Access to health care and its determinants: The case of older persons in Chivi South district, Zimbabwe.

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Declaration

I, Evelyne Muzvidziwa, candidate 216076132, declare this thesis report as my original work.

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Signed: ----  ---------

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Supervisor: Dr Jayanathan Govender

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Dedication

Firstly, l would like to thank God for opening doors and for his grace in guiding me through my PhD studies.

Secondly, to my darling mom, Ms. Shuvai Muzvidziwa (vamugwadzi), *" **Proverbs 31:25-26,** "Strength and dignity are her clothing, and she laughs at the time to come. She opens her mouth with wisdom, and the teaching of kindness is on her tongue". You are my angel, and I thank God for you every day.*

Lastly, my grandmother (Mbuya Majoni), I know you will celebrate with me; part of me died when you left. Keep resting in power. ***1 Peter 3:4**: "You should be known for the beauty that comes from within, the unfading beauty of a gentle and quiet spirit, which is so precious to God."*

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ABSTRACT

This study investigates the accessibility of health care services by older persons living in rural areas of Chivi South district. Access to health care has remained invisible in the scholarship in third-world countries like Zimbabwe. In this respect, the study explores the lived experiences of rural older persons residing in Chivi South, a research site embedded in political uncertainty and economic quagmire bedeviling Zimbabwe. This qualitative study was anchored on the interpretivist approach. A sample of 10 key informants and 20 older persons participated in key informant and in-depth interviews. This study established four key findings that will contribute immensely to the sociology of ageing in poor-resourced settings such as Zimbabwe. The cultural meaning of illness among older persons is essential in creating *acceptable* healthcare services. The consequences of not making a more enabling and inclusive environment for older persons will have a dire impact on healthcare delivery. Changes in policies that support more preventative health and social care globally instead of a reactive approach, which is wholly unsustainable for today's ever-growing population. In Zimbabwe, older persons are often treated as a homogenous group with similar needs, leading to blanket interventions that overlook individual differences. This has resulted in poorly conceptualized and targeted assistance programs, failing to address local needs. Socially constructed narratives of successful ageing could inform the design of appropriate geriatric policies and programs to transform the healthcare needs of older persons in Zimbabwe. The key findings of the study show that the older persons living in the rural areas of Chivi South district experience challenges such as limited access to economic resources, traveling long distances to access healthcare services, inequalities in the healthcare service delivery system, reduced health status, limited availability, acceptability, and accessibility of healthcare services and *inter alia*. These challenges limit older persons from accessing much-needed healthcare services. The preeminent aim of this study is informed by the theoretical accounts of Penchansky and Thomas (1981) and Giddens (1984). The structures that frame rural healthcare provision ultimately function as key determinants of the nature and scope of healthcare service utilization, which propounded the structuration theory. Based on the subjective narratives of the research participants, the uniqueness of this study is anchored on its ability to offer a sociological foundation for developing innovative interventions and workable public policy options that support the aging population in African rural spaces. The

study showed evidence of how social determinants of health may help reduce disparities in healthcare access for older persons in rural settings. Older persons, especially those residing in poor communities, have unique needs when addressing social health needs. The ageing population in Zimbabwe faces socio-economic predicaments and various challenges in the healthcare sector. It is particularly challenging to manage social connectedness in rural areas because of the issues around accessibility of health care, i.e., physical, financial, and societal barriers, making these multifaceted but crucially critical social determinants of health. Any efforts to improve the health and well-being of older rural persons address rural-urban disparities in healthcare needs and include a focus on the social determinants of health.

Keywords: *accessibility, ageing, healthcare, older persons, policy, rurality, social determinants, Zimbabwe*

List of acronyms

ADL	Active Day Living
AIDS	Acquired Immune Deficiency Syndrome
ATR	African Traditional Religion
AU	Africa Union
CDC	Communicable Disease
CDNC	Chronic Non-Communicable Diseases
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CSD	Chivi South District
DHA	District Health Administrator
ESAP	Economic Structural Adjustment Programme
HAI	Help Age International
HIV	Human Immunodeficiency Virus
ILO	International Labour Organization
IMF	International Monetary Fund
LMIC	Low-Income Countries
MDG	Millennium Development Goal
MHCC	Ministry of Health and Child Care of Zimbabwe
MIPAA	Madrid Plan International on Ageing
NCD	Non-communicable diseases
NGO	Non-Governmental Organization
NSSA	National Social Security Authority
PHC	Primary Health Care
SADC	Southern African Development Community
SAP	Structural Adjustment Program
SDG	Sustainable Development Goals

SDH	Social Determinants of Health
SSA	Sub-Saharan Africa
TB	Tuberculosis
UN	United Nations
UNICEF	United Nations International Children's Emergency Fund
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organisation
ZANU PF	Zimbabwe African National Union-Patriotic Front
ZEPARU	Zimbabwe Economic Policy Analysis and Research Unit

Contents

CHAPTER 1

Introduction to Chapter

In Chapter One, the researcher presents the background of the study, objectives, and critical research questions. The chapter focuses on healthcare access from a global and post-independence (Zimbabwe) perspective. The chapter sets out the paradoxes of access to health care for rural older persons from the international and continental (Africa), policy agendas of healthcare delivery in post-independence Zimbabwe, and how neo-liberal policies and socio-political components have precipitated a healthcare crisis in the already collapsing healthcare sector in the once vibrant 'Jewel of Southern Africa.' In this milieu, the researcher argues that the rural older persons in Chivi South district face many diverse obstacles when attempting to access quality healthcare that should be appropriate, timely, and cost-effective. Oleribe et al.,2019 asserted that geographic isolation, economic instability, provider shortages, fragmentation of care, funding disadvantages, and resource limitations in the healthcare system are hindrances for older persons in terms of accessing healthcare. The two major concerns for the ageing discourse in SSA are the "vulnerability of older persons to detrimental health outcomes," including the high prevalence of NCDs, disabilities, and limited access to health care (Aboderin, 2010; Mulumba et al., 2014).

Older persons with CSD are not an exception regarding the overall challenges the public healthcare system encounters. There are dire consequences if older persons are neglected. They face many challenges, leading to more severe health conditions such as cancer and diabetes, which burden the healthcare system. The lack of access to and availability of healthcare services may lead to unmet healthcare needs and poor healthcare outcomes, particularly for the older population. Older persons start along the path previously traveled by other groups formerly considered 'minorities,' including people with disabilities and women, as they seek recognition and inclusion in issues regarding their healthcare needs. As Watkins et al. (2012) supported, healthcare needs assessment is essential because it leads to agreed priorities and resource allocation to improve health outcomes and reduce inequalities. The failure and total collapse of good governance and the rule of law in Zimbabwe have affected the healthcare sector in Zimbabwe, worsening the plight of various vulnerable groups, including rural older persons.

The economic dilemma and prevailing political crisis are the main deterrent factors that have led to the healthcare enigma in Zimbabwe, particularly in rural settings. This turmoil has further weakened communities and family-level arrangements for caring for and supporting older persons. Healthcare challenges faced by older persons find complementarity in the works of Hosseinpoor et al. (2016), who also argued that the effects of ageing, low economic status, and inadequate access to healthcare contribute to older persons' poor health status. The policy challenges associated with the health of older populations in sub-Saharan Africa (SSA) have intensified in recent years, centering on concern about older persons' vulnerability to ill health and their exclusion from health services. Despite international policy calls and formal expressions of commitment by SSA governments, comprehensive policy action has remained scant (McDaniel & Zimmer, 2013; Aboderin, 2011). This impasse reflects a lack of political will and uncertainty about required policy approaches, engendered by wide gaps in the region's understanding of old age-related health. In this chapter, the researcher highlights the healthcare challenges older rural persons face. Further, the overview and rationale of the study are presented. The statement of the problem, the significance of the study, objectives and key research questions, and the structure of the thesis are also given.

1.1 Background to the Study

Population ageing is a major global trend that affects all countries, albeit at different paces and levels (Dugarova & Gülasan, 2017; World Bank Group, 2016). Ageing as a process comes with many social problems, including health, especially among those living in rural Zimbabwe, mainly older persons. Therefore, there is a dire need to provide older persons with reliable access to comprehensive health care (affordable, appropriate, available, acceptable, and accessible). Concerns that have heightened the vulnerability of older persons emanate from the high risk of ill health and disability from age-related chronic non-communicable diseases (CNCDs). These are often a result of a lifetime of exposure to conditions of deprivation, a growing prevalence of modifiable CNCD risk factors, and the lack of access to essential healthcare services (Abida et al., 2019; Mangundu et al., 2019).

