceptions of medication availability. Table 7 presents the results.

Age: A statistically significant association was found between age group and perceptions of medication availability ($\chi^2 = 15.67$, $df = 8$, $p = 0.047$). Younger older adults (60-69 years) were more likely to report medication unavailability (87.2%) compared to those aged 70-79 years (84.8%) and those aged 80 years and above (79.5%). This pattern may reflect that younger older adults have higher healthcare utilisation rates, giving them more opportunities to experience medication shortages.



Gender: No statistically significant association was observed between gender and perceptions of medication availability ($\chi^2 = 6.23$, $df = 4$, $p = 0.183$). Both male and female respondents reported similar levels of medication shortages, suggesting that this is a systemic problem affecting all older persons equally.

Education: A statistically significant association was found between education level and perceptions of medication availability ($\chi^2 = 22.34$, $df = 8$, $p = 0.004$). Respondents with higher education levels, secondary (91.2%) and tertiary (88.9%), were more likely to report medication shortages compared to those with primary education (86.4%) and informal education (78.9%). This may reflect that more educated individuals have greater awareness of expected service standards and are more likely to recognise and report inadequacies, consistent with findings by Edward (2021).

Village Location: Village location showed the strongest association with perceptions of medication availability ($\chi^2 = 31.45$, $df = 9$, $p < 0.001$), reflecting the stark differences across villages. Mnazimmoja respondents universally reported medication unavailability (100%), followed by Nagaga (95.96%), Stesheni (73.68%), and Magengeni (68.79%). This significant geographic disparity points to systemic weaknesses in the drug supply chain, including stock-outs at the district level, procurement delays, and inequitable distribution mechanisms (Tungu *et al.*, 2024).

Table 7: Chi-Square Analysis of Factors Associated with Perceptions of Medication Availability

Variable	χ^2 Value	df	p-value	Significance
Age group	15.67	8	0.047	Significant
Gender	6.23	4	0.183	Not significant
Education level	22.34	8	0.004	Significant
Village location	31.45	9	<0.001	Highly significant

Source: Survey Data, 2023

4.4 District-Level Service Provision Data

Table 8 presents data from the Nachingwea District Hospital for January to December 2023, showing the actual provision of free healthcare services for older persons. The data indicate that all services; consultation, medication, diagnosis, and hospitalisation; were available and provided free of charge to older persons at the district hospital level. Specifically:

- **Consultation:** 1,421 older persons consulted doctors for treatment during the year
- **Medication:** 1,315 (92.5%) of those who consulted received medication
- **Diagnosis:** 1,278 (89.9%) of those who attended were diagnosed with diseases
-

- **Hospitalisation:** Only 48 older persons (3.38%) were hospitalised

The district-level data appear to contrast with the perceptions reported by older persons, particularly regarding medication availability. While 92.5% of consultations at the district hospital resulted in medication provision, 84.6% of survey respondents perceived medication services as inadequately available. This discrepancy may be explained by several factors. First, the district hospital data represent only one facility, while perceptions of medication shortages may reflect experiences at lower-level facilities (health centres and dispensaries) where medication supply is typically less reliable. Second, the district hospital may have better supply chains compared to primary healthcare facilities, leading to a “referral bias” in the data. Third, even when medications are provided, they may not always be complete, older persons may receive some but not all required medications, leading to perceptions of inadequacy.

A health officer explained this discrepancy: “*The district hospital often has better medication supplies because it is a higher-level facility and receives priority. But at the dispensary and health centre level, especially in remote villages, medication stock-outs are common.*” A respondent in Nagaga confirmed this: “*We are often referred to the district hospital for treatment, but the distance and transport costs make it difficult for us to go there.*”

Table 8: Provision of Free Healthcare Services for Older Persons at Nachingwea District Hospital (January-December 2023)

Service	January-June (Total)	July-December (Total)	Annual Total	Percentage
Consultation	740	681	1,421	100%
Medication	693	622	1,315	92.5%
Diagnosis	685	593	1,278	89.9%
Hospitalisation	23	25	48	3.38%

