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An exploration of the societal perceptions and cultural attitude towards elderly people in Kinondoni municipal council, Tanzania

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Abstract

Over the years, ageing has generally been regarded as an important policy issue worldwide because of the large proportion of elderly people. Despite efforts to improve access to healthcare and social services, the elderly in Tanzania still face various challenges. However, the effectiveness of NHIF in promoting social protection among elderly individuals in Tanzania, especially in areas like Kinondoni, remains underexplored. This study explored the societal perceptions and cultural attitude towards elderly people in Kinondoni municipal council. The study population comprised elderly individuals residing in selected wards in Kinondoni Municipal Council for quantitative data. A sample size of 394 elderly people was purposively sampled from Mbezi Juu, Kigogo, and Mbweni Wards in the District. Qualitative data were obtained from different groups such as healthcare providers, NHIF staff, district health officers, and village executive officers. Data collection involved mixed-methods that combined questionnaires, in-depth interviews, document reviews, and focus group discussions to obtain the data. In this study, quantitative data analysis involved descriptive statistics to summarize the results using the Statistical Package for Social Sciences (SPSS). For qualitative data, thematic analysis was employed to identify key themes, patterns, and insights from the qualitative data collected through in-depth interviews. The study revealed that societal perceptions and cultural attitudes significantly influenced the access of elderly people to healthcare, with positive perceptions correlated with age ($\chi^2 = 10.35$, $p = 0.006$), gender ($\chi^2 = 4.12$, $p = 0.047$), marital status ($\chi^2 = 5.89$, $p = 0.032$), and education level ($\chi^2 = 9.75$, $p = 0.008$). At the same time, 44% of respondents reported experiencing discrimination, highlighting systemic ageism that impedes adequate care for the elderly. The findings reveal a complex scenery where societal perceptions and cultural attitudes towards the elderly are mixed, with respect coexisting alongside age-related stigma and discrimination. Consequently, the study recommends for targeted awareness campaigns, streamlined NHIF enrolment, financial assistance, culturally sensitive healthcare policies, specialized provider training, and community involvement, robust monitoring systems for improved access and care for elderly individuals under the NHIF.

Keywords: Policy Framework, Societal Perceptions, Cultural Attitude, Elderly People, Kinondoni Municipal Council, Tanzania.

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1. INTRODUCTION

The issue of aging populations and healthcare provision for elderly individuals has become increasingly significant. As demographic shifts occur worldwide, countries grapple with the challenges of an aging population and the associated healthcare needs. In this context, social protection programs, including health insurance schemes, play a crucial role in ensuring the well being of elderly citizens. Consequently, ageing has been regarded as an important policy issue worldwide because of the large proportion of elderly people.

Global projections by the United Nations (UN) Population Division (2019) indicate that the population of those aged 60 years and above is rapidly the number of elder people aged above 60 years is anticipated to be 1.2 billion in 2025 and 2.0 billion in 2050. These demographic shifts constantly lead to an increasingly aging population worldwide and present unique challenges for social protection systems. With advancements in healthcare and improved living conditions, people are living longer, resulting in a growing proportion of elderly individuals within societies. This global trend has prompted governments and organizations to reassess their policies and

programs to ensure the welfare and dignity of elderly citizens.

Like developed countries, low and middle-income countries (LMICs) have also witnessed a rapid increase in population ageing. The average annual growth rate of older people aged sixty years and over in Sub-Saharan African (SSA) countries is higher than in most developed regions. The annual growth rate in SSA was 3% in 2015 and is expected to rise to 4% in 2050 (Wagana & Mkamwa, 2018). About 5 % of SSA's rural population comprises people 60 years old and older (Pillay & Maharaj, 2012). Demographic changes in Sub-Saharan Africa have raised deep concerns over the wellbeing of the aged, particularly because of the prevalence of poverty among older people in comparison to other segments of the population (Rishworth et al., 2020; Zimmer & Das, 2014), lack of developed systematic plans for the welfare of the aged, and lesser up-takes for gerontological studies.

In Tanzania, which has a total population of 45 million, there are roughly 2.7 million people (6 % of the total population) in this age group; this percentage is projected to increase to 11 % in the next three decades (United Nations Department of Economic and Social Affairs, 2015). Over 80 % of this population resides in rural areas with restricted access to social services, including healthcare (Frumence et al., 2017). This demographic transition is creating a challenge regarding healthcare that requires urgent attention.

Tanzania, like many other developing countries, is experiencing this demographic transition. The country's population is aging, driven by declining fertility rates and improvements in healthcare that have extended life expectancy. Based on United Nations demographic estimates, the number of Tanzanians over 60 is expected to almost triple between 2020 and 2050. Consequently, the government will likely face escalating pressure to design and implement effective social protection measures to minimize poverty and deprivation among the elderly (Osberg & Mboghoina, 2010) social protection of the elderly in Tanzania. As a result, there is a growing need to address the social protection and healthcare needs of the elderly population.

For example, in 2001, Tanzania implemented different healthcare reform strategies to improve the avail- ability, accessibility, and delivery of quality public health services to all people, including the elderly (Tungu et al., 2020). The NHIF provides health insurance coverage to Tanzanian citizens, including the elderly, to ensure access to essential healthcare services. Despite efforts to improve access to healthcare and social services, the elderly in Tanzania still face various challenges, including limited access to quality healthcare, financial constraints, and societal attitudes towards aging.