Ageist stereotypes, prejudice, and discrimination are substantive barriers to health equality concerning the quantity and quality of care provided to older patients and their health-related outcomes (Benyamin & Burns, 2020; Wyman et al.,2018). The stereotypes and

discriminatory tendencies against older persons impact the health and well-being of older persons and thereby present barriers to health equality. In Zimbabwe, Older persons face severe challenges, including fragile livelihoods, weak social security support, and poor access to health and care services. Dassah et al., 2018, assert that access to healthcare in rural areas is globally impeded by physical, human, structural, and societal barriers in the healthcare system. Access to quality healthcare for older persons is essential to reducing health inequality. In a study conducted in Zimbabwe, Kidia (2018) opined that healthcare delivery was in a dire state caused by the authoritarian rule of former President Robert Mugabe. The wake of a military intervention resulting in the resignation of the 93-year-old Zimbabwean leader and assumption of office by President Emmerson Mnangagwa was a moment for political and economic reform, but also for those working in the health sector to start the process of rebuilding by effecting meaningful change on the healthcare system that does not depend on donor aid. Zimbabwe has been in a severe crisis, which has seen a once lively and vibrant society failing due to political insecurity, chaos, misgovernment, and economic meltdown. In Zimbabwe, most of the population lives in rural areas with the greatest need for and least access to health services. Against this background, the country's broader economic collapse has brought back hyperinflation, shut factories, pushed the official unemployment rate to an estimated 90%, and seen most of the population sink deeper into poverty. This has further exacerbated the plight of older persons' access to health care.

The Zimbabwean economy has been characterized by a high inflation rate, shortage of foreign currency, inadequate investment, budget deficit, and stagnating unemployment (Mapuva, 2017). Consequently, rural livelihoods historically subsidized by urban wages have become increasingly vulnerable, resulting in untold hardships for ordinary Zimbabweans, especially the vulnerable, including the aged (Muzingili & Gunha, 2017). Accessibility of healthcare in rural areas is globally impeded by physical, material, human, financial, and managerial resources and societal barriers in the healthcare system. A study conducted in Chad by Azétsop and Ochieng (2015) highlighted that the situation is dire in rural areas where the supply of healthcare services is low. Zimbabwe is significantly affected by infrastructural decay and a lack of basic health supplies. According to Loewenson et al. (1991), people in rural Zimbabwe walk between 10 and 50 km to access

the nearest health facility. A report by the International Labor Organization (ILO, 2015) shows that 56 percent of people living in rural areas worldwide do not have access to essential healthcare services, more than double the figure in urban areas, where 22 percent are not covered. The situation is worsened by the lack of health workers in Zimbabwe's rural areas compared to urban areas (Mangundu, 2020; Chikanda, 2006). Of concern were the rural health facilities that were operated by only one or two nurses (18 out of 45 [40%]), which does not meet the minimum standard of three nurses, as determined by the Ministry of Health and Child Care's policy (ZimStats, 2015). This will also contribute to inadequate time to attend to the patients.

The hyper-inflationary environment experienced in Zimbabwe during 2000–2010 eroded the savings of older persons and pensions, which comprised their social security. Low access to healthcare and social security (pension, social grants, and insurance) for older persons and the unavailability of medicines for chronic non-communicable diseases at public health facilities in Zimbabwe increased health-related expenditure among older persons (WHO, 2017). This challenging environment, combined with poor budgetary allocations in the healthcare system, strains various groups, including older persons, consequently pushing them into poverty and poor health. A country's spatial inequality in health conditions (state of people's health and health services) can create social, economic, and political problems in that country and other countries, especially neighbouring countries. Access to health services is a critical factor in the human development of any country (Kruk et al., 2018). The rise of inequalities among and within countries negatively affects access to health care. Older persons in Zimbabwe face severe challenges, including fragile livelihoods, weak social security support, and poor access to health and care services.

1.2 Understanding the Paradox of Healthcare access for Rural Older Persons: A global perspective

The United Nations (UN) (2015) observed that the global population of older persons would have doubled from 542 million in 1995 to about 1. 2 billion in 2025. In addition, HelpAge International, cited in Ndabeni et al. (2014), validated this view, contending that older persons over 65 will outnumber children under 14 by 2045. According to Boudoulas et al. (2017), life expectancy has generally increased due to developments in the medical

field, research, and technology attributed to medical advances. The rise in the number of older persons in developing countries increases the burden of providing social services, including healthcare services., Access to and use healthcare services is a global problem affecting developed and developing countries.

Population ageing can no longer be ignored as it is associated with severe implications for the strained healthcare systems in most parts of the world. For example, underfunding and lack of policies to support the ageing population culminate in poor health outcomes among older persons. Older persons live significantly longer in most parts of the world than in previous decades (UN,2019). The 21st century is witnessing a rapid demographic change due to a worldwide increase in people aged 65 and above (Leeson, 2018; Chun & Tung, 2014). In the modernization process, improved food security, nutrition, and public health advances in medical technology and socioeconomic development. According to the UN world population ageing report in 2019, the decline in fertility has increased human longevity, resulting in ageing populations in developed and less developed countries (Robine, 2018; Kinsella & Phillips, 2005).

Rural older persons have less access to healthcare services because of their geographical location, which is also aggravated by poor socio-economic conditions. This puts them at a disadvantage compared to urban dwellers, making it difficult for older persons with reduced mobility and limited access to healthcare services (ILO, 2015). In Zimbabwe, there are more older persons in rural areas where health facilities are limited compared to the urban areas where there are more facilities where there are few older persons; that disequilibrium creates inequality. Where healthcare is accessible, older persons, particularly those in developing countries, are often exposed to healthcare professionals with little knowledge of their distinct health issues and healthcare services that are not age-appropriate (UN, 2015). Older persons are often affected by chronic diseases and disabilities; hence, they would require access to and utilization of healthcare services and facilities. By 2015, Zimbabwe had 1.25 nurses per 1000 population, far below the global median of 2.84, translating to three nurses per 1000, which indicates a critical shortage that needed immediate resolution to enhance the accessibility of healthcare. It is particularly worrying that the government has performed so little to address these shortages, which makes it impossible to provide adequate healthcare to people (Roets et al., 2020).

Older persons face declining health and age-based disabilities caused or exacerbated by external factors such as limited access to appropriate and affordable healthcare and unhealthy lifestyles throughout their life course. One crucial determinant of health seeking among rural older persons is the accessibility of medical care and barriers to care that may develop because of location, financial requirements, bureaucratic responses to the patient, and social distance between client and provider (Chinyakata & Raselekoane, 2021). In rural areas, low literacy levels can be a significant obstacle preventing older persons from identifying health problems. Access to primary healthcare is central to the performance of healthcare systems worldwide. The importance of service delivery for people has resulted in the measurement of utilization and access having a prominent role in the health policy literature (Kruk, 2018; Levesque et al., 2013). Understanding the healthcare decision-making process and identifying determinants of the healthcare behaviour of older persons is essential for guiding policy aimed at creating or improving healthcare services for this group.

1.3 Challenges in Accessing Healthcare by Older Persons in Africa

Access to healthcare for older persons in Africa is a dilemma that needs to be addressed, and there is a need to check the capacity, resources, and political will to improve the lives of older persons, especially those who reside in rural areas. According to a 2017 UN report on population ageing, Africa's older persons population is expected to grow faster than in any other region globally. The continent's population aged 65 and above is projected to increase more than threefold between 2017 and 2050, from 69 to 225 million (UN, 2017). For example, in Malawi, Rwanda, Uganda, and Zimbabwe, the report anticipated that older populations would quadruple by 2050. Some African countries, such as Nigeria, Ethiopia, and Congo (World Bank, 2019), which have the largest population in Sub-Saharan Africa, do not have functional policies focused on older persons. Nevertheless, even when countries have policies focused on older populations, the lack of coordination between government agencies and insufficient budgets makes implementing those policies challenging. African countries are also struggling with political and social unrest and environmental-related issues, leading to a lack of robust data and slow implementation of healthcare policies (Azevedo, 2017). Access to healthcare remains a significant concern for most older persons (Fulmer et al.,2021). A process-driven approach to care cannot fully

meet the complicated health requirements of older persons. Furthermore, some older persons never had formal employment and consequently have no social security and pension access. Research has shown rural and urban healthcare service utilization to be similar, and rural and urban populations are similarly satisfied with access.

1.4 Healthcare in SSA Africa

According to a UN report 2015, there were 46 million people aged 65 and above in SSA. The UNDESA observes that the world's population is ageing rapidly, mainly in low-income countries, including Africa (UN,2015). Based on the above, Van Rooy et al. (2015) argued that all countries must deal with aspects of an ageing population. Similarly, Dhemba (2015) posits that Lesotho and Zimbabwe have the most significant number of older persons in the Southern African region. In SSA, the healthcare systems are poorly developed and always overstretched in capacity, the proximity of healthcare facilities, availability of drugs, qualified personnel, and disengaged healthcare services for older persons.