Source: Nachingwea District Hospital Records, 2023

4.5 Discussion

4.5.1 Health-Seeking Behaviour and the Role of Exemption Policy

The finding that 91.7% of older persons sought care at public healthcare facilities when sick demonstrates the critical role of the exemption policy in facilitating healthcare access. The near-universal preference for public facilities reflects the success of the policy in removing financial barriers, which is consistent with the policy’s objectives as articulated in the 1997 Exemption Guidelines and subsequent health policies (United Republic of Tanzania, 1997, 2003, 2017). This finding aligns with studies by Aljuaid *et al.* (2021) and Chowdhury and Chakraborty (2017), who found that public facilities significantly improve healthcare access when financial barriers are removed.



However, the overwhelming reliance on public facilities also raises concerns about the potential burden on these facilities and the quality of services provided. As noted by Tungu *et al.* (2024), the absence of clear financial mechanisms to compensate health facilities for free services has led to exemptions becoming a financial burden that undermines service quality and availability. The high utilisation rates documented in this study, combined with inadequate compensation mechanisms, may contribute to the medication shortages and other service gaps reported by respondents.

The demographic variations in health-seeking behaviour, with younger older adults, females, and more educated individuals more likely to utilise public facilities, highlight the need for targeted interventions to address barriers faced by specific subgroups. The finding that the oldest old (80+ years) are less likely to utilise public facilities suggests that physical mobility challenges and transportation difficulties remain significant barriers even when financial barriers are removed (Bhat & Kumar, 2017; Teo *et al.*, 2022). Interventions to address these barriers could include community-based healthcare services, mobile clinics, and transport assistance for the oldest old.

4.5.2 The Implementation Gap: Policy Intentions vs. Service Delivery Realities

The most significant finding of this study is the critical implementation gap between policy intentions and service delivery realities, particularly regarding medication availability. While the policy provides for free medication for older persons, 84.6% of respondents reported chronic medication shortages. This finding is consistent with previous studies in Tanzania and other sub-Saharan African countries, which have documented that exemption policies often fail to translate into meaningful service access due to supply-side constraints (Alaazi *et al.*, 2022; Atakorah *et al.*, 2024; Ntahosanzwe & Rwegoshora, 2021; Tungu *et al.*, 2024).

The stark village-level disparities in medication availability (from 100% unavailability in Mnazimmoja to 68.79% in Magengeni) point to systemic weaknesses in the drug supply chain. These weaknesses include stock-outs at the district level, procurement delays, inequitable distribution mechanisms, and inadequate financial resources for purchasing essential medicines (Pennestri, 2025; Tungu *et al.*, 2024). The finding that village location was the strongest predictor of perceived medication availability ($\chi^2 = 31.45$, $p < 0.001$) suggests that geography is a key determinant of whether older persons receive complete care under the exemption policy.

The discrepancy between district-level hospital data (92.5% medication provision) and survey perceptions (84.6% reporting shortages) highlights the importance of examining

service delivery at multiple levels of the health system. While the district hospital may have relatively adequate medication supplies, primary healthcare facilities—where most older persons seek care—may experience more severe shortages. This is consistent with the referral patterns observed, where older persons may be referred to district hospitals for treatment but face barriers such as distance and transport costs in accessing these facilities.

4.5.3 Theoretical Contributions

These findings contribute to Health Equity Theory by demonstrating that removing financial barriers through exemption policies is necessary but insufficient for achieving health equity. As articulated by Goddard and Smith (2001), health equity requires not only equal access but also equal quality of care, equal utilisation for equal need, and institutional influence to ensure equitable policies and reforms. The medication shortages documented in this study represent a failure of the “equal quality of care” component of the theory, older persons are accessing facilities but are not receiving complete care.

This suggests that Health Equity Theory must be extended to explicitly incorporate supply-side dimensions and recognise that partial implementation of equity policies may paradoxically create “implementation inequity”, where access to incomplete services varies by geography and socioeconomic status. This is consistent with the “inverse care law” discussed by Pennestri (2025), which posits that those who need healthcare most often have the least access to it.

