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Research Paper

Universal Health Coverage: A Qualitative Study of Urban Communities in Tanzania

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ABSTRACT: *This is a report of a qualitative cross-sectional study conducted in twelve urban communities in Tanzania to explore how urban communities experience and define disparities in universal health coverage. Tanzania sanctions free access to an 'essential package of health services as a means towards universal health coverage. The study was motivated by the fact that; many health sector reforms intended to achieve universal health coverage (UHC) have often adopted a technocratic top-down approach, with little attention being paid to the urban communities' perspective in identifying context-specific gaps to inform the design of such reforms. This usually led to transformations that are unresponsive to local urban needs. The study revealed that 'the essential package of health services under implementation in Tanzania, created a universal sense of entitlements to free healthcare at public healthcare facilities in the country for the targeted vulnerable groups. However, there is frequent unavailability of some services in the package forcing patients to seek such services in private healthcare facilities. This has led to inequities in population coverage, access and financial protection. Most respondents reported the affordability of medical costs at private facilities as the main barrier to universal financial protection. From the perspective of urban Tanzanians, gaps in financial protection are mainly triggered by supply-side access-related barriers in the public health sector such as; shortages of medicines, emergency services, shortage of health personnel and facilities, poor health workers' attitudes, and perceived poor quality of health services. The study discovered that the journey toward UHC in Tanzania requires the institution of appropriate interventions to fill the financial protection gaps and the access-related gaps. The continuing Health Sector Reforms undergoing in the country need to address context-specific gaps and be carefully crafted to avoid creating a sense of universal entitlements in principle, which may not be effectively received by beneficiaries due to contextual and operational bottlenecks.*

KEYWORDS: *Universal health coverage, Gaps in healthcare coverage, Urban communities, Tanzania*

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I. INTRODUCTION

This paper presents the findings of the study conducted in Dar es Salaam, Tanzania, to verify how urban communities in Tanzania experience and define gaps in the coverage provided by their Tanzania healthcare system. The rationale is to ensure that future interventions, within this context, are aligned with people's actual needs; respecting responsiveness as an acknowledged global basic policy objective of UHC reforms [1] decades of international efforts to improve healthcare, the global community is still facing significant inequalities. One of the challenges within the global "Sustainable Development Goals" is, reducing the number of deaths occurring in developing countries due to inequitable access to healthcare [2]. Searching for more effective ways to reduce this challenge, the international community endorsed social protection mechanisms as a new development priority [3]. These efforts have translated into the concept of Universal Health Coverage (UHC).

Many developing countries have embarked on health system reforms aimed at achieving the mentioned Universal Health Coverage (UHC) [4, 5]. Such reforms involved the expansion of public healthcare financing systems to pool resources across a wide range of prepaid financing sources, as replacements for out-of-pocket payments [5, 6]. These involved the introduction of a telephone levy in the case of Gabon to voluntary and involuntary health insurance in Tanzania and other developing countries [4, 7].

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The policy objective of universal health coverage is to ensure that all citizens (universal population coverage) enjoy adequate coverage by prepaid financing systems (universal financial protection) and have access to needed health services of good quality (universal access) [5, 8]. These three main dimensions of universal health coverage: population coverage, financial protection and access to services; are interlinked and interdependent [9]. Universal population coverage is attained when there is no systemic exclusion of certain population groups (especially the poor and vulnerable) and when all citizens enjoy the same entitlements to the benefits of public funding, irrespective of their political affiliations, race, gender, tribe, socio-economic status, geographic locations or any other differences [10, 5]. Universal financial protection is attained in the absence of; 'significant' out-of-pocket payments, fear of and delay in seeking healthcare due to financial reasons, borrowing and sales of valuable assets to pay for healthcare, and critical income losses due to healthcare payments [11, 12, 13].

Universal access is achieved when it is considerable: availability of health services, personnel and facilities; fair accessibility of health services to people; acceptability in terms of appropriate client-provider relationships and attitudes towards each other; accommodation in terms of timeliness, appropriateness and quality of services; and affordability in terms of cost of services relative to client's ability-to-pay [14, 15]; UHC thus, can only be realized if universal access is attained in conjunction with a realization of the other two dimensions of UHC such as universal population coverage and financial risk protection. A deficiency in any aspect of these three main dimensions signifies a gap that needs to be filled for UHC to be achieved.

Global debates [16], and to some extent national level aggregates and economic modelling [17, 18], have extensively been used to ascertain gaps in universal health coverage in various contexts and to suggest possible solutions. Less attention has been paid to the identification of context-specific gaps in universal coverage from the perspective of the urban community. This scarcity of evidence is somewhat worrying considering that the World Health Organization (WHO) distinguishes responsiveness as an intrinsic objective of any healthcare system and one that needs to be maintained in the pursuit of universal health coverage [19]. This is undesirable because many reforms in developing countries have often been implemented following a top-down approach, with little attention being paid to documenting and exploring gaps in coverage as experienced by communities [20]. This qualitative study aims to fill this knowledge gap by exploring how urban communities in Tanzania experience and define gaps in the coverage provided by their healthcare system.