Financial costs are among the most critical barriers affecting poor people's access to healthcare. However, access to healthcare is complex because barriers can comprise a delay in the decision to seek care, a delay in reaching an adequate facility, and a delay in receiving care once at the facility (Thaddeus & Maine, 1994). Access to appropriate healthcare remains a significant concern for most of the ageing population in SSA. Older persons spend more per capita on healthcare than others in low- and middle-income countries and use far more healthcare services than younger groups. Although older adults vary significantly in health status, most have at least one chronic condition requiring care. Older persons also vary in their demographic characteristics, which leads to differences in their demand for and utilization of health services. This culminates in a heavy burden linked to user fee policies and higher levels of unmet need for health care (Masiye et al.,2016; Lagarde & Palmer, 2008). However, user fee exemption alone does not eliminate barriers to poor service access; a comprehensive protection package should reduce out-of-pocket payments and indirect costs.

Older persons in SSA usually retire in rural areas, characterized by poor infrastructures and acute problems of essential healthcare service provision (Kimokoti & Hamer, 2008; Okojie, 1988). Access to and use of health services are also related to socio-economic conditions in

later life. Poor access to healthcare is one of the significant impediments to balanced growth in rural communities worldwide. An assessment by Oleribe et al. (2019) indicated that in rural areas, a lack of access to skilled service providers or human resources for health and financial obstacles mainly prevent critical health services from being accessed and adequately delivered to those who need them the most. This results in hampered health outcomes. Africa faces significant challenges in healthcare financing. The ability of governments to allocate and sustain financial accessibility to their health systems highlights some strategies for facilitating access to health care, especially in developing countries. Although the population of older persons in Africa is increasing and becoming increasingly vulnerable due to urbanization, breakdown of family structures, and rising healthcare costs, most African countries have no social health protection for older persons (Pillay & Maharaj, 2012). The lack of robust healthcare systems shifts the economic burden on family members.

As the population increases, the demand for health services also increases (Lange & Vollmer, 2017); older persons need more resources to meet their needs. Older persons are believed to lack access to even primary healthcare and, crucially, to have less access to services than younger age groups, suggesting an element of age-related exclusion. Many older persons spend additional years coping with more outstanding chronic health issues that necessitate attentive care from their medical professionals. Older persons are marginalized by the lack of influence over public policy and public provision, compared with those of working age, which follows from the status accorded them by the "discourse of age" (Walsh et al.,2017; Kelly et al.,2019). Because of this, older persons receive a disproportionate share of the healthcare services provided. The care of today's older persons is particularly challenging due to the wide range of physical and mental disorders prevalent among them and the wide range of care facilities where they receive services.

Studies suggest that older populations are more likely to experience malnutrition, chronic, physical, and mental conditions, hearing and sight difficulties, depression, and dementia (Fávaro-Moreira et al.,2016; Aboderin, 2010). As an illustration, studies conducted in Kenya and South Africa identified that lack of income, the absence of family support, physical inaccessibility of health service providers, and practicing quacks are the significant factors deterring older persons from seeking healthcare services (Ladha et al., 2009; Paxton,

2008). In the countries mentioned above, the under-utilization of health services in the public sector has been a universal phenomenon (Nteta et al., 2015). Moreover, significant challenges affect African rural areas, such as lack of healthcare service facilities and transport. This argument is informed by Naher et al. (2020), noting that the sick are carried on the backs of young men or bicycles to the nearest clinic. Maphumulo & Bhengu (2019) argued that in cases where clinics are available, there is often a lack of adequate equipment or trained health personnel, coupled with demand for payment before providing services, all constrain the health of older persons. Healthcare access and utilization are of significant interest to rural development because they are vital elements of well-being and components of human capital (Titus, 2015). Without health insurance, rural people often cannot afford primary healthcare; lack of financial protection may lead to or deepen poverty, undermine health, and exacerbate health and socioeconomic inequalities among poor and vulnerable groups such as older persons.

1.5 Accessibility Challenges in Zimbabwe

Accessibility of healthcare in rural areas is globally impeded by physical, material, human, financial, managerial resources, and societal barriers in the healthcare system. Developing countries like Zimbabwe are significantly affected (Roets et al., 2020). A study conducted by Mangundu (2020) ascertained that access to healthcare services in rural Zimbabwe is further impeded by a lack of infrastructure that includes dirty roads that are not maintained and infested with potholes, creating barriers to transport. Economic challenges also compound it. These bridges have collapsed because heavy rains are not repaired, hindering the traveling of patients during critical times and negatively affecting the timely delivery of medical supplies to rural healthcare centers. Older persons in CSD, Zimbabwe, lack access to health care. One of the many factors contributing to this challenge is the lack of physical infrastructure, a significant deterrent to providing comfort to the aged. Most older persons, especially in rural areas, belong to the poorest and most vulnerable groups. Their capacity to satisfy their basic needs decreases as age increases. Older persons need better access to physical infrastructure, both in their own homes and in public spaces.

Health policy in Zimbabwe stipulates that there should be a clinic within an 8km radius. However, places like the resettlement areas established after the 2000 land reform programme do not have health facilities, and people travel more than 20km to access

healthcare (Ministry of Health and Child Care, MoHCC, 2017). The country's Constitution states that every citizen has the right to access essential healthcare services (Constitution of Zimbabwe Amendment (4:76) Act, 2013 Zimbabwe). On the contrary, people living in rural areas struggle to access healthcare services. The lack of investment in health is reflected in the limited availability, accessibility, affordability, and adequacy of health services, especially in rural areas (Oleribe et al.,2019). There is a need to explore older persons' perceptions regarding access to healthcare in rural areas using the case of CSD. This problem is worthy of study because the inability to access healthcare services is directly related to poor health outcomes.

1.6 Healthcare Delivery System in Zimbabwe

In Zimbabwe, the public health system is the largest provider of healthcare services, complemented by mission hospitals and healthcare delivered by non-governmental organizations (NGOs) (Mhike & Makombe, 2018). These two entities are in place to plug the gaps in financing, infrastructure development, and other critical needs in health care provision, which the government cannot address. In recent years, economic decline and political instability have reduced healthcare budgets, affecting healthcare services at all levels. The country's poorest have suffered the most in the past five years, with a 40 percent drop in health care coverage (UN, 2019a). Zimbabwe has poor and unequal health conditions regarding people's health and health services. The country's health system is facing severe challenges, including spatial inequalities as well as overall poor conditions of health service delivery (Mutizwa-Mangiza, 2018).

According to Isbell & Kronke (2018), the first decade of redistributive policies in Zimbabwe witnessed improvements in access to health and education by the previously marginalized Black majority and marked improvement in resource allocation. Since early 2000, Zimbabwe has been going through a severe economic recession that has impacted the population's health and operations of the health sector. The level and quality of healthcare delivery have been drastically affected by broader economic and political conditions. A profile of Zimbabwe's health sector shows that Zimbabwe's public health sector performance was reasonable before implementing Structural Adjustment Programmes (SAPs) (1980 to 1990). Based on its socialist-driven ideology at independence (1980), the

government designed programmes and policies targeting expanding healthcare to the Black population that constituted the majority in the country. Examples include the free health for all policy, rehabilitating and expanding rural health centres (which increased by 58% from 1980 to 1985), Zimbabwe Expanded Programme on Immunization (1981), declaration of diarrheal disease control as a national priority in 1982, Children's Supplementary Feeding Programme, National Village Health Worker Programme (1981), Traditional Midwives Programme (1981) and the Zimbabwe National Family Planning Programme (1981) among other programmes and policies (Dashwood, 1996).

The deterioration of Zimbabwe's healthcare services coincided with a decline in demand for health services after introducing a system of user fees (Mhazo & Maponga, 2022). For many Zimbabweans, especially the most vulnerable, user fees are a barrier to healthcare services, while wealthy Zimbabweans can seek treatment in private clinics or neighbouring countries. Healthcare providers face challenges in implementing government policy for free-of-charge health services for pregnant and lactating mothers, children under five, and those over 60 without substantial financial support (Hatt et al., 2013). Therefore, the Zimbabwean healthcare system is now heavily dependent on donor funding. This challenging environment, combined with the lack of support, strains various groups of society, including older persons, leaving their health care unmet. Non-state actors are increasingly filling this void but are constrained by inadequate resources to provide meaningful social support.