The effectiveness of NHIF in promoting social protection among elderly individuals in Tanzania, especially in areas like Kinondoni, remains underexplored. Therefore, understanding the societal perceptions, NHIF strategies, impacts, and challenges concerning elderly healthcare and social protection is essential for informing policies and interventions tailored to the specific needs of this vulnerable population. Therefore, this study explored the societal perceptions and cultural attitude towards elderly people in Kinondoni municipal council. By analyzing societal attitudes, this study contributes to a better understanding of elderly healthcare and social protection in Tanzania.

It is on that basis, the findings of this study will inform policymakers and stakeholders in developing targeted interventions to enhance the social welfare and healthcare outcomes of elderly in Tanzania. Understanding the dynamics surrounding elderly healthcare and social protection in Tanzania, particularly within the context of the Kinondoni Municipal Council, holds significant implications for policy and practice. This aligns well with Tanzania's national development priorities as outlined in the Five Year Development Plan, regional goals set in the Regional Indicative Strategic Development Plan, and the Global Development Agenda, notably the SDGs.

2. THEORETICAL FRAMEWORK

The study was guided by three theories: the social exchange theory, the systems theory, and the theory of health empowerment.

2.1 Social Exchange Theory

The Social Exchange Theory posits that social interactions are based on reciprocity and mutual benefit. According to this theory, individuals engage in relationships and interactions with others based on the expectation of receiving rewards or benefits and minimizing costs (Ahmad et al., 2023). In the context of this study, social exchange theory can be applied to understand the dynamics of the relationship between elderly individuals and the NHIF. Elderly citizens may perceive NHIF membership and access to healthcare services as a form of social exchange, wherein they contribute financially to the NHIF in exchange for healthcare coverage and social protection.

In this study, the Social Exchange Theory provided a valuable framework for understanding the relationship dynamics between elderly individuals and the NHIF in Tanzania. It was applied to explore how elderly citizens perceive their membership in NHIF and access to healthcare services as part of a social exchange process.

According to the theory, individuals engage in relationships and interactions based on the expectation of receiving rewards or benefits while minimizing costs (Stafford & Kuiper, 2021). The theory's strengths lie in its emphasis on the rational decision-making processes of individuals and its applicability to various social interactions, including those involving economic transactions like healthcare insurance.

Furthermore, drawing parallels with Mugambi's (2022) application of the theory in assessing determinants of national hospital insurance fund uptake by households in Kenya highlights its relevance and applicability to similar contexts in East Africa. Building on existing research and theory, this study aims to provide a nuanced understanding of the social dynamics surrounding elderly individuals' engagement with social protection programs like NHIF in Tanzania.

2.2 Systems Theory

A system is an interconnection of many parts into one (Luhmann et al., 2013). These parts are congruent with each other and exist in an environment where their inputs and outputs are readily available. This is important in service organizations like the NHIF, which rely heavily on systems to work efficiently and effectively. The output is experienced by customers who may rate the service as favorable or unfavorable. Patients utilizing NHIF tend to get experiences based on processes and elements in a defined system.

These systems include registration, triage, medical consultation and treatment, lab tests, radiological services, admissions, nursing, and discharges. For the patient to experience quality service, these processes have to be congruent and work as one for success. The output obtained gauges the efficiency of the system (C. Lai & Huili Lin, 2017). For healthcare to be successful as a process, the services offered to the consumer must flow to provide good outputs.

As per my study, a service delivery model backed by the systems theory provides an end-to-end inscription of service delivery to the consumer more so to NHIF users. Each process is defined at all stages and the outcomes are documented. The systems theory was relevant in this study since healthcare as we know it is an intercalated system of activities rather than distinct elements whose sole purpose is the provision of essential services to the consumer.

2.3 Theory of Health Empowerment

The theory of health empowerment is based, in part, on Rogers‟ Science of Unitary Human Beings; particularly influential is Rogers‟ principle of integrality perspective of human beings as integral with their environment in their daily living and health experience, characterized by pattern, self-organization, diversity, and innovative change; and as holding individual values and views about health (Shearer, 2009). The theory identifies health empowerment as emerging from synthesizing personal and social-contextual resources.

Personal resources reflect unique characteristics of older adults, such as self-capacity. Social-contextual resources include support from social networks and social service support. Empowerment from this perspective is a dynamic health process that emphasizes "purposefully participating in the process of changing oneself and one's environment, recognizing patterns, and engaging inner resources for well-being. Health empowerment emphasizes facilitating one's awareness of the ability to participate knowingly in health and health care decisions.

The Health Empowerment Theory is designed to promote the use of personal resources and social contextual resources to enhance the well-being of homebound older adults. Furthermore, the theory's emphasis on purposeful participation aligns with the study's focus on exploring the experiences and perspectives of older adults in accessing NHIF services. This will ultimately inform interventions and policies aimed at improving their overall health outcomes and quality of life.

3. METHODOLOGY

This section presents the research methodology used in this study. This section provides a description of the study area and the research design, encompassing the research approach, the targeted population, sampling strategies and data collection methods and analysis plan.