II. METHODOLOGY

The researchers conducted a qualitative cross-sectional study in the Dar es Salaam region in Tanzania to explore how urban communities experience and define disparities in universal health coverage in Tanzania, a country which endorses free access to an "essential package of health services" as a means towards universal health coverage. Dar es Salaam has an estimated population of over seven million residents, which is about 12% of the entire population of Tanzanians [21]. The region has about 1,204 health facilities, comprised of 175 public and 1,029 private facilities. The data was collected from September to December 2020, within the framework of an exploratory qualitative study aimed at informing a subsequent discrete choice experiment [22].

Dar es Salaam is a region and the major city in the country, but there are several cities, municipalities and towns throughout the country. History shows that; Dar es Salaam, also known as "Haven of Peace", was given its name by Majid bin Sayyid, Sultan of Zanzibar in 1866 [23]. Under German rule, Dar es Salaam was the administrative and commercial centre of the colony, a position it also maintained under British trusteeship up to the independence of Tanganyika in 1961 [23]. Dar es Salaam remains the largest city in the country. The city has an average population density of about 5,000 per square kilometre. The population is both comparatively youthful and predicted to rise from today's approximately 7 million; to more than 50 million by 2060, which may make the city one of the largest cities in Africa [23]. Such growth will undoubtedly cause further strain on the city's infrastructure and service systems, especially healthcare services. As the commercial and industrial capital of the country, Dar es Salaam hosts a much higher concentration of trade, services and manufacturing than elsewhere in Tanzania. Its central business district is the largest business area of the country; and is home to the central bank, stock exchange, largest business towers, and transportation hubs. In recent years, the central business district has become a source of merchandise for countries such as the Democratic Republic of Congo (DRC), Rwanda, Zambia and Malawi [23]. Like other cities in the country, the city is not short of healthcare challenges.

Within the context of this study, we purposely collected information on perceived and experienced gaps in universal health coverage from the target population. We collected information from both adult community residents and health workers from selected health facilities. Purposive and snowball sampling techniques were used. In brief, based on an anticipated saturation point, stratified purposive sampling was used to select participants for 48 semi-structured interviews among community residents and 12 key informant interviews with health workers. A total of 60 residents participated in the study. Because of their experiences with the challenges that community residents face when seeking care, health workers were included in the study

as key informants to enhance the credibility of the findings, by cross-checking their responses with the answers provided by community residents. The health workers were selected from purposefully sampled healthcare facilities to reflect variations in healthcare provision in the study area. The sampled facilities were comprised of two public regional referral hospitals (Amana and Temeke regional referral hospitals); two public health centres (Buguruni and Buza) and two dispensaries (Tandika and Vingunguti). The health workers that were interviewed from these facilities were comprised of two medical officers, two clinical officers, two nurses/midwives, two lab technicians, two pharmacists and two health secretaries. All respondents were identified, contacted, and interviewed. All interviews were conducted in secure enclosed places at the community and facility levels, respectively.

Due to the less sensitive nature of the study topic, interviews made it relatively easier to explore consensus and differences in opinions on UHC gaps among community residents. To respect local socio-cultural concerns, interviews were gender-specific and conducted on an individual basis. All interviews were conducted either in Kiswahili or both English and Kiswahili depending on the respondent's preference. The first author conducted all interviews. Two different, but mirrored, interview guides containing semi-structured interviews, open-ended questions and probes were used to facilitate the interviews. The relevant sections of the guides covered the following topics: cost and payments associated with seeking healthcare, access to health providers, facilities and medical products, transportation and distance to facilities, perceived quality of healthcare (waiting times, perceived quality of drugs) and attitude of health workers among others. All interviews were tape-recorded and transcribed verbatim into English for analysis. The collected data were analysed using the thematic method to identify the community's perception of gaps in universal health coverage [24]. Analysis began with independent reading, coding, and categorizing of themes of the transcripts by all three authors. All analysts approached the material inductively, letting codes and categories emerge as they worked through the transcripts [25]. At a later stage, the three researchers brought together the results of their analyses to identify overarching themes. Codes were re-categorized into broad and subthemes, reflecting the various dimensions of universal coverage and the context-specific issues raised in the data, respectively.

Discrepancies in interpretations across the three authors were reconciled by returning to the text and notes taken during data collection for further analysis. Findings are presented along the three-dimensional UHC framework: universal population coverage; financial protection; and access to healthcare. To avoid redundancy, affordability as a dimension of access has been reported under financial protection. Touchingly chosen quotations from the qualitative transcripts have been included in the results section to illustrate the main findings, and to give voice to interviewed respondents. The research was approved by the University of Dar es Salaam, Tanzania and an 'Official Clearance Letter' was subsequently issued. Oral informed consent was obtained from all participants before the beginning of the interviews. Before interviews, the objective of the study, procedures to be followed, and the benefits of participating in the study were explained to all respondents and all sampled respondents consented to and participated in the study. To ensure confidentiality the names of the respondents were not recorded. Throughout the study, a sense of trust to ensure that respondents were aware of the aim of the study and their rights as study respondents was ensured.