Zimbabwe instituted primary healthcare (PHC) systems and developed a pyramidal referral model to support the primary care level (Sanders et al.,1998). Clinics and district hospitals were intended to provide local services for uncomplicated cases, referring patients with more severe conditions to regional/provincial and central hospitals. Firstly, patients will usually utilize the healthcare center that is nearest to them, mainly if alternative and more appropriate sources of care are not available. Limited resource availability impedes appropriate utilization and referral patterns (Dassah,2018). The absence of specialist health services in Masvingo province (which has the largest hospital facility that serves districts such as Chivi South) because of the institution's dilapidated infrastructure and equipment, most patients are at the mercy of private healthcare facilities and must fork out hefty dollar-denominated fees for even essential services. The inappropriate effectiveness and

availability of referral facilities will remain a problem until quality accessible (and affordable) primary and secondary level care is available close to the rural areas. Poor healthcare access impedes global balanced growth in rural communities (International Fund for Agricultural Development (IFAD) Report, 2016).

1.7 The Plight of Older Persons in Rural Areas – "The Forgotten Group."

Health issues affecting older persons in rural areas are under-researched. Pertinent knowledge about factors relating to healthcare challenges is required to influence policy change. The standard narrative of considering older persons as a burden to the pension, medical, and socio-economic system must be debunked. Zimbabwe was one of the few countries in SSA to have a pension system or social welfare policy, a significant source of sustainment for older persons. However, the economic downturn in Zimbabwe has made older persons worse off than the past generation because healthcare is scarce, the family fabric has been eroded, and there is no social welfare to cater to their needs. Economic change, new social and political control forms, and new religions have eroded older persons' dominant economic position. In the face of poverty and pandemics, changing family structures within the Zimbabwean context has eroded the social net for older persons who rely on their families to look after them.

African countries, Zimbabwe included, are affected by a wide range of economic, social, and political problems, extreme disempowering and debilitating chronic poverty, the effects of economic structural adjustment programmes, and massive unemployment (Thomas et al.,2017). The care for older persons primarily relies on family members; however, with inconsistencies in job security in Zimbabwe, the care quality is poor and unsustainable. Traditionally, the extended family system was responsible for providing social support and care to its members. However, migration, modernization, and urbanization have diminished kin support for older persons (Dhlamini-Sibanda et al., 2017). The lack of social protection and social investment in Zimbabwe has a devastating impact on improving health and further widens the health inequalities gap, especially in the aging population. In an ideal economy, the government should provide grants to senior citizens. However, in Zimbabwe, it has been challenging to provide this safety net to the senior citizens, and they have been forced by the situation to fend for themselves. Given that their abilities are now

compromised due to age, it is difficult for older persons in Zimbabwe to make ends meet (Ministry of Local Government, Public Works and National Housing, 2015).

According to HelpAge International (2020), the older persons population (aged 65 and over) in Zimbabwe increased from 253.13 thousand persons in 1971 to 688.43 thousand persons in 2020, growing at an average annual rate of 2.07%. As such, in numbers, it makes 760,000 older persons, with 80% of them living in abject poverty, according to statistics from the Zimbabwe Statistics Agency (ZIMSTAT) (2021). Most older persons are not counted as they are found in remote parts of the country, where they hardly receive government and non-governmental organizations' aid. Poverty among older persons contributes to homelessness, malnutrition, unattended chronic diseases, lack of access to safe drinking water and sanitation, unaffordable medicines and treatments, and income insecurity. Even though the older persons population has had legal cover since 2012, it has hardly been implemented due to the poor economic status of Zimbabwe. In 2012, Zimbabwe approved the Older Persons Act, which called for granting allowance and other social welfare benefits to the country's aging population. Nevertheless, as the country's poverty levels surge alarmingly, its operation remains a mirage (Dhemba,2013). The lack of implementation of the Older Persons Act was also reflected in the findings of Makinde (2005: 65), whose study in Nigeria established that in developing countries, most policies fail at the implementation stage because policymakers pay little attention to implementation.

The World Health Organization's (WHO) global strategy and action plan on ageing and health highlighted the challenges most countries face in responding to the long-term care of their ageing populations (WHO, 2016). This WHO action plan will work depending on each country's context, available resources, and societal choices about the distribution of the overall care costs for older persons. In Zimbabwe, the plan is not feasible as the government is struggling to meet the basic demands and needs of the citizens. The debate of the WHO action plan on the ageing population has been largely absent in Zimbabwe's economic and political arenas, further derailing universal healthcare coverage and the protection of older persons. A strong, coordinated global response is vital in mitigating the older persons' devastating social and economic consequences.

1.8 The "Ghost" of Economic Structural Adjustment Programme and Healthcare Delivery in Zimbabwe

In 1991, Zimbabwe adopted the economic structural adjustment programme (ESAP) under the auspices of the World Bank (Government of Zimbabwe, 1990). As elsewhere, this package of economic reforms included reduced social expenditure, currency devaluation, and trade liberalization. In the health sector, the collection of user fees was introduced, and in 1993-1994, fees were increased (Bijlmakers et al., 1995). Contrary to World Bank claims, social expenditure in Zimbabwe has not succeeded in shielding people with low incomes from adjustment. Indeed, poor people have disproportionately borne the burden of adjustment in terms of falling real incomes and reduced access to health (Lennock, 1994). When Zimbabwe became independent in 1980, the government inherited a fragmented health service, which was urban-centered and focused on curative services (Chinemana & Sanders, 1993; Loewenson et al., 1991). Post-independence policies were designed to ensure more significant equity in access to health services and to strengthen preventive services. At independence, government facilities were accessible to 90% of the population.

The Economic Structural Adjustment Programme (ESAP) was a neo-liberal market-driven policy measure adopted as a prescriptive solution to the economic crises of the 1980s (Zhou & Zvoushe, 2012). Although the neo-liberalists favour the International Monetary Fund (IMF) and World Bank (WB) reform packages, SAPs were, to a more significant extent, disastrous in the different sectors of the economy ranging from people's lives, health, education, agriculture, and the macro and micro economy in Zimbabwe. The adoption of ESAPs in 1991 presented a change in public health policies. Streamlining of public sector employees, privatization, user fees, and reduction of the public health grant were rolled in as driving forces of ESAP. The government's stricter enforcement of a user fee system erected barriers to healthcare in the way of poorer social groups who were, typically, those most in need of health services.

The introduction of ESAP in Zimbabwe came with conditionalities that affected the public health grant, leading to a reduction of subsidies, a decline in the drug budget, reduced maintenance, a reduction of salaries and incentives for health personnel as well as cuts in expenditure for public health programmes (Nyambuya,1994). It also affected the affordability and accessibility of health care by the poor, high medical costs, increased

circulation of unprescribed drugs, and brain drain. Over the years, however, there have been clear indications of growing inequities in health provision and healthcare because of ESAP. Before the economic meltdown that started after introducing economic policies such as ESAP and the Zimbabwe Programme for Economic and Social Transformation (ZIMPREST), the government used to provide 65% of healthcare services and is now struggling to fund the health system. Instead, health services have been privatized, making it even worse for low-income people, especially those in rural areas, to access health services. In rural settings, older persons are particularly disadvantaged by such reforms due to their increased healthcare needs.

1.9 The '*Zanufication'* of Healthcare Delivery in Zimbabwe: The Era of Robert Mugabe

In 2008, Physicians for Human Rights witnessed the utter collapse of Zimbabwe's health system, once a model in Southern Africa. A report entitled *Health in Ruins: PHR Reports on the Man-Made Health Crisis in Zimbabwe* in 2009 called into question the legitimacy of a regime that abrogated the most basic state functions in protecting the population's health (Physicians for Human Rights, 2009). As the report documents, the Robert Mugabe regime had used any means, including politicizing the health sector, to maintain its hold on power. Instead of fulfilling its obligation to progressively realize the right to health for the people of Zimbabwe, the Government has taken the country backward, enabling the destruction of health, water, and sanitation services (Kidia, 2018). Zimbabwe's political, economic, and human crisis has been well documented in the world's media (Tshabangu, 2019). While the relentless targeting of President Robert Mugabe's opponents is well known, less understood is the effect of the political turmoil on the health of all Zimbabweans and the ability of the government to maintain its healthcare services. The collapse of health systems in Zimbabwe is more shocking given the fact that, at one time, the country had an effective, functioning, and well-funded healthcare system (Kidia, 2018; Meldrum, 2008).

According to Kidia (2018), 65 percent of the severe social and economic challenges since the Mugabe era have resulted in an unprecedented deterioration of healthcare infrastructure, loss of experienced health sector personnel, and a drastic decline in the quality of health services available to the population. The people's right to health was compromised by the

state of the economy in 2008. Health service delivery was also crippled by corruption, such as the theft of drugs and equipment from hospitals and hospital officials' flouting of tender processes for personal gain (Bonga et al.,2015). The government of Robert Mugabe presided over the dramatic reversal of its population's access to food, clean water, basic sanitation, and health care. The available funds used by the ruling party had gone to finance security apparatus like the army and police, deploying them to consolidate ZANU PF's hold on power instead of prioritizing healthcare (Gain, 2015).