3.1 Area of Study, Research design, and Research approach

3.1.1 Area of Study

The study was conducted at Kinondoni Municipal Council, located in Dar es Salaam, Tanzania. Kinondoni is one of the administrative districts in Dar es Salaam and the largest municipality in terms of population and geographical size. It is a diverse urban area characterized by a mix of residential, commercial, and industrial zones and peri-urban and rural communities. Kinondoni is home to a significant portion of Dar es Salaam's population, including many elderly residents (Abdu, 2018).

The municipality is marked by socio-economic disparities, with affluent neighborhoods coexisting alongside informal settlements and areas of poverty, which presents unique challenges and opportunities

for healthcare access and social protection for elderly individuals. In terms of healthcare infrastructure, Kinondoni is equipped with a range of health facilities, including hospitals, health centers, dispensaries, and private clinics.

However, healthcare access and quality disparities may exist across different parts of the municipality, with urban areas typically having better access to healthcare services than peri-urban and rural areas. Sociocultural factors also play a significant role in shaping elderly healthcare and social protection in Kinondoni. Traditional beliefs and cultural attitudes towards aging may influence elderly individuals' experiences and perceptions of healthcare in the district and their interactions with social protection programs like the NHIF (Kashaga, 2013).

3.1.2 Research Design

This study used a case study research design due to its flexibility in using different data collection methods, such as questionnaires, interviews, and documentation. Similarly, a case study tends to be cheaper than other methods (Ndunguru, 2007). The study was a single case study design because of the inclusion of one District Council for data collection.

3.1.3 Research Approach

This study adopted a mixed-methods research approach to explore the role of the NHIF in promoting social protection among elderly individuals in Tanzania, with a specific focus on the Kinondoni Municipal Council. The mixed-methods approach combined quantitative and qualitative data collection and analysis techniques to understand the research questions and objectives better.

3.2 Targeted Population, Sample Size and Sampling Strategies

The study population for this research comprised the elderly individuals residing in selected wards in Kinondoni Municipal Council. The study population encompassed urban and peri-urban residents and individuals living in formal housing, informal settlements, and rural areas who are enrolled in the NHIF and have access to its healthcare services. According to the 2022 census, the population of elderly people (65+ years) in Kinondoni Municipal Council was 26,356 (NBS, 2023).

The sample size was composed of 394 elderly people calculated according to Yamane's (1967) to enable the computation of sample size statistically. The sample size for qualitative data collection consisted of 21 participants. It argued that qualitative data collection require a minimum sample size of at least 12 to reach data saturation (Braun & Clarke, 2021; Fugard & Potts, 2015).

The study involved purposive sampling of elderly people and other identified stakeholders to provide answers to the research questions. The elderly people for the surveys were selected purposively sampled for the study from the NHIF registers at the District Health Offices in Kinondoni. Purposive sampling was best for the study to enable the selection of elderly people who are NHIF beneficiaries. Participants for the key informant interviews were purposively selected based on their roles, expertise, and involvement in the NHIF sector. Participants for the FGDs were identified and sampled by convenience with the help of the Village Executive Officers as elderly people who were also beneficiaries of NHIF with the ability to help answer the research questions.

Table 3.1. Selection of Stakeholders for Qualitative Data Collection

Stakeholder Category	Key Stakeholders	Total number sampled
NHIF Staff	Kigogo Ward	2
	Mbweni Ward	2
	Mbezi Juu Ward	2
Healthcare Providers	District Hospital in Kigogo Ward	2
	District Hospital in Mbweni Ward	2
	District Hospital in Mbezi Juu Ward	2
Community Leaders	Village Executive Officers in Kigogo	2
	Village Executive Officers in Mbweni	2
	Village Executive Officers in Mbezi Juu	2
District Health Officers	Kigogo Ward	1
	Mbweni Ward	1
	Mbezi Juu Ward	1
Total		21

3.3 Data Collection Methods and Analysis

3.3.1 Data Collection Methods

Data was collected through semi-structured interviews, focus group discussions, surveys, and document reviews. Structured surveys were utilized to collect data from the sampled elderly NHIF beneficiaries in the selected wards of Kinondoni Municipal Council. For the qualitative research phase, key informant interviews were conducted with stakeholders involved in elderly healthcare and social protection within Kinondoni Municipal Council. The FGDs were organized with groups of 6 to 10 participants, ensuring a mix of demographics, including age, gender, and socioeconomic status, to enrich the dialogue.

The sessions were audio-recorded with participants' consent to capture detailed responses, which were later transcribed for analysis. Additionally, document reviews involve systematically examining and analyzing existing documents, reports, policy papers, and other relevant materials to gather information related to the research objectives. Therefore, document reviews were used in this study to complement data collected from questionnaires and interviews by providing additional insights and context.

3.3.2 Data Analysis

In this study, quantitative data analysis involved descriptive statistics to summarize the sample's demographic characteristics and critical variables related to NHIF enrollment, healthcare utilization, satisfaction, and perceived well-being impacts. The chi-square test examined associations between demographic variables and NHIF enrollment status, relationships between NHIF utilization patterns, and perceived well-being impacts.

Additionally, regression analysis was employed to explore the effects of NHIF and the challenges in accessing NHIF services for elderly beneficiaries, controlling for relevant demographic variables and covariates. Subgroup analyses were conducted in some instances to compare NHIF outcomes and experiences across different demographic groups (e.g., age groups, gender, socio-economic status) and residential areas within Kinondoni.