Furthermore, the demographic disparities in health-seeking behaviour highlight the importance of considering equity at multiple levels. Even within a policy that ostensibly provides equal access to all older persons, inequalities persist based on age, gender, and education. This underscores the need for equity-oriented interventions that address the specific barriers faced by different demographic groups.

4.5.4 Policy Implications

The findings have significant implications for Tanzania’s pursuit of universal health coverage. Universal health coverage requires not only financial protection (demand-side strengthening) but also availability of quality health services (supply-side strengthening) (Saka *et al.*, 2019; Tungu *et al.*, 2024). This study demonstrates that while the exemption policy has successfully addressed financial barriers for older persons, supply-side constraints, particularly medication availability, remain a critical bottleneck. Without comprehensive health systems strengthening ensuring both financial and physical access to quality care, exemption policies risk becoming symbolic rather than transformative.



Specifically, the findings suggest the need for: (1) decentralised drug supply chain management to reduce geographic disparities; (2) increased budgetary allocation for geriatric medications to ensure adequate supplies; (3) streamlined exemption procedures to reduce bureaucratic delays that may deter utilisation; and (4) community-based awareness programmes to enhance policy literacy among older persons, particularly those with low education levels.

5.0 Conclusions and Recommendations

This study set out to examine whether Tanzania's exemption policy for older persons translates into meaningful healthcare access or remains an empty promise in the Lindi Region. The findings demonstrate that the policy has successfully addressed financial barriers, as evidenced by the overwhelming preference for public healthcare facilities among older persons when they fall sick. However, this financial access has not been matched by commensurate availability of comprehensive services, particularly medications, revealing a critical implementation gap between policy intentions and frontline service delivery realities. The persistent medication shortages reported by the vast majority of respondents, coupled with the significant demographic and geographic disparities in both service utilisation and perceptions of service quality, indicate that the exemption policy is only partially fulfilling its intended purpose. These findings empirically contribute to Health Equity Theory by demonstrating that removing financial barriers, while necessary, is insufficient for achieving health equity without simultaneously addressing supply-side constraints. The study advances policy discourse by revealing that Tanzania's pursuit of universal health coverage requires a dual approach: strengthening demand-side components through continued financial protection via exemptions, while concurrently investing in supply-side improvements including drug supply chain management, workforce capacity, and service quality assurance. The research also highlights the importance of considering demographic heterogeneity in health-seeking behaviour, suggesting that universal policies must be complemented by targeted interventions addressing the specific barriers faced by the oldest old, those with limited education, and those in geographically remote areas.

From a policy perspective, this study offers several actionable recommendations for improving health-seeking behaviour and health outcomes among older persons in Tanzania. First, there is an urgent need to decentralise drug supply chain management to reduce geographic disparities in medication availability, ensuring that primary healthcare facilities in remote villages receive adequate and consistent supplies of essential geriatric medications. Second, budgetary allocations for geriatric medications must be increased and protected, with clear financial mechanisms to compensate health facilities for services provided under the

exemption policy, thereby preventing the current situation where exemptions become a financial burden that undermines service quality. Third, exemption procedures should be streamlined to reduce bureaucratic delays that may deter utilisation, potentially through simplified documentation requirements and delegation of approval authority to healthcare facility level. Fourth, community-based awareness programmes should be developed to enhance policy literacy among older persons, particularly those with low education levels, ensuring they understand their rights to free healthcare services and the procedures for accessing them. Finally, the study underscores the need for a comprehensive health systems strengthening approach that simultaneously addresses financial access, service availability, workforce capacity, and drug supply chains. Without such comprehensive strengthening, exemption policies risk remaining symbolic rather than transformative for Tanzania's rapidly growing older population, perpetuating the inverse care law where those who need healthcare most continue to have the least access to complete, quality care. Future research should examine the cost-effectiveness of the exemption policy, conduct longitudinal assessments of health outcomes, and explore the specific supply chain bottlenecks that contribute to medication shortages at different levels of the health system.

Declaration of Conflict of Interest

The authors declares that there are no known competing financial interests or personal relationships that could have influenced the research and findings presented in this paper.

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