Against a backdrop of access to healthcare has become difficult for older persons because they are vulnerable and cannot walk long distances. They lack the financial resources to seek healthcare. Older persons in rural areas are the worst affected by the economic decline because these are low-income areas. This is where the ruling ZANU PF's election campaigns are concentrated, with youth militia controlling the activities in the rural areas because they do not want them to be influenced by opposition politics. This has resulted in restricted donor activities, which worsens the health crisis since the healthcare system is dominated by donor support. The alarming increase in infectious diseases results from economic hardship and the government's deliberate policy decisions to support the military and secret police at the expense of the healthcare sector (Mugumbate & Nyoni, 2018). The healthcare system, like most public services, collapsed under the rule of former President Robert Mugabe.

Since 2000, Zimbabwe has failed to provide an efficient and effective basic healthcare system (Nhapi, 2019). According to a report by the Zimbabwe Human Rights Forum in 2009, a myriad of factors caused by poor governance and the collapsed economy has manifested in the flight of qualified health workers, poor remuneration, insufficient funds for the Ministry of Health and Child Care to run health programmes, lack of drugs in health institutions, poor water and sanitation facilities right across the country and expensive, unaffordable health care (Azevedo, 2017). All these problems culminated in various crises, such as the cholera epidemic in 2008, the partial or complete closure of central referral and district hospitals, and the general collapse of the health delivery system.

1.10 Healthcare Expenditure in Zimbabwe

Before 2009, Zimbabwe's health system had been severely weakened by the protracted effects of HIV and AIDS, the out-migration of skilled personnel, and a lengthy economic crisis (Haley et al.,2017). There was a sharp decline in key indicators such as coverage of primary healthcare interventions and health outcomes (Hutton, 2008). The increasing burden of treatment, care, and support arising from both communicable and non-communicable diseases weighed heavily on the public health system and communities in general (World Bank, 2015). There is also growing evidence of a significant share of the urban poor population's poor health status and limited access to care. For example, in its 2014 budget, the government allocated too little to the health sector. The MoHCC was allocated US$330 million (down from US$407 million in 2013), which amounted to 8% of the 2014 budget, while public hospitals were given US$25 million for operations even though, by January of 2014, they owed various suppliers an estimated $33 million (ZEPARU, 2015). The country's deepening economic crisis severely affected public health delivery in general and poor people's access to health care as the government could no longer sustain the user fee waiver for adults over 65 years.

With billions of American dollars of domestic debt and millions more in stolen public funds, Zimbabwe has recently relied on funding agencies to support healthcare services (Azevedo, 2017). USAID invested nearly US$100 million annually in Zimbabwe to support healthcare programmes that treat and prevent diseases and help make healthcare services more accessible to families. In 2001, African countries met in Abuja, Nigeria, to commit at least 15% of their national budgets to the health sector in what became known as the Abuja Declaration (WHO, 2001). The idea behind the Abuja declaration was to reduce unsustainable donor dependency and reliance by African countries in the healthcare sector and to scale up domestic resource mobilization for self-funding. However, Zimbabwe has not fulfilled the promise because of significant corruption in public procurement and poor government planning.

Contrary to the commitment made during the Abuja Declaration of 2001, the Minister of Finance and Economic Development, Mthuli Ncube, presented the country's 2022 national budget to the Parliament of Zimbabwe (Zimbabwe Institute for Democracy 2021). However, as was the case in previous budgeting years (2018 [8.9 %]; 2020 [10.8 %]), the

2021 national budget did not reflect the recommended 15% of the national budget to the health sector. Instead, the health sector allocation was 12.7% of the total ZWL$ 927.3 billion (US$2.5 billion). Zimbabwe's healthcare system remains dilapidated mainly due to misgovernance and skyrocketing inflation (Mutizwa-Mangiza, 2018; Shumba et al., 2020). Hence, there is a need to boost government spending on rural health centres to avoid dependence on donor financing and to cater to over 70% of Zimbabwe's population that lives in rural areas (UNICEF, 2020).

1.11 International, Regional, and Local Policy Agendas on Health Care Relevant to Older Persons

This section focuses on international, regional, and local healthcare policies for older persons. Globally, the UN has mainstreamed aging through policies and conventions, including The United Nations Principles for Older Persons adopted by the UN General Assembly (Resolution 46/91) on 16 December, 1991. WHO, Member States and Partners develop Global Strategy for Ageing and Health 2016-2020 and The Decade of Healthy Ageing 2020-2030. African countries have also created policies for old age throughout the AU, the African Union Regional Policy Framework and Plan of Action on Ageing 2003 (AU-Plan), calling on governments to forge policy action to promote older persons' health and advance well-being in old age. Additionally, the African Union (AU) Protocol on Older Persons' Human Rights in Africa makes recommendations for member states to enhance the delivery of social services among older persons. Zimbabwe has laws governing older people's rights and social protection, even though it has not ratified the AU treaty. The Older Persons Act [Chapter 17:12] of 2012 and the Social Welfare Assistance Act [Chapter 17:06] of 1988, among other pieces of law, and Sections 21 and 82 of Zimbabwe's national Constitution Amendment No. 20 of 2013 clearly state these rights. Zimbabwe has thus developed a climate conducive to all stakeholders, including the government and non-governmental organizations (NGOs), taking part in delivering services for older persons. The section also discusses Aging policies in Zimbabwe since these are the backbone of understanding healthcare issues in the study area. Of note is the legislation, which includes social security and free healthcare plans (MHCC, 2017).

1.11.1 International Policy

The MIPPAA's agenda focuses on three priority areas: older persons and development, advancing health and well-being into old age, and ensuring enabling and supportive environments (UN,2002). It was agreed among 159 governments but was not legally binding, and its implementation was voluntary (HelpAge International, 2012). Policies and agendas for the care of and access to healthcare by older persons have become essential to address the issues of exclusion and vulnerability of this population group. According to a United Nations Development Programme report (UNDP, 2015), policy implementations and the new agenda must go beyond treating older persons as vulnerable. Older persons must be recognized as active agents of societal development to achieve transformative, inclusive, and sustainable development outcomes. Population ageing is a major global trend that affects all countries, albeit at different paces and levels (Dugarova & Gülasan, 2017; World Bank, 2016). Therefore, fundamental policy and attitudinal shifts on ageing and old age are needed to reflect and promote the contributions of older persons to society. Instead of focusing on the negative aspects of ageing, public debates, and policies must promote older persons and their agency as a solution to many development challenges.

1.11.2 Regional Policy Imperatives

Cognisant that Africa is not a region but a continent, this section focuses on Africa. In this regard, the region adopted the AU-Plan on ageing. Article 15 of the AU-Plan on access to healthcare states that state parties shall guarantee the rights of Older Persons to access health services that meet their specific needs, take reasonable measures to facilitate access to health services and medical insurance coverage for Older Persons within available resources; and ensure the inclusion of geriatrics and gerontology in the training of healthcare personnel (Saka et al., 2019). They share the same trajectory, but when it comes to policies and agendas, it is not a one-size-fits-all. Countries in Africa are going through rapid demographic, economic, and social transitions and represent cultural and geographical contexts. These frameworks, to which all SSA countries are (plural) signatories, emphasize a need for measures to advance health service provision and training to ensure practical, fully accessible prevention, control and management and disability care for age-related NCD (UN, 2002; AU/HAI, 2003). Motivated by MIPAA and the AU Plan, several SSA nations have formulated policies on the health of older persons and age-related NCDs.

There is a lack of insight into specific strategies formulated, approved, or executed across countries.

Existing social services, healthcare in particular, primarily do not cater explicitly to the needs of older persons (Aboderin, 2008a; McIntyre, 2004; WHO, 2006), and only a handful of countries operate a formal, old-age social security system (Botswana, Lesotho, Mauritius, Namibia, Senegal, and South Africa). A poignant example of a lack of social provision is the widespread exclusion of older persons from humanitarian responses in emergencies, such as Darfur (Bramucci & Erb, 2007). The central argument that underpins the unsuccessful implementation of these frameworks is that tiny effective policy action has ensued, with SSA health systems remaining largely inaccessible and unresponsive to older persons and age-related NCDs. Furthermore, there is a dearth of systematic information across countries regarding the nature and specific shortcomings of health service provision and the key impediments to effective policy action. This argument was further purported by Aboderin (2015), who outlined a lack of conviction and action in old age-related healthcare where there is a myriad of public health and development challenges, such as legislation and budgetary constraints. Additionally, the African region still faces acute resource constraints such as persisting infectious and rising chronic diseases financial, medical, and human capacity.