III. UNIVERSAL HEALTH COVERAGE IN TANZANIA

Tanzania is the United Republic with an area of 947, 300 square kilometres, and an estimated population of 61,280,743 million [21]. Currently, about 36.2 % of the population of Tanzania live in urban areas and the rest resides in rural areas [21]. The life expectancy is 66.4 years and the infant mortality rate is 34.2 per 1,000 live births. The country is divided into 31 regions of which 26 regions are on the mainland and 5 in Zanzibar. These regions are subdivided into councils. The councils administer and provide some public services, including health services. Since independence, various reforms to improve access to healthcare services among other services have been implemented [26]. In the process, various policies, strategies, and measures were introduced [27].

Tanzania like other developing countries has been reforming the healthcare sector to accelerate its socio-economic development knowing that a healthy nation is disposed to prosper. In this endeavour, Tanzania declared diseases, poverty and ignorance as national enemies [28]. Tanzania thus declared that all healthcare services must be provided free of charge in public healthcare facilities to all citizens. Tanzania also expanded education by instituting free Universal Primary Education (UPE) for all citizens and also introduced various large commercial farms and industries in her effort to develop the country. In other developing countries, it was thought that these transformations would accelerate national development [29]. Studies conducted in the 1970s, however, have shown that economic growth has not at all been able to reduce levels of poverty both in absolute and relative terms [29]. Influenced by "urban bias theory," much focus of these transformations was directed to rural areas purported to hold the majority of poor citizens. The 'urban bias theory' argues that rural areas in developing countries are facing acute poverty because more resources are allocated to urban development [30]. The theory thus, assumed that there remains a class conflict between the urban and rural populations resulting in

the systematic under-development of rural areas and therefore the persistence of poverty in rural areas [30]. However, several critiques have now arisen. This study builds upon the need to understand the question of urban population inequalities that render poor people in urban areas unable to access healthcare services in Tanzania taking Dar es Salaam as a case study.

The government from time to time instituted various mechanisms to improve healthcare through various sectorial and multispectral reforms. Apart from earlier health sector reforms conducted under the general national policies to speed up national development as informed by the Arusha declaration; the recent Health Sector Reform began in 1994[31]. Only four years after the first specific policy for health in 1990. The policy and the reform it instigated aimed to improve healthcare by among others providing basic primary healthcare and ultimately universal health coverage. However, notwithstanding the government commitment, the share of public spending on healthcare has remained relatively minimal and dwindled over time. Available statistics show that in the past ten years (2008-2017), the average share of the government budget on the health sector stood at 8.9% of the total government budget. That was somehow encouraging compared to past decades. Astonishingly, from 1918 the share of the government budget for health started to decrease to less than 7% [32]. In 2020/2021 the share further dropped to…. of the total national budget. In terms of GDP, public health expenditure increased from 2.56% of GDP in 2011/12 to 3.5% in 2015/16 [33]. This was lower than the 5% of GDP suggested by United Nations (UN) to achieve UHC and economic wellbeing. This shows that Tanzania's spending on health is still less than half the 15% recommended in the Abuja Declaration [34]. In its journey toward universal health coverage in the country, the government introduced insurance cover and waivers and exemptions. The government also established a 'national package of essential health interventions. The following subsection will delve into these initiatives one after the other starting with health insurance cover.

3.1. Health Insurance

In its effort to achieve UHC after the introduction of user fees, Tanzania introduced health insurance and waiver and exemption systems for the destitute. The main health insurance introduced were the National Health Insurance Fund (NHIF) and the improved Community Health Fund (iCHF). NHIF was established in 1999 as a scheme mostly for public servants and their families. It covers about 7% of the Tanzanian population, offering them a comprehensive benefits package including general outpatient and inpatient care, specialized surgery, pharmaceuticals, optical services, orthopaedics and other services. iCHF is a combination of the Community Health Funds (CHF), which started in 2001 to cover the rural informal sector population and Tiba kwa Kadi (TIKA) started in 2009 to the cover urban informal sector. iCHF officially started in 2018. The fund covers less than one-quarter of the Tanzania population, offering them a limited benefit package at primary and hospital healthcare within the councils, mostly inpatient and outpatient curative services.