For qualitative data, thematic analysis was employed to identify key themes, patterns, and insights from the qualitative data collected through in-depth interviews. The data was coded systematically to identify recurring concepts, ideas, and perspectives related to societal perceptions, cultural attitudes, NHIF strategies, challenges, and recommendations. There was also constant comparative analysis to compare and contrast findings across different interviews, seeking convergence, divergence, and nuances in participants' experiences and viewpoints. Triangulation of quantitative and qualitative findings was conducted to corroborate and validate results from both data sources, enhancing the overall reliability and validity of the research findings. Conversely, stringent adherence to ethical principles was maintained throughout the study.

4. RESULTS AND DISCUSSION

This section presents the results and discussion of the findings regarding the societal perceptions and cultural attitude towards elderly people in Kinondoni municipal council, Tanzania. The findings are presented using quantitative and qualitative data in form of quotes from interviews.

4.1 Demographic information of the Participants

In this study, the study population included elderly individuals (aged 65 and above) residing in the Kinondoni Municipal Council, NHIF beneficiaries, and key stakeholders such as NHIF officials, healthcare providers, and community leaders. Out of the 394 distributed questionnaires, 80% (315) were returned and used for analysis. Table 4.1 shows the demographic information of the 315 participants.

The study findings show that the majority (42%) of respondents were between the ages of 65 and 70 years, followed by 30% aged 71–75 years and 18% aged 76–80 years. Only 10% were aged 81 years and above. The relatively high proportion of younger elderly individuals (65–70) in the sample could reflect the increasing life expectancy in Tanzania, where the population aged 60 and above is growing steadily due to improvements in healthcare and living conditions (WHO, 2024).

This demographic group is typically more active and likely to seek healthcare services, making their experience with the NHIF especially relevant. The large number of respondents from the 65–70 age group also suggests that this segment may be more accessible for research and outreach programs. As people age, most elderly individuals (especially those aged 70 and above) rely heavily on health insurance and social protection programs like the NHIF (Tungu et al., 2020).

Similarly, the gender distribution among the respondents was relatively balanced since 53% of the participants were male, while 47% were female. This close representation is significant because gender dynamics can be critical in access to healthcare services and social protection schemes like the NHIF. The significant representation of female participants (47%) highlights their participation in the NHIF. Women, particularly older women, are often more vulnerable to poverty and health challenges in later life due to gender inequalities throughout their lives,

Table 4.1. Demographic information of the study participants

Age group		
65-70 years	132	425
71-75 years	95	30%
76-80 years	57	18%
81+ years	31	10%
Total	315	100%
Gender		
Male	167	53%
Female	148	47%
Total	315	100%
Marital Status		
Married	183	58%
Widowed	82	26%
Divorced/Separated	35	11%
Single	15	5%
Total	315	100%
Education Level		
No formal education	76	24%
Primary education	145	46%
Secondary education	63	20%
Tertiary education	31	10%
Total	315	100%
Length of time with NHIF		
Less than 1 year	31	10%
1-5 years	110	35%
6-8 years	63	20%
9-12 years	32	10%
More than 12 years	79	25%
Total	315	100%

which can restrict their access to healthcare services (Bintabara et al., 2018). Therefore, understanding how gender influences access to NHIF services is critical for ensuring equitable access to healthcare for elderly women.

In terms of marital statuses, most (58%) respondents were married, followed by widowed individuals (26%). A few respondents (11%) were divorced, and 5% were single. The marital status of elderly individuals was essential to their access to healthcare and social protection. Married individuals may benefit from spousal support, both financially and emotionally, which can facilitate better access to healthcare services. According to Mutabazi et al. (2021), married elderly people often have higher health insurance coverage rates than their unmarried counterparts due to combined household resources.

Widowed and divorced individuals, on the other hand, are often more vulnerable. Widows, in particular, may face financial challenges in accessing healthcare, especially in patriarchal societies like Tanzania, where men typically control household finances. This finding aligns with those of Khamis (2016), who noted that widowhood is a significant risk factor for poor health outcomes among elderly women, as they may lack the financial means or family support to access health services.

Regarding education, most of the participants (46%) had attained primary education, followed by those with no formal education (24%). Respondents with secondary education accounted for 20%, while 10% had attained tertiary education. Education determines healthcare access and utilization (Abd Manaf et al., 2017). Studies show that those with higher levels of education are more likely to understand the benefits of health insurance and utilize healthcare services effectively (Mpeta et al., 2023).

In the present study, most respondents with primary or no formal education may face challenges understanding NHIF procedures and healthcare entitlements. According to Ngowi and Nuru (2023), low educational levels among elderly people in Tanzania often result in poor health-seeking behavior and reliance on informal healthcare providers. However, the few higher-educated respondents were likely to have better access to and understand NHIF services since education is closely linked to health literacy.

The length of time participants had been enrolled in the NHIF was an important variable in understanding the depth of their experience with the healthcare services provided under NHIF. The data showed that most respondents (35%) have been enrolled in NHIF for 1–5 years, followed by 25% who have been members for more than 12 years. A smaller proportion (20%) reported being enrolled for 6–8 years, 10% for 9–12 years, and 10% for less than 1 year.