1.11.3 The Local Context: Healthcare Policies for Older Persons in Zimbabwe

According to Chapter 17, Section 11 of the Constitution of Zimbabwe is committed to providing social protection to its senior citizens (Constitution of Zimbabwe, 2013). This has been demonstrated by signing different treaties and human rights declarations. Zimbabwe adopted the Principles for Older Persons, Resolution 46/91 by the UN General Assembly in 1991, and the Madrid International Plan on Ageing of 2002. In both cases, member states must provide social protection to older persons. Article 22 of the United Nations Declaration of Human Rights of 10 December 1948, which Zimbabwe is also a signatory, attests to the right of all citizens, including older persons, to social protection. The Act has not been implemented due to a lack of funding (Kidia, 2018). Section 82 (c) of the constitution of Zimbabwe specifically states that the ‘State must take reasonable legislative and other measures within the limits of the available resources to it, to achieve the progressive realization of medical rights of people over the age of 65. Health facilities are

not aligned with the Constitution of Zimbabwe, which entails the right to healthcare for all citizens. It also provides that every citizen of Zimbabwe has the right to access essential healthcare services.

The Public Healthcare Bill was gazetted on the 1st of December 2017, replacing the outdated Public Health Act enacted in 1924 as there have been changes in disease patterns, epidemiology, and other health models (Phiri, 2017). It was gazette on the 1st of January 2018. The Act seeks to provide for the rights, duties, powers, and functions of all parties in the public health system, to provide measures for the administration of public health, to repeal the Public Health Act (Chapter15:09), and to improve the health sector, quality of life, and healthcare for all people in Zimbabwe. According to health experts, the Public Health Act made it difficult to effectively respond to some diseases as the Act did not recognize them. The Public Health Act was also not to date with HIV and AIDS and non-communicable diseases (NCDs) that have become a menace in the health sector.

Despite adopting various resolutions as those described above, there has been little government budgetary allocation to implement the Public Health Act due to the fiscal constraints faced by the country (Dhemba, 2015). Implementing government policy to provide free medical services to people older than 65 has proved challenging. This is exacerbated by the deterioration of healthcare provision in Zimbabwe, with a fall in demand for service following the introduction of user fees, which came into effect in 1992 following the introduction of ESAP (Health Transition, 2013). This was a barrier to essential services for vulnerable populations such as children and older persons. These fees, often applied ad hoc, vary from provider to provider (Health Transition, 2016). Demographic trends show that in developing countries, most older persons live in rural areas (ZimStats, 2019). Therefore, the need to conduct research focusing on this population is a worthwhile endeavor. The healthcare system can barely meet the population's needs due to a lack of investment and the increasing burden of CDs and NCDs, including HIV and AIDS (Help Age Zimbabwe, 2016). Help Age International (2016) reported that older persons in Zimbabwe are affected mainly by NCDs, such as hypertension and other cardiovascular diseases, diabetes, cancer, general body pains (especially arthritis), urine and fecal incontinence, and eye and hearing problems. The ageing population will increase the

disease burden related to chronic and multiple chronic conditions, increasing healthcare and health budget demands.

Before 2009, Zimbabwe's health system was severely weakened by the protracted effects of HIV and AIDS, the out-migration of skilled personnel, and a lengthy economic crisis (Chevo & Batasara, 2011). There was a sharp decline in key indicators such as coverage of primary healthcare interventions and health outcomes (Gregson et al., 2010). The increasing burden of treatment, care, and support arising from CDs and NCDs weighed heavily on the general public health system and communities (World Bank, 2015). Like other developing countries, Zimbabwe faces disparities in health outcomes based on socioeconomic status. There is also growing evidence that a significant share of the urban poor population has poor health status and limited access to care Kuddus et al.,2020).

Health policies for older persons in developing countries hardly feature in most global health policy debates and forums (Rhanabat et al., 2019). Current health programmes seem to focus more on youth, women of bearing age, infants, and adolescents; all these programmes exclude older persons' health issues. For example, the MoHCC and NGOs in Zimbabwe do not often have programmes that cater to the needs of older persons. Unlike children, youth, and women who were given a high profile in the Millennium Development Goals (MDGs) (now Sustainable Development Goals [SDGs]) agenda, older persons are not targeted as a specific group in terms of healthcare services provision and utilization, thereby depriving them of vital ageing information which could help them to make critical health decisions. With ageing and health-related issues not being highlighted by governments, international bodies, and the media, the likelihood of reducing health inequalities associated with older persons is low.

The Government of Zimbabwe restructured its policies to adhere to the conditionalities tied to SAPs, including removing state subsidies to cut expenditure. Hence, it could not subsidize the healthcare sector (Bond & Manyanya, 2002). Moreover, it had to prioritize programmes that only focused on reproductive and maternal care. The limited resources have led to minimal facilities offering essential health services from the state sector and NGOs, few of which address the healthcare needs of older persons. There is a need for further monitoring and evaluation to inform the health system's response to the needs of

older persons, the promotion of self-management and ageing in community settings, and more education and training in geriatric care and gerontology.

1.12 Problem Statement

This study seeks to bridge the research gap in understanding issues affecting older persons' health and raising awareness for possible policy intervention. Several scholars provided an in-depth analysis of rural older persons' availability and challenges in accessing healthcare services (Chigudu, 2019; Dhemba, 2015; Mugwagwa et al., 2017; Taruvinga & Gozho, 2015). There are many factors contributing to Zimbabwe's healthcare disaster. Zimbabwe's deepening economic crisis severely affects the government's ability to fund public health delivery and restricts poor people's access to health care. In this study, the researcher argues that access to health care must be comprehensive, especially among rural older persons.

At the turn of the century, Zimbabwe went through a period of political plurality and tensions in governance systems. Demographic trends show that in Zimbabwe, most older persons live in rural areas (Makore & Al-Maiyah, 2021). Healthcare priorities are primarily focused on young children and their mothers and seldom target the healthcare needs of older persons, and educational priorities firmly target the needs of younger people (Golinowska et al., 2016). The indigent access to healthcare experienced by older persons often results from policy priorities that explicitly undervalue the benefits of treating this group of citizens. In Zimbabwe, lack of access to reliable healthcare financing in older persons poses serious development challenges, and it is detrimental to healthy ageing, mainly because the elderly population is known to be facing various health challenges which require substantial financial costs.

With increasing longevity and debilitating chronic diseases, older persons will need better access to physical infrastructure in the coming years. Lack of physical infrastructure is a significant deterrent to providing comfort to the aged. Many older persons need better access to physical infrastructure in their homes and public spaces. The situation in rural areas is poor because healthcare services are low (Mangundu et al., 2020). This view hinders older persons from seeking health care, especially those who reside in rural areas where the challenges of mobility and distance compound them. The Constitution states that

every citizen can access essential healthcare services (Constitution of Zimbabwe Amendment (4:76) Act, 2013). On the contrary, people living in rural areas struggle to access healthcare services. The lack of investment in health is reflected in the limited availability, accessibility, affordability, appropriateness, and adequacy of health services, especially in rural areas. Older persons in Zimbabwe travel long distances to access healthcare in clinics and hospitals despite constitutional provisions compelling the government to provide this fundamental right to its citizens within reasonable proximity (Azevedo, 2017). Zimbabwe is facing severe socio-economic problems, resulting in various challenges in health institutions, including critical shortages of drugs and human capacity, such as doctors and nurses. Villagers in CSD are among millions of people with little access to health care.

The lack of access to and availability of healthcare services may lead to unmet healthcare needs and poor healthcare outcomes, particularly for older persons. Considering the above, the current study further claims that rural older persons face many factors regarding healthcare access. Older persons in rural areas face many diverse obstacles when they seek to access quality healthcare that is appropriate, timely, and cost-effective in areas where there is less access to such care (Johnson et al., 2006). Additional challenges in accessing healthcare in rural areas are identified by Brems et al. (2006). These include geographic isolation, economic instability, provider shortages, discontinuity or fragmentation of care, funding disadvantages, stigma, and lack of socio-cultural and regional factors that modulate health perceptions, illness presentations, and interactions between older persons and providers of healthcare services. Arguably, older persons with CSD are not an exception. In their fragility, older persons are active beings perceived as resourceful actors who make decisions from a set of alternatives available in the enabling and constraining structure.