3.2. Waiver and Exemptions

Similarly, the government introduced waivers and exemptions to cover vulnerable groups. These have been defined to include pregnant mothers and children under the age of five years who are at a greater chance of being affected by diseases, especially communicable ones. These are directed to get free-of-charge medical services on essential reproductive and child health-related problems. Also, the policy identifies people who are suffering from diseases such as diabetes, HIV/AIDS, leprosy, TB, polio, and cancer, as eligible for exemptions [36]. The list also includes elder citizens above 60 years. The government require private health care providers with service contracts with the government to administer exemptions and present their bills to the ministry responsible for health for refund. As for waivers (a temporary relief that forgives patients who prove to be very poor and unable to pay), the government has made it clear that these have to be granted based on the experience and discretion of health workers in consultation with local (community) leaders who may officially recommend people who are too poor to afford charges at health facilities [35, 36]. The practice is that people to be exempted are recommended by village councils, approved by Word Development Council (WDC) and endorsed and offered permit cards by the council.

3.3. Essential Package of Health Services (EPHS)

The Essential Package of Health Services (EPHS) policy was introduced in 2000, but could not be fully implemented because of inadequate funding and other health systems constraints. Thus, the government revised this policy in 2013 and renamed it the National Essential Health Care Interventions Package-Tanzania (NEHCIP-Tz). Because the initial policy failed because of financial constraints the revised policy committed the available scarce financial resources to interventions which would provide the best 'value for money to improve efficiency, equity, political empowerment, accountability, and effectiveness [37]. The main focus was on reproductive, maternal, newborn and child health interventions. These services were delivered through public health facilities and by private healthcare facilities with service-level contracts with the government. The ministry responsible for health established mechanisms to ensure regular supervision and monitoring of the

provision of the services. The services were provided at all levels of healthcare facilities from primary to tertiary and to all age groups according to need.

The essential intervention package thus comprised: HIV/AIDS and STD diagnosis and management, education and communication of gender-based violence and nutrition care (provided to all age groups); new-born care and neonatal conditions, prevention and management of immunisable diseases, and prevention and management of childhood illness (provide to children); adolescent sexual and reproductive health, antenatal care, care during childbirth, care of obstetric emergencies, new-born care, postpartum care, post-abortion care, family planning, prevention and management of infertility, and prevention and management of reproductive cancer(provided to all above 15 years old); and reproductive health of the elderly (provided to elders above 50 years old).

The services are given to all women indiscriminately as they need and involve: family planning, folic acid, Iron tablets, tetanus toxoid, safe abortion services, HIV/STIs screening services, confirmation of pregnancy, monitoring of the progress of the pregnancy and assessment of maternal-fetal wellbeing, and counselling on nutrition, breastfeeding and healthy lifestyle. Others are screening of protein and anaemia including blood groups, Deworming, identification and treatment of bacteria, identification of treatment of problems complicating pregnancy, hypertension, bleeding, prevention and treatment of malaria, and others. Along with these services TB and HIV/AIDS, leprosy, and epidemics (Cholera, Meningitis, Plague, Yellow fever, Measles, Polio, and others) cases were also handled without payment. Also, the government had special intervention programs for prevention, management and control of non-communicable diseases such as acute and chronic respiratory diseases, cardiovascular diseases, diabetes, cancers, mental health, substance abuse and others which though not fully provided free but were greatly subsidized. There is also special intervention on neglected tropical diseases affecting such as river blindness, Lymphatic elephantiasis, Trachoma, plague, bilharzia, human African sleeping sickness, soil-transmitted intestinal worms and leprosy which the government combat from time to improve healthcare.

3.3.1. Delivering the EPHS to different population groups

The government's strategy for implementing the EPHS includes specific activities to improve equity of access for specific populations; these include women, the indigent, and rural populations. The government considers the following groups to be vulnerable: poor people, women, children, orphans, people with disabilities and the elderly, persons living in hard-to-staff areas, and displaced persons (including refugees and persons displaced due to natural disasters). To address the needs of these vulnerable groups the Ministry and stakeholders will continue conducting outreach/mobile clinics to reach hard-to-serve populations; and consider the construction of new health facilities in underserved areas, taking into consideration issues of access by vulnerable groups. The Ministry will also conduct sensitization meetings in communities to create awareness about available services and the need for these special groups to access them.

3.3.2. Providing Financial Protection for the EPHS

The government EPHS through various means such as: sponsoring health insurance for civil servants (contribute 3% of each employee to top up their 3% income contribution for health insurance); regulating health insurance for nongovernmental formal sector employees; sponsors health insurance for informal sector employees (through a national insurance fund, through subsidies to community-based health insurance, etc.). Community-based insurance is available in all parts of the country. These initiatives cushion citizens from financial stress when they get sick following the cost-sharing policy that began in 1993 requiring all patients to pay for healthcare services [37]. The government has introduced exemptions and waivers to reduce the financial burden on poor households. The waiver system is reportedly not working well in practice. It is ineffective due to the poor not gaining access to intended waivers, due to either lack of information or denial of the waiver by a provider. Waived patients also reportedly face stigmatization and other disadvantages while attending health services compared to people who pay for services either directly through off-pocket payments or insurance [38].