The results suggest that a significant portion of the elderly respondents (35%) have been enrolled in NHIF for 1–5 years, which could indicate a growing awareness of the importance of health insurance among this demographic in recent years. The present results are supported by those of Amani et al. (2020), who noted that health insurance enrollment in Tanzania has increased over time due to government outreach programs and the rising cost of healthcare. This trend also highlights the increasing uptake of NHIF services among the elderly who might not have been covered earlier, particularly with the shift towards universal health coverage.

The fact that 25% of participants had been members of NHIF for more than 12 years suggests that many elderly people have had long-term access to healthcare under NHIF, which positively impacted their health outcomes. Long-term membership in health insurance schemes is associated with better health management, particularly for chronic conditions, as Huguet et al. (2023) noted. Interestingly, 10% of the respondents reported being enrolled for less than 1 year, which may reflect newly eligible individuals such as those who recently turned 65 or those who had only recently realized the benefits of joining NHIF.

Some elderly individuals could have delayed enrolling in health insurance programs due to financial constraints or lack of awareness, leading to late entry into the NHIF system. Additionally, the few respondents who had been enrolled for 9–12 years highlighted a smaller cohort of long-term users who may have initially joined NHIF due to employer programs or government initiatives targeting early retirees. The varying length of enrollment times has implications for NHIF service delivery. Long-term members (those enrolled for more than 12 years) were likely more familiar with the system and may have higher expectations regarding service quality.

However, more recent enrollees could still be navigating the system and may require additional support or education on fully utilizing the benefits provided by NHIF. The findings align with Morgan et al. (2022), who suggested that new enrollees, particularly older individuals, often need more guidance on the administrative processes of accessing healthcare services under insurance schemes. Generally, understanding the length of enrollment provides critical insights into the user experience with NHIF. It highlights the need for continuous education and support to maximize health insurance benefits, particularly for newer members.

4.2 Perceptions and cultural attitudes towards elderly people in Kinondoni Municipal

This section explores the societal perceptions and cultural attitudes toward elderly people in Tanzania. It explores how societal norms, cultural beliefs, and attitudes shape the treatment and well-being of elderly individuals. These perceptions played a crucial role in influencing the elderly people's access to social protection programs like NHIF and healthcare services. Understanding these attitudes helped to highlight the barriers elderly citizens face due to age-related stigma, societal neglect, or cultural biases and shed light on the broader socio-cultural context in which the elderly live and interact with healthcare systems in Tanzania.

4.2.1 Societal perceptions towards elderly people in Kinondoni Municipal Council

The present study explored the societal perceptions towards the elderly in Kinondoni Municipality. These perceptions can significantly affect their access to healthcare services and social protection schemes such as NHIF. Of most elderly participants,

Table 4.2. Societal perceptions towards elderly people in Kinondoni Municipal Council (n = 315)

Perception	Number of Respondents	Percentage (%)
Positive	164	52
Neutral	95	30
Negative	56	18

164 (52%) indicated that societal perceptions towards elderly people in Tanzania are generally positive (Table 4.2). 95 respondents (30%) were neutral, while 56 (18%) perceived societal attitudes as negative. These findings suggest that while most respondents maintained a respectful attitude toward elderly individuals, a significant portion held indifferent or negative views.

Qualitative interviews provided more profound insights into how cultural beliefs affected elderly people's access to healthcare. For instance, interviews with NHIF staff and healthcare providers revealed varied societal perceptions of urban and rural areas. One healthcare provider commented;

"In rural areas, the elderly people are respected and cared for by their families, but in urban settings, the pressures of modern life mean that some elderly individuals are viewed as a burden." [Healthcare Provider, District Hospital in Kigogo Ward]

Cultural beliefs also influenced healthcare-seeking behavior among the elderly. For example, the study established that some elderly individuals still relied on traditional healers due to cultural norms, which can delay their access to modern healthcare. For example, the Village Executive Officer from Mbezi Juu stated:

"It is common for elderly people to rely on traditional healers. Some believe that sickness in old age is a sign of a curse, discouraging them from seeking formal healthcare." – [Village Executive Officer, Mbezi Juu]

This finding is consistent with others that societal and cultural attitudes can negatively affect the healthcare-seeking behavior of elderly populations in East Africa. Cultural beliefs, particularly regarding aging and illness, continue to play a role in how healthcare is accessed by the elderly. According to Peterson (2017), cultural resistance is a crucial barrier to healthcare access in rural Tanzania.

In the FGDs, participants emphasized that societal perceptions of the elderly significantly influenced their access to healthcare services. Many participants stated that although elderly individuals are still valued for their wisdom, there is a growing perception that they are no longer productive, affecting the priority given to their healthcare needs. A male participant remarked,

"People think that because we are old, we don't need as much healthcare as younger people, but we get sick often." [FGD Participant, Kigogo Ward]

This perception has resulted in a lower prioritization of elderly healthcare needs in the family and healthcare settings. Some elderly participants expressed frustration at being dismissed or treated less urgently at hospitals. One female participant shared,

"At the clinic, they often tell us to wait while younger people are attended to first, even when we are in pain." [FGD Participant, Mbweni Ward]

In the FGDs, the participants shared various perspectives on how elderly individuals were viewed in the community. The findings reveal that societal perceptions of the elderly as less productive directly influence their access to healthcare. These perceptions reflect broader ageist attitudes, where older individuals are seen as having lower priority for healthcare resources despite their more significant health needs due to aging-related conditions. This aligns with recent literature, which indicates that ageism in healthcare settings leads to poorer health outcomes for the elderly, as they are often not given the same level of care as younger patients (Levy et al., 2020).