1.13 Purpose of the Study

This study explores the acceptance of access to healthcare and its determinants, focusing on older persons in CSD, Zimbabwe. By exploring the accessibility of healthcare services in modern rural spaces, the study seeks to contribute to contemporary debates on the sociology of older persons. The research topic will be guided by Penchansky and Thomas's (1981) access to healthcare framework exploring the following aspects regarding availability, accessibility, accommodation, affordability, acceptability, and appropriateness of healthcare

services and the social determinants of healthcare that may hinder or promote rural older persons use of healthcare services.

1.14 Conceptual Framework

This study is anchored on Giddens' structuration theory (1984), complemented by Bourdieu's social capital theory (1977) and Penchansky and Thomas' model of healthcare access (1981). The basis for selecting these two frameworks is grounded in the pretext that the former provides a more sociological explanation of macro and micro influences of structural properties that affect day-to-day actions. Alternatively, the theory provides abstract lenses through which agents act and respond to structures that are either constraining or enabling. Penchansky and Thomas' framework of healthcare access (1981) offers strategic conceptual tenets that provide a complimentary approach to structuration theory and argues that access to healthcare does not generally refer to the use of a healthcare system or the factors that influence that use, nor does the health of the clients measure it. Instead, access to healthcare refers to the compatibility between a person and the healthcare system available to them, and it is measured by factors that assess patient satisfaction or prevent them from using healthcare services. Within this framework, the notion of access, as often used in discourses of healthcare systems, reflects the relationship between the characteristics of the study participants (agents in the Giddensian perspective) and expectations of the service providers that make the model best fit in this study. Anthony Giddens and Pierre Bourdieu emphasize the importance of agency and structure in modifying social systems. Giddens' structuration concept suggests that structure can change agents, while Bourdieu's concepts of 'habitus,' 'field,' and 'capital' represent actors with structured social spaces and symbols. Access to reliable healthcare depends on internal and external factors, highlighting the interplay between internal and external forces in a given social system.

1.15 Research Objectives and Questions

1.15.1 Main Objective

To investigate access to and social determinants of healthcare services for older persons in Chivi South rural Zimbabwe.

1.15.2 Objectives of the Study

To examine the factors that shape/influence access to healthcare services among older persons in CSD

To analyze the perceptions and experiences of older people in accessing healthcare services.

To evaluate the structural factors that influence access to healthcare services by older persons in CSD.

To evaluate the available healthcare services in meeting the needs of older persons.

1.15.3 Research Questions

What factors shape/influence access to healthcare services by older persons in CSD?

What are the perceptions and experiences of older persons in access to healthcare services?

What structural factors influence access to healthcare by older persons in CSD?

To what extent are the healthcare services available and accessible to older persons in CSD?

1.16 Operationalisation of terms

1.16.1 Access to Health Care

Access to health care is a complex, universal concern identified as a fundamental human right (Guilford & Morgan, 2013). Penchansky and Thomas (1981) defined access as the degree of fit between the consumer and the service; the better the fit, the better the access. It is optimized by accounting for the following dimensions: accessibility, availability, acceptability, affordability, and adequacy (or accommodation). The dimensions of access are independent yet interconnected; each is important to assess access achievement.

1.16.2 Social Determinants of Health Care

The World Health Organization (WHO) defines social determinants of health as the conditions in which people are born, grow, live, work, and age (WHO,2021). These circumstances are shaped by the distribution of money, power, and resources at the global, national, and local levels. The social determinants of health are primarily responsible for health inequities, the unfair and avoidable differences in health status seen within and between countries**.**

1.17 Outline of the Thesis

This thesis comprises nine chapters covering the Introduction, Literature Review, Theoretical Framework, methodology, Presentation of Findings and Discussion, and Summary and Conclusion.

Chapter 1: Introduction

This chapter provides the thesis's background, presentation, and sample area. It presents a nuanced description of the research problem. It exposes the knowledge gap, where entrenched institutionalized ageism is used to discriminate against older persons in the context of access to healthcare resources, and how healthcare programmes are silent regarding the aging population in developing countries.

Chapter 2: Literature Review

This chapter also conceptualizes the background and context of the research. It analyses existing literature, identifying a diverse range of past and current research limitations, simultaneously providing an entry into the conventional debate of health care access in a rural Zimbabwe setting. Thus, the main objective of this chapter is to locate the study in the empirical, conceptual, and theoretical literature on access to health care where the lack of investment in health is reflected in the limited availability, accessibility, affordability, appropriateness, and adequacy of health services, especially in rural areas.

Chapter 3: Theoretical Framework

This chapter reflects on the theoretical framework underscoring the study. In order to provide a more theoretical approach, this chapter discusses the pertinent principles of Giddens' (1983) structuration theory, demonstrating how the recurring relationship among older persons (agency) and structural conditions affect access to health care services.

Chapter 4: Methodology

This chapter presents the methodological facet of the study, steps, and pragmatic research methods used in data collection. The chapter focuses on the methodological options available to address the main objective of this study outlined in the above section (1.5.1 The Research Objective), which is: To investigate access and social determinants of health care services for older persons in Chivi South rural district, Zimbabwe.

Chapter 5: Culture, sociality, and healthcare dynamics among older persons in CDS

This chapter reflects on how illness and disease can be seen as cultural and biomedical constructs in sub-Saharan Africa and Africa. As a result, there are many varied perspectives on and approaches to treating various ailments in sub-Saharan Africa. In order to understand determinants of health among older persons in sub-Saharan Africa, researchers must consider socioeconomic, cultural, and environmental conditions, as well as changing healthcare utilization patterns.

Chapter 6: Navigating the physical and structural barriers to healthcare utilization by older persons

This chapter is based on how physical and structural impediments affect the delivery of healthcare services for older people in CSD, which is the main issue covered in this chapter. There are three main structural and physical barriers. Additionally, there are geographic location dynamics, inadequate transportation systems, and the cost element.

Chapter 7: Re-examining the quality and appropriateness of health care services for older persons

This chapter examines healthcare services availability, appropriateness, and effectiveness for older persons in rural areas. It analyzes available medical services and contextualizes them to their needs. The quality and relevance of services are crucial for older persons' healthcare utilization.

Chapter 8: Social inequalities and dynamics of health care access among older persons

This chapter hinges on the Bourdieusian framework to analyze the social inequalities among older persons in CSD. Older persons in Zimbabwe face exclusion and vulnerability, affecting their prospects for healthy ageing in CSD and their prospects for healthy aging.

Chapter 9: Summary and Conclusions

This integrative chapter precisely summarises the findings and presents final comments on the most critical points of the study. At its closing stage, this chapter explores contributions made by the research to the board of knowledge, context-specific recommendations, and suggestions for further research.

1.18 Conclusion

This chapter has presented the background of the study. In order to provide a transparent background understanding of the study, this chapter explored the harrowing facts that affect access to healthcare for rural older persons in the 21st century. An analysis of the global, regional, and country patterns that hinder the implementation of "*proper acceptable"* healthcare for this vulnerable group. The chapter affirms that the challenges older persons face in Zimbabwe are compounded mainly by the lack of political will and acute resource constraints, further impeded by the collapse of the healthcare system. To address the main objective, key sub-questions, and objectives are clearly defined in this chapter. The chapter also explored the increasing aging population and the need for policy frameworks and agendas to develop metrics for older persons. The selection of Chivi South as the research site is clearly explained in this chapter. The next chapter provides a review of extant literature.

Chapter 2

LITERATURE REVIEW

2.0 Introduction

This chapter reviews terminologies and concepts related to access to various healthcare services. It explains this research's many dimensions and conceptual frameworks to evaluate access to healthcare services for older persons. It deliberates on the complexity and multi-dimensions of access to health care and provides the relevant theoretical and conceptual frameworks underpinning the study. It draws on the deliberations associated with the discourse on access to health care and its determinants, focusing on older persons living in a rural setting. It also covers the multi-dimensionality of the definition of the term "access," as proffered by different scholars. Literature attests to a lack of empirical evidence on access to health care for older persons. Previous studies have mainly focused on the biomedical aspect without incorporating the social aspect of access to health care (Anderman, 2016; Braverman, 2016; Artiga & Hinton, 2016). Although the biomedical model is a vital part of the healthcare system and has contributed to improving the health status, it fails to acknowledge that not all individuals can afford the medical technologies and resources that are a part of the biomedical model of health. This is an essential factor as it contributes to the differences experienced by different population groups regarding health status. The social model of health is another approach that attempts to address the broader aspects that influence health (social, cultural, environmental, and economic factors) rather than focusing on disease and injury. The literature review follows a structural pattern that allows a comprehensive examination of different streams of arguments supported by empirical evidence in analyzing access to health care and its determinants by the older persons living in rural areas of Chivi South District, Zimbabwe. The review explores the accessibility of healthcare services in modern rural spaces. While some authors have focused on biomedical issues, others have analyzed the importance of social and cultural aspects, focusing on how access to health care can impede individuals' access to health care.