IV. GAPS IN UNIVERSAL COVERAGE EFFORTS IN TANZANIA

There are many gaps in Tanzania's efforts toward the attainment of UHC. The gaps exist in the implementation of exemption and waivers, health insurance and the essential package of health services. The study explored how urban communities experience and define gaps in universal health coverage in Tanzania, a country which implemented the above initiatives as a means toward universal health coverage. The policy objective of universal health coverage is to ensure that all citizens (universal population coverage) enjoy adequate coverage by prepaid financing systems (universal financial protection) and have access to needed health services of good quality (universal access) [5, 8]. These three main dimensions of universal health coverage: population coverage, financial protection and access to services are interlinked and interdependent [38]. The study specifically explored how urban communities experience and define gaps in 'the essential

package of health services' implemented as one of the means to attain universal health coverage in the country. Findings from the study regarding the gaps in achieving the three dimensions of UHC in this aspect are presented below starting with the population coverage gaps, followed by financial protection gaps and finally universal access gaps.

4.1. Population Coverage Gaps

The research did not discover systemic exclusion of population groups based on socioeconomic status in the coverage of essential packages of health services. Residents generally reported a sense of entitlement to free provision of these services at all public facilities and the facilities with service level agreements with the government to offer such services.

> "Healthcare facilities in our area offer free services for all even when you are admitted. No payment is demanded" (Interview 10: Female)

Further analysis of the interviews, however, revealed the geographical exclusion of residents from certain urban communities from an effective essential package of health services because they were far from public healthcare facilities. In private healthcare facilities, residents argued that it is practically not possible to access services from the essential package of health services free of charge, since services offered by such facilities are paid on an out-of-pocket or insurance basis.

> "When you go to private healthcare facility in this area, you pay first to see the doctor, and then when you test, and when medicines are prescribed to you, you must pay. All services are for payment" (Interview 12: Female).

All health workers confirmed that geographical disparities in population coverage result from the operational ineffectiveness of the service level agreements with the government. None of the private health facilities identified in the study area was under the service level agreements. Health workers interviewed reported that some patients think that all services offered in government healthcare should be offered free of charge, while it is the services from the essential health package alone are the ones offered free. Some also think that essential health packages are offered in all facilities public or private but they are denied services at private healthcare facilities. They added that even in those facilities with service level agreements with the government, not all essential health packages are provided. In most cases, it is only maternal and neonatal services are provided. One of the respondents confirmed this fact stating, that not all essential health packages are provided in private healthcare facilities with the service level agreement with the government.

> "I was pregnant and travelled upcountry, I went to a private hospital for medical services…They said that I was lucky I am pregnant. They only offer neonatal and maternal services because that is their agreement with the government" (interview 04, Female).

4.2. Financial Protection Gaps

All community residents who participated in the study reported being charged fees for the treatment received at public facilities except for services included in the essential package of health services. The services were paid through out-of-pocket or insurance and very few are exempted and must have exceptions to be offered free medical service. Despite their awareness of and experience with subsidized healthcare provision at public facilities, respondents reported frequently being compelled by circumstances to seek care at private facilities and thus, incur substantial payments. They justified their need to do so in regards to several shortcomings in public health service provision, namely: shortages of medicines and health workers, insufficient health facilities and equipment, poor access to emergency services, bad attitude toward health workers, overcrowding and perceived poor quality of care, among others.

> "Government healthcare facilities are always crowded and have poor services so if you have the money you go to private healthcare facilities" (Interview 4. Male).

Both community respondents and healthcare providers consistently reported out-of-pocket payments to be the main barrier to seeking healthcare. As a consequence of financial unaffordability, community respondents reported delays in seeking healthcare, refusing facility admissions, and demanding early discharge to reduce their medical bills sometimes.

> "Sometimes there is a necessity to be admitted but considering the shortage of money, if you don't have insurance cover you refuse because you cannot pay" (Interview 06, Male).
>
> "Some patients cannot pay for all the services so when they must be admitted, they get discharged early on their request because of their shortage of funds" (Medical Officer, Regional Hospital).

To meet the cost of seeking the much-needed healthcare, community residents reported reliance on sales of belongings, borrowing, and contributions from family members. These are all implicit indicators of gaps in financial protection.

> "Our businesses are for subsistence, so if we get sick, we sale our properties, borrow or seek friends and relatives' assistance to pay for healthcare services" (Interview 09, Male)

All the 12 health workers interviewed had insurance coverage from National Health Insurance Fund (NHIF). This enabled them to access services at no direct cost, even from private health facilities registered by

the fund. At the time of the study, very few (about 17) respondents had insurance coverage. But all had information about the insurance though many were not motivated to join because of unaffordability and perennial drug stock-outs of public healthcare facilities.

4.3. Universal Access Gaps

4.3.1. Shortcomings in public health service provision

There are gaps in public provision which expose community residents to financial risk and compel them to seek care from private facilities. This represents the main gaps when considering the access dimension of universal health coverage in urban poor areas and slums. The gaps such as the shortages of medicines and health workers, insufficient health facilities and equipment, overcrowding, poor access to emergency services, poor attitude of health workers, and poor quality of care are common in public healthcare facilities. These are further explored under the following thematic topics.