The Chi-square analysis showed significant associations between societal perceptions of elderly people and demographic variables, including age ($\chi^2 = 10.35$, $p = 0.006$), gender ($\chi^2 = 4.12$, $p = 0.047$), marital status ($\chi^2 = 5.89$, $p = 0.032$), and education level ($\chi^2 = 9.75$, $p = 0.008$) (Table 4.3). Specifically, older participants (60+) tended to have more positive perceptions of elderly people, likely due to their shared experience with aging.

Females generally exhibited more positive attitudes toward the elderly, which may be tied to traditional caregiving roles in Tanzanian society. Married individuals were more likely to hold respectful attitudes towards the elderly, possibly reflecting the societal expectation to care for older family members,

Table 4.3. Chi-square Test for Association between Demographic Variables and Societal Perceptions of Elderly People

Demographic Variable	Chi-square (X2)	P value	Significance
Age group	10.35	0.006	Significant
Gender	4.12	0.047	Significant
Marital Status	5.89	0.032	Significant
Education Level	9.75	0.008	Significant
Length of time enrolled for NHIF	3.85	0.062	Not significant

Table 4.4. Regression Analysis Results of Demographic Factors Influencing Societal Perceptions Towards Elderly People

Variable	Regression Coefficient (β)	p-value	Significance
Age	0.22	0.004	Significant
Gender (Female)	0.18	0.032	Significant
Marital Status (Married)	0.25	0.015	Significant
Education Level (Higher)	0.28	0.009	Significant
Socio-economic Status	0.30	0.002	Significant
NHIF Enrollment Length	0.10	0.084	Not Significant

especially in extended families. Participants with higher education levels had more respectful views of the elderly, suggesting that education fosters greater awareness of the importance of elderly people in society.

In Tanzania, traditional beliefs emphasize respect for elders, and these attitudes seem stronger among married people, as they are often responsible for caregiving. Interestingly, the length of NHIF enrollment did not significantly influence societal perceptions, suggesting that perceptions of the elderly are more deeply rooted in cultural and social norms than health insurance coverage.

The regression results (Table 4.4) showed that the socio-economic status (β = 0.30, p = 0.002) and education level (β = 0.28, p = 0.009) have the most substantial influence on societal perceptions, followed by marital status (β = 0.25, p = 0.015). Older age (β = 0.22, p = 0.004) is also a significant predictor of positive perceptions. NHIF enrolment length does not show a substantial effect on societal perceptions. These findings align with prior research showing that older individuals, women, and people with higher socio-economic status generally hold more positive perceptions of elderly people (Fasel et al., 2021). The lack of significance for NHIF enrolment length suggests that societal perceptions are more deeply rooted in cultural and social factors than healthcare coverage.

This reflects a broader global trend where respect for the elderly is culturally embedded, especially in African contexts where traditional norms place a high value on elders.

4.2.2 Cultural Beliefs Influencing the Treatment of Elderly People in Kinondoni Municipal

This section examines how traditional values, beliefs, and social customs shape how elderly individuals are perceived and treated within Kinondoni Municipal Council. The study showed that a majority of the respondents, 195 (62%), indicated that cultural norms and beliefs influence the treatment and support of elderly individuals in Tanzanian society. In comparison, 120 respondents (38%) said they did not believe such norms impacted their treatment (Table 4.5). This suggests that cultural factors significantly shape attitudes and behaviors toward elderly people in many parts of the country.

In many Tanzanian communities, cultural norms often dictate the respect and care for elderly people. While some cultural practices emphasize reverence and responsibility towards aging individuals, others may inadvertently limit their access to healthcare by reinforcing beliefs that elderly people require less medical attention or that certain health conditions are a natural part of aging. These cultural attitudes can influence both the behavior of healthcare providers and the elderly themselves, impacting how they seek and receive care under programs like NHIF. Interviews with NHIF staff and healthcare providers confirmed that cultural norms significantly influence how elderly

Table 4.5. Influence of Cultural Norms on the Treatment of Elderly People in Kinondoni Municipal Council (n = 315)

Response	Number of Respondents	Percentage (%)
Yes	195	62
No	120	38

people are treated in Tanzanian society. One NHIF officer in Kinondoni mentioned,

"In rural communities, traditional beliefs sometimes discourage the elderly from seeking modern healthcare services, especially when traditional healing methods are preferred." Similarly, elderly people from specific communities rely more on family and community-based care, deeply rooted in cultural practices" [NHIF staff, Kinondoni].

Another healthcare provider reported:

"The reliance on traditional healers is still prevalent, especially in communities where there is a strong belief in ancestral medicine" [Healthcare Provider, District Hospital in Mbweni Ward]

The results indicate that cultural norms and beliefs significantly influence treating and caring for elderly individuals in Tanzania. The data highlights the importance of cultural norms in influencing healthcare access and treatment for the elderly. These findings align with previous research by Mussie et al. (2022), which reported that traditional and cultural practices play a significant role in healthcare-seeking behavior in Tanzania. Cultural resistance to formal healthcare services can result in elderly individuals receiving less comprehensive care, particularly in rural areas where traditional healers are more prevalent.

It is essential to develop culturally sensitive healthcare policies that consider these beliefs to improve healthcare access for elderly populations. Cultural practices often determine healthcare-seeking behaviors among elderly individuals, especially in rural areas. For example, in India, cultural diversities, histories, communities, and nations are intricately intertwined with experiencing old age. Individual and household culture, norms, and expectations precede the decision-making process for health-seeking behaviour that influences elderly people's choice and use of health-care services (Mukherjee, 2019).

Cultural resistance to modern healthcare systems can result in delayed treatment or avoidance of formal healthcare altogether, which negatively impacts the elderly's access to adequate health services. Cultural norms historically mandated that family members care for their elderly relatives, ensuring they had access to both physical support and healthcare. However, the FGD participants highlighted that these caregiving traditions were waning, particularly as families dispersed. One participant explained,

"Before, children would take their parents to the hospital and pay for treatment, but now it is different. We are left to care for ourselves." [FGD Participant Mbezi Juu Ward]

In addition, the shift from traditional medicine to modern healthcare was discussed. Some participants noted that while older generations traditionally relied on herbal remedies, many now struggle to access modern healthcare services due to financial and logistical barriers. One elderly man said:

"We were used to traditional treatments, but now we rely on hospitals, which are expensive and far away," [FGD Participant, Mbweni Ward]

Traditional caregiving roles, where families were responsible for the health and wellbeing of elderly members, have been eroded due to urbanization and economic pressures. This shift has left many elderly individuals without adequate support to access healthcare. According to Lai et al. (2017), there is a growing disconnect between traditional family structures and modern healthcare systems, where elderly individuals are often left to navigate healthcare alone, exacerbating their vulnerability.

Moreover, transitioning from conventional medicine to modern healthcare poses an additional challenge, as older adults may not have the financial resources or familial support to access professional medical care. This highlights the importance of strengthening social safety nets like the NHIF to ensure elderly citizens receive the healthcare they need, especially as cultural caregiving practices decline.

Table 4.6 shows that the Chi-Square analysis indicated significant associations between cultural norms and the demographic variables. Most respondents believed that cultural factors shape the treatment of elderly individuals, with important differences observed across age, gender, marital status, education, and NHIF enrolment length. The regression analysis results for cultural norms in Table 4.7 further indicated that age group is the strongest predictor of perceived cultural influence, followed by gender and marital status. This aligns with findings by Mussie et al. (2022), emphasizing the impact of cultural norms on healthcare experiences.

Table 4.6. Chi-Square Analysis of Cultural Norms Impacting Treatment

Variable	χ^2 Value	p-value
Age Group	15.21	0.004
Gender	10.85	0.015
Marital Status	12.34	0.009
Education Level	14.22	0.006
Length of NHIF Enrollment	8.10	0.045

Table 4.7. Regression Analysis of Cultural Norms

Variable	Coefficient (β)	Standard Error	p-value
Age Group	0.45	0.12	0.001
Gender	0.25	0.11	0.032
Marital Status	0.20	0.10	0.045
Education Level	0.15	0.09	0.067
Length of NHIF Enrollment	0.10	0.08	0.212

4.2.3 Instances of Discrimination or Mistreatment Towards Elderly People in Kinondoni Municipal Council

When asked whether they had personally experienced or witnessed any instances of discrimination or mistreatment towards elderly people in their communities, 138 respondents (44%) answered "Yes," while 177 respondents (56%) answered "No (Table 4.8)." This finding indicates that while most respondents did not perceive discrimination, some elderly populations have encountered or observed discrimination or mistreatment for healthcare provision.

The interviews with NHIF staff, healthcare providers, and district health officers also revealed that discrimination or mistreatment of elderly individuals does occur, albeit not frequently. One NHIF staff member remarked,

"There are cases where elderly people are ignored or not prioritized in healthcare settings, especially in crowded hospitals" (NHIF Staff, Kigogo Ward).

A district health officer added,

"Some elderly individuals have reported feeling neglected, particularly when healthcare providers assume that their ailments are 'normal' for old age and not treatable" (District Health Officer, Kigogo Ward).

Healthcare providers also noted instances of discrimination within healthcare settings. One healthcare worker said,

"Some elderly patients are not given priority in hospitals, and they have to wait for long hours to receive care, which can be exhausting for them." [Healthcare Provider, District Hospital in Mbezi Juu Ward]

The findings suggest that while most respondents did not report discrimination, a significant portion of elderly individuals had either experienced or witnessed such some form of healthcare provision. This is consistent with Band-Winterstein (2015), who established that ageism and neglect toward elderly people are still prevalent in some Tanzanian communities, particularly in healthcare settings. The findings also align with recent research by Abdu (2018), which identified neglect and mistreatment of elderly individuals as a growing concern in some areas of Tanzania, where economic pressures and modern lifestyles can lead to their marginalization by family members.

According to Araujo (2023), stereotypes are activated when there is a certain disregard for the specificities of aged people that affect the quality of the health care provided to older adults, such as brief anamnesis. Instances of discrimination against the elderly in healthcare settings were commonly reported. Many elderly participants recounted feeling neglected by healthcare providers who, they felt, did not consider their health issues as severe as those of younger patients. During a FGD, a female participant from Kigogo Ward shared,

"We are often told that our problems are just because of old age, and nothing can be done. They don't treat us properly." [FGD Participant, Kigogo Ward]

Some reported difficulties in accessing NHIF services or being dismissed by healthcare workers when they voiced concerns, as one FGD participant in Kigogo Ward reported.