4.3.2. Availability and accessibility of health services

Frequent drug stock-outs dominated all the interviews with health workers in public facilities. Respondents suspected that drugs were being badly managed and/or purposely redirected towards private provision by the same providers serving at the public facilities. Health workers in public health facilities, however, attributed the shortages to inadequate supplies from Medical Store Department (MSD), the only government entity mandated to supply medical and medical supplies to public healthcare facilities in the country.

> "Drugs are always out of stock in public healthcare facilities. The supplied drugs are sold at nearby pharmacies. In many cases they direct us to buy medicine from private owned pharmacies nearby" (Interview 07, female)
>
> "Drugs are supplied, but are not enough to cater for the requirements, patients are many" (Clinical Officer, Health Centre).

The government noticed that some government-subsidized drugs are sold to private Accredited Drugs Dispensing Outlets (ADDO) operating near government facilities and then re-sold to patients attending healthcare services in public facilities and directed that all such ADDO must be at least 500 metres away from public healthcare facilities to prevent the theft. This directive has not been observed to date. There are many pharmacies as close as 50 metres from these facilities as revealed in this study. The Pharmacy (Accredited Drugs Dispensing Outlets) (Standards and Ethics for Dispensation of Medicines) Regulations, 2019 provides in part as follows:

> 30.-(1) An Outlet shall be exclusively established in rural and peri-urban areas as determined by a local government authority. (2) Every Outlet shall be located at a distance of not less than 500 metres in radius from a pharmacy, 150 metres in radius from an Outlet in peri-urban areas, and 100 metres in radius from an Outlet in rural areas, and such distances may be determined or varied depending on the population of a particular area or any other factor as may be determined by the Council

Public sector healthcare workers indicated that they cope with drug shortages by postponing treatment, referring patients to private pharmacies, and/or referring clients to another health facility. Yet again, this confirms how gaps in public provision feed gaps in financial protection, as described in the section above sometime.

> "Sometimes even drugs out of stock are prescribed and we are asked to buy them from private Accredited Drugs Dispensing Outlets (ADDO) operating nearby. If you do not have the money to buy the prescribed drug, you stay without taking the drugs" (Interview 20, Female).
>
> "When drugs are not available we ask patients to check after three or four days if the drugs may be brought" (Clinical Officer, Health Centre).

Community residents identified poor access to emergency services as an additional gap in access and defined it in terms of a lack of adequate equipment and staff at public facilities. Specifically, residents complained that compared to private facilities, where service provision is generally rated adequate, public facilities lacked the basic resources to provide adequate healthcare. They also noted that public health staff frequently resided far from the facility, hampering the provision of services in a timely fashion. Health workers confirmed the veracity of community concerns but attributed shortages in both equipment and staff to circumstances beyond their control. Staff shortages were cited to explain the public facility overcrowding, resulting in long waiting times and severe patient complaints.

> "Most of the healthcare facilities have inadequate staff. WHO's minimum requirement for health professionals is 23 professionals per 10,000 population. But what exists is less than required, we have less than one-half of the required staff here" (Medical Officer, Hospital)
>
> "Many health workers stay far from their working stations in this city, this affects the quality of healthcare provided to us, patients" (Interview 16, Male).

The interviews revealed that accessibility gaps largely result from the uneven geographical distribution of public facilities. It was discovered that large portions of the population reside not far from private facilities. It is only when they are unable to seek healthcare from these facilities due to the affordability concerns described earlier, that these residents opt to go to public healthcare facilities which give relatively cheap healthcare services than their counterpart private facilities.

> "We normally come for service in this public healthcare facility because drugs are cheap than private facilities but the problem is that in most cases drugs are not available" (interview 11, female).

4.3.3. Acceptability and accommodation-related gaps

Community respondents further complained of poor attitudes and behaviour of healthcare workers and poor quality of health services. These complaints indicate the existence of additional gaps in access, pertaining specifically to the acceptability and accommodation dimensions, respectively. Community residents reported rudeness, favouritism and lack of sense of care as the main negative attitudes of health workers in public health facilities as compared to private facilities where workers are more attentive, courteous and gracious. Respondents complained that in public facilities, workers are unfriendly, and over or under-prescribed the same kinds of drugs irrespective of their medical condition. Respondents further protested that these negative attitudes effectively limit access to services, since those community residents who cannot stand the impolite attitudes of health workers often avoid seeking healthcare at public healthcare facilities.

> "In government facilities, if you know someone, you are fine. But if not, hmm! You cannot get prompt service and you will spend many hours suffering, some workers are impolite" (Interview 11, female).

Respondents further explained that they experience poor attitudes from health workers more often when they are seeking maternal care:

> "Nurses shout and insult us during labour and delivery. They yell at us, telling us to keep quiet, rebuking us that they were not with us when we were getting pregnant. We are tired of the nurses" (Interview 07, Female).