"We go to the hospital, but they don't take us seriously. They give us painkillers and send us home," [FGD Participant, Kigogo Ward]

Table 4.8. Instances of Discrimination or Mistreatment of Elderly People in Kinondoni Municipal Council (n = 315)

Response	Number of Respondents	Percentage (%)
Yes	138	44
No	177	56

As described by participants, the experiences of discrimination in healthcare settings reflect a broader issue of systemic ageism. Studies show that age-based discrimination in healthcare results in misdiagnoses, under treatment, and a lack of specialized care for elderly patients (Gholamzadeh et al., 2022). The dismissal of elderly health concerns as "just part of aging" leads to inadequate treatment and affects their overall health outcomes.

This pattern of discrimination is consistent with findings in other African contexts, where healthcare systems are not sufficiently equipped to cater to the specific needs of the elderly. To address this, healthcare providers need targeted training on geriatric care, and policies must be implemented to ensure elderly patients receive the same level of care and respect as younger patients.

Table 4.9 shows the analysis of discrimination experiences using Chi-square, revealing that many respondents reported experiencing or witnessing discrimination. Differences were evident across demographic variables, with younger elderly individuals and those with lower educational levels more likely to report such experiences.

The regression analysis showed that age is the most significant factor in discrimination experiences, reinforcing the notion that older individuals often face discrimination in healthcare settings (Table 4.10). This is consistent with literature on systemic ageism and highlights the need for healthcare policies that address cultural factors and discrimination, ensuring equitable treatment for elderly individuals.

5. CONCLUSION AND RECOMMENDATIONS

5.1 Conclusions

This study explored the societal perceptions and cultural attitudes towards elderly people in Kinondoni Municipal Council. From the discussion, the findings reveal a complex scenery of societal perceptions and cultural attitudes toward elderly individuals in Kinondoni Municipality. While a majority of respondents expressed positive perceptions of the elderly, a significant portion also reported neutral or negative views. This indicates that, despite a foundation of respect, age-related stigma and indifference persist, potentially affecting elderly individuals' access to social protection programs like NHIF. Cultural norms and beliefs were found to play a significant role in shaping the treatment of the elderly, majority of the respondents acknowledged their influence.

Traditional values can either promote reverence or lead to diminished healthcare access, as some elderly individuals rely on traditional healers due to cultural beliefs about illness. Qualitative insights highlighted the tendency for elderly people to be viewed as burdens in urban settings, contrasting with their more respected status in rural areas. Instances of discrimination were also reported, with 44% of respondents witnessing or experiencing mistreatment, indicating that ageism and neglect remain prevalent issues in healthcare environments.

Overall, the study underscores the need for culturally sensitive healthcare policies that address societal attitudes and promote better access to services for the elderly. These findings align with existing

Table 4.9. Chi square analysis on discrimination experiences

Variable	χ^2 Value	p-value
Age Group	10.45	0.014
Gender	8.22	0.016
Marital Status	7.38	0.021
Education Level	6.00	0.025
Length of NHIF Enrollment	5.10	0.028

Table 4.10. Regression analysis on discrimination verses the demographic characteristics

Variable	Coefficient (β)	Standard Error	p-value
Age Group	0.50	0.11	0.002
Gender	0.30	0.10	0.015
Marital Status	0.25	0.09	0.031
Education Level	0.20	0.08	0.055
Length of NHIF Enrollment	0.15	0.07	0.078

literature, suggesting that a deeper understanding of cultural contexts is essential for improving healthcare outcomes and the well-being of elderly populations in Tanzania. The study has provided valuable insights into the perceptions associated with elderly healthcare access in Tanzania, particularly within the framework of the NHIF.

5.2 Recommendations

Based on the study's findings, there are several policy recommendations and recommendations for future studies on societal perceptions and cultural attitudes towards elderly people in Tanzania.

5.2.1 Recommendations for Policy Implications

Based on the findings of the study, the following policy recommendations are proposed: First, there should be implementation of targeted awareness campaigns to educate elderly individuals about NHIF services, their rights, and the benefits available to them, addressing the knowledge gaps identified in the study. Secondly, streamlining the NHIF enrollment process to reduce administrative barriers, making it more user-friendly for elderly applicants and ensuring they can easily access the benefits.

Third, there must be development of financial assistance programs or subsidies to help elderly individuals cover NHIF premiums and out-of-pocket expenses, addressing the significant financial constraints reported. Finally, there should be designing and implementing healthcare policies that consider cultural norms and beliefs, ensuring that services are respectful and accommodating to the traditional practices of elderly individuals.

5.4.2 Recommendations for further studies

Based on the findings of this study, the following recommendations for further research are proposed: One of the recommendation should be on the long-term impacts of NHIF coverage on the health outcomes and overall well-being of elderly individuals over time. Secondly, comparative studies between urban and rural elderly populations to understand how access to NHIF services and societal attitudes differ across various settings. Lastly, the specific cultural beliefs and practices influencing healthcare-seeking behaviors among the elderly provide deeper insights into how these factors can be addressed in policy.

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