Many of the healthcare workers interviewed did not support the community's views about their unethical behaviours and their lack of care for patients. They thus claimed to provide healthcare services to the utmost level of their abilities and according to their profession. Very few of the healthcare workers interviewed (less than one quarter) admitted that some of their fellow workers treat badly patients and are unethical. They explained that, compared to healthcare workers working in private healthcare facilities, some of them do not have a sense of care, don't listen properly to patients, communicate well with them and address well their complaints. Generally, it was revealed that residents perceive services provided at public healthcare facilities as inappropriate and inferior, compared to those offered in private healthcare facilities. They, therefore, expressed a stronger preference for seeking care at private facilities than at public ones.

> "To be frank, we go to public healthcare facilities because we have to. Private healthcare facilities offer better services than public ones, therefore, we prefer attending healthcare services there. But we cannot afford all the time, thus we opt for public services because though they are inferior, they are a bit cheap" (Interview 13, Female).

V. DISCUSSION

This study discloses the views and experiences of urban communities' residents regarding the existence of gaps in three universal health coverage dimensions: population coverage, financial protection and access to services. The study, distinctively, illustrates the perspective of community members and voices their concerns because as health stakeholders they rarely get the opportunity to actively contribute to the health reform process in their country. Community responses constitute an additional source of evidence to inform current universal health coverage debates and health reforms in Tanzania, advancing knowledge on gaps in universal health coverage beyond what has already been reported in recent studies [17, 39], expert opinions, and policy analyses [39]. We acknowledge that this study was only conducted in one city and among a few purposively sampled respondents, whose views may therefore not necessarily represent the opinions of all urban community residents and all health workers in all countries; but it expresses the views and opinions of the population of the communities in the contexts similar to the studied areas. Thus, we trust that lessons from the results are transferable to other urban areas in Tanzania where currently more than one-quarter of the population lives [40].

The findings are also relevant to account for the situation of the places with similar health system characteristics [41] and at least partially transferable to other urban settings in Developing countries which experience similar to Tanzania's health system characteristics. Our study confirmed the existence of clear interrelated gaps in the three main dimensions of UHC, as defined by urban communities, indicating synergy between community perspective on UHC and current global debates [11, 42, 43, 44]. In terms of population coverage, the unanimous sense of entitlement to coverage for essential health packages of public funds (tax revenue) at public health facilities expressed by the study respondents, implies that the country has made some improvements toward UHC [38]. In practical terms, the existence of geographical inequities in population coverage confirms the assertion that universal health coverage entitlements often differ substantially in reality

[45]. Also, the operational challenges in effectively implementing the service level agreements at the local level, as evidenced in our study, support findings from previous studies on the Tanzania service level agreements [46, 47]. This, by implication, suggests a weakness in effectively extending the government's healthcare services provision function to the private healthcare facilities within a pluralistic healthcare system like Tanzania's [46].

Furthermore, our findings indicated that geographical disparities in population coverage have resulted in perceived inequities in financial protection. Being near or seeking healthcare from public facilities was perceived to be associated with opportunities for greater financial protection than being far from or seeking healthcare from private healthcare facilities. This implies that the provision of the essential health package has mostly been effective when considering the financial dimension (i.e. out-of-pocket payments) at public facilities. The existing literature reveals incidences of illegal or informal charges for medical services that ought to be offered free, in some settings [10, 48]. This evidence has been reported within contexts where direct out-of-pocket payments are still implemented in public healthcare facilities for the vulnerable [10, 48, 49]. This important financial protection gap has been revealed in this study but is also noticeable in earlier published studies within Tanzania [50]. This possibly suggests that informal payments within the public sector are more likely to arise within contexts where exemption systems exist parallel to out-of-pocket payments like in a system currently existing in Tanzania [51, 35]. Thus, with the existence of formal and informal payments at public facilities, our findings indicated that communities perceived themselves to be more exposed to financial risk due to out-of-pocket payments for medical treatment they pay to healthcare in all facilities, transportation costs, and purchases of drugs. The majority of potential financial protection barriers identified in this qualitative study are not likely to be reflected in quantitative studies. The reason is that urban poor residents normally perceive such costs as substantially high, unaffordable and potentially catastrophic, and hence, either completely avoid seeking healthcare or adopt certain coping mechanisms to avoid incurring the costs. Our findings, therefore, support the widely documented evidence confirming such cost-avoiding and coping strategies as very important indicators of gaps in financial protection within poor urban settings [11, 52].

Contrary to how it is in rural areas, the literature revealed that short distances to health facilities and cheap transportation be the facilitator to accessing services in urban areas but are usually disrupted by traffic jams especially when a patient is not transported using an ambulance [54]. This implies that UHC reforms, including support for community residents to improve access to transport during healthcare seeking, can facilitate progress towards universal health coverage in urban Tanzania, and within other poor developing countries' settings. Interestingly, most of the reported gaps in financial protection and population coverage are often triggered by access-related gaps in the public health sector. Affordability of medical costs remains the main access barrier to seeking healthcare in urban Tanzania.

In line with earlier studies in Tanzania, supply-side deficiencies, ranging from drug shortages to perceived poor quality of care, were also reported as barriers to accessing healthcare in public facilities [50, 55]. These perceived access-related gaps, especially supply-side deficiencies in the availability of medical products, equipment and facilities, are also frequently reported by studies within other developing countries' settings [56, 57]. However, some studies from Burkina Faso, for instance, revealed that, unlike what has been reported in our study, respondents had relatively good perceptions about the attitude of their healthcare workers [56]. This is probably due to contextual differences between the two health systems or to underlying differences in expectations about what constitutes a good quality of care. In urban Tanzania, these access-related gaps have led to low satisfaction with services provided by public facilities, and hence, a high preference for private facilities, as already reported in previous studies [58]. This further widens gaps in financial protection, since private facilities charge high prices for their services than public ones.

It should be noted that although the community perceived better quality of care at private facilities, in line with what was reported in other studies within developing countries' settings [59], the reality of such facilities providing high standard quality of care may differ substantially. In urban Tanzania, for instance, probably only some private facilities have a better capacity in terms of infrastructure, medical equipment and personnel than most public facilities. Most private facilities that exist in the study area are mainly individual business organizations, with few staff, who cannot handle certain serious medical cases. It is not surprising, therefore, that these private-for-profit providers do not qualify for Service level agreements with the government. The perception of relatively low quality of care at public facilities, therefore, mainly comes from the increased utilization rates in these facilities, which has been induced by the community's desire to access healthcare free of charge or at a low and affordable cost. This has led to frequent shortages of medicines and increased providers' workload, and hence probably less attention spent on clients.

Again, this difference in the quality of care between public and private health facilities borders on health systems governance, specifically the role and capacity of government to regulate private health facilities. Several implications for people-centred universal health coverage policy reforms in Tanzania, and similar developing countries' contexts, can be drawn from our study. The clear illustration of an interrelationship of gaps in universal health coverage implies the need for an integrated and inclusive approach to fill existing gaps

[42]. To move toward UHC in Tanzania, the possibility of an effective public-private partnership needs to be explored, to harness the potential of the private sector to complement the UHC efforts in the public sector [60]. The contracting arrangement under the service level agreements in Tanzania, therefore, offers great prospects for universal financial protection, if its implementation can be strengthened through a governmental commitment to regular payments of bills and expansion to cover all services under the essential health package. Other recommendations on how to strengthen the essential health package outlined by [61] should also be considered.

Given that, in Tanzania, private facilities provide approximately 40% of health services, they are perceived to provide the best quality of care and are located mostly in urban areas [62]. A strategy that effectively integrates both the public and private sectors will be essential for filling gaps in universal health coverage for urban areas. UHC can be achieved to the extent that community residents perceive less difference in cost and quality when seeking healthcare from any type of facility. This could also imply reforms in the purchasing function of the health system, by introducing effective purchasing, storage and distribution systems [34, 63]. This has the potential of reducing geographical inequities in population coverage of public funds, financial protection and access to quality healthcare [11, 37]. The above recommendation, however, needs to be supported by improvement in the quality of services and an expansion of the service provision capacity of the public health sector. However, directly overcoming the access-related gaps in the public health sector is a complex issue, since such gaps are also generally rooted in the low economic development of the country [44]. Insufficient funds to supply enough drugs, train more health professionals and adequately motivate them, provide sufficient health facilities, accommodation for health workers and enough ambulances, is one root cause of the supply side gaps [64, 65, 66].

Given the obstacles to raising additional domestic revenue from the traditional UHC revenue sources (taxes and insurance contributions) within poor settings, overcoming these access-related gaps in urban Tanzania may require economic empowerment, increased external intervention and alternative innovative mechanisms of raising additional revenue for the health sector [11, 65]. The creation of a health telephone levy like in the case of Gabon may be one of the options for additional funds for improving UHC in the country. After all, it has been used to improve other sectors in the country.

VI. CONCLUSION

This study has demonstrated the ability of urban communities to identify and define gaps in universal health coverage through their own experiences and within their local contexts. From the perspective of urban residents, there is a unanimous sense of entitlement to coverage of public funds in Tanzania. However, uneven distribution of public and private facilities, ineffective public-private services level agreements and several shortcomings or gaps in public service provision, has resulted in inequities in effective population coverage, financial protection, and access to quality healthcare services. We recommend that 'people-centred' and 'fault–fixing' approaches be employed in all health-related interventions and reforms implemented toward achieving UHC. These will enable simultaneous implementation of appropriate demand and supply side interventions to tackle the community-defined financial protection gaps in the public sector. Effective health sector reforms need to adopt a bottom-up approach driven by local evidence reflecting context-specific needs. Current UHC reform options being explored in Tanzania need to target filling the specific universal health coverage gaps identified by community residents. Further research is therefore needed to demonstrate the potential of such reforms to fill context-specific gaps.

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