Universal access to healthcare has been in past and current debates worldwide; it has been given priority to undo the inequalities between populations. In raising this critical debate, questions are raised about how access can be measured to evaluate whether access to healthcare exists. If it exists, what is meant by 'access to healthcare'? According to Gulliford (2013), access to healthcare is a multifaceted phenomenon that is notoriously challenging to describe. Access to healthcare analysis focuses on disparities and inequities in the accessibility and utilization of healthcare. Access to adequate and equitable healthcare is the heart of the SDGs' discourse on achieving health for all (Hashemi et al.,2017). Therefore, a thorough analysis of access to healthcare services requires a comprehensive definition as a reference point to build an analytical framework.

International organizations, such as WHO and the UN, have championed this discourse to resolve worldwide inequality in access to healthcare for older persons. Rational resource allocation and priority-setting tools are utilized nationally to achieve equity of access, i.e., equal access for equal needs. Access disparities may also be caused by the personal, social, and cultural obstacles that patients must overcome to obtain healthcare. These constraints often pose more serious challenges for the population's marginalized sections. Whether or not individuals with equal needs get equal access to healthcare services depends on the personal, financial, social, and cultural barriers they face (Gulliford, 2020). Promoting equality entails ensuring services are accommodating and responsive to all groups, including those with stigmatized conditions.

2.1 Conceptualizing the Multifaceted Definitions of "Access to Health Care."

Access to health care is complex as it may mean many different things to different people. It is "not limited to the availability of care, the ability to get to and pay for available care, or the act of seeking and utilizing available care" (McGrail, 2012, p. 32). Potential or *realized* access is influenced by many other social and geographical aspects (Wong et al., 2012; Wang, 2012; Whippo, 2011). Thus, the entry has many complex and challenging meanings; hence, the definitions being proffered have no clear consensus regarding the purpose and how the concept can be measured. Geographers and public health researchers recognize the accessibility of health care as contingent upon the interplay of a variety of spatial and non-spatial factors that include geographic distance, cost, availability of healthcare services, and so on (Hawthorne & Kwan, 2013). Access, characterized as "the timely use of personal

health services to achieve the best health outcomes" (Baggett et al., 2010, p.41), is an essential component of health policy. Access to healthcare is determined by the interaction of individuals, households, social and physical settings, and healthcare institutions (Levesque et al.,2014). So far, various frameworks have been used to conceptualize access to healthcare. Andersen's' Behavioural Model of Health Service Use, Frenk's framework, Levesque's Conceptual Framework for Healthcare Access, and Penchansky and Thomas' are the most often utilized access frameworks. According to Penchansky and Thomas (1981), access to healthcare is defined as the degree of "fit" between customers' demands and the healthcare system.

Gulliford (2017) defined access as the potential or the actual entry of an individual or population group into the healthcare system; they further highlighted that 'having access' denotes the potential utilization of a healthcare service when required. Gaining access refers to the initiation process of utilizing a healthcare service, and this is viewed as a realized need to use healthcare services. Access to healthcare services follows similar conceptual, methodological, and measurement variations that make it difficult to define "access." Research on access to healthcare services is split between diverse approaches. Medical research (health research) has investigated access as a formal entry point into the healthcare system, with measurements including demand, utilization, availability, service provision, quality, and health outcomes. It needs professionally defined services (Kruk et al., 2018). Conversely, social science and behavioral research pivot around health-seeking behavior before the formal entry into the healthcare system, such as individual, interpersonal, and societal influences on access to healthcare services (Kruk et al., 2018). Despite some efforts to integrate the two perspectives, empirical research has remained scarce (Doetsch et al., 2017).

Some researchers have defined access as the ability to access healthcare services (Levesque, 2013; Theodo et al., 2007). System infrastructure affects access by accommodating or limiting use through hours of operation, the appointment system, walk-in facilities, and telephone services. Access to healthcare services is a complex behavioral phenomenon influenced by availability, distance, costs, quality of care, social structure, and health-related beliefs (Balabanova & McKee, 2000a). Access to health care can be defined in various ways, and in its narrowest sense, it refers to geographic availability (Syed et

al.,2013). Coming up with a universally acceptable definition for access is complicated as many factors influence the concept. Access to healthcare definitions often conceptualize access as a one-stop encounter with the health system hindered by various barriers. They need to address the complexities of accessing healthcare, such as non-linear relationships, continuums of time, and skills required for care provision, especially in LCIM countries. Khan and Bhardwaj (1994) have argued that assessing access by measuring care affordability or provider availability needs to be more adequate and appropriate in fostering an understanding of healthcare access. These prominent complexity characteristics may be more evident in low-income nations with pluralistic, underfunded, loosely controlled health systems.

However, access to health care remains complex, as exemplified by the authors' various interpretations. Access is an essential concept of healthcare policy and research related to health, yet it has yet to be defined imprecisely. Institute of Medicine (IOM, 1993) refers to “access” as the entry into or use of the healthcare system, while others characterize factors influencing entry or use of the healthcare system (Anderson & Newman, 2005; Aday & Anderson (1975), interrogate the basis of the actual meaning of the concept of access. Thus far, access has been more apolitical than an operational idea, and few attempts have been made to provide formalized conceptual or empirical definitions of access.

The complexity issue is that traditional models tend to concentrate on individual decisions while needing to be more adequate considering the complexity of the processes involved on the demand side. This covers how decisions are socially ingrained, which can either facilitate or obstruct access (Andersen, 1995). The affected person must, therefore, make several decisions, each requiring trade-offs and the weighting of possibilities, to respond to various incentives and overcome multiple barriers concurrently. Contrarily, much research on access to care uses the implicit assumption that people are rational decision-makers when faced with straightforward choices and have access to appropriate information about their illness and the effects of various actions. A multi-layered intra-family and community discourse that draws on formal and informal norms, networks, and relationships also influences how decisions about seeking care are formed. Failure to consider these intricate variables while emphasizing the individual will obscure a significant layer of impact and

restrict comprehension of how people obtain care (McKian et al., 2004). This is particularly significant concerning life experiences rooted in culture, especially for older rural persons.

Access to health care is of particular concern given the centrality of poor access in propagating poverty and inequality. Thus far, the definition of access has been more political than an operational idea, as authors have attempted to provide a formalized conceptualized and empirical idea (Aday & Andersen, 1975). A few authors equate access to entry into or use of the healthcare system; for example, the first barrier to access refers to entry into a healthcare facility. Access to health care refers to the ease with which individuals can obtain the medical services they need. Access to health care has varying meanings in different countries across developing and developed economies (Kruk, 2018). In developed economies, it is often equated to the access status of healthcare insurance. In developing economies, it is viewed primarily across two dimensions: the physical reach of a healthcare facility and its affordability to the patient. Access to quality healthcare includes primary healthcare, preventive services, and other healthcare services on a continuum of care provided by the healthcare delivery system. Although it is acknowledged that access to healthcare is a social determinant of health, this construct has many different dimensions (McGibbon et al., 2008). To distinguish between "having access" and "gaining access," which refers to the potential to utilize healthcare services vs. the actual beginning of service use, two terms have been used to define healthcare access (Aday & Andersen, 1975, p.10).

2.1.1 Barriers to Access to Healthcare

Inadequate retirement benefits, social marginalization, a lack of access to essential services, poor health care, food insecurity, and a lack of affordable housing are just a few of the daily problems that older persons face (Patel, 2015). Accessibility issues make it difficult for someone to use the available services when needed (Scheer et al., 2003, p. 221). These obstacles can be roughly categorized as procedural, environmental, and structural. The diagram (see below) has provided a thorough description of environmental barriers, which include societal attitudes, architectural design, climate, and topography (WHO & WB, 2011). Ecological constraints include public transit access, a publicly financed ambulance system, and private transportation (Smith, 2008). Financial restrictions, known as structural barriers, prevent people from accessing services like medical rehabilitation, high-quality,

properly fitted, functional, durable medical equipment, and repairs for that equipment (Smith, 2008). Access to healthcare is a multidimensional concept encompassing several overlapping and interlinked factors. The broader factors include financial, physical, and socio-cultural dimensions. Together, these factors lay the groundwork for a healthy patient-centered approach to healthcare access and offer a comprehensive picture.

Source WHO, (2013). "Health for All." (Groves et al.,2011)

2.1.1.1 Structural/Ecological Barriers

According to Carrillo et al. (2011), structural barriers are either logistical or systemic and keep people from obtaining healthcare for older persons. Financial barriers, Poor physical structures, Inadequate government specialist services as barriers to accessing health care services, and unreliable and unavailability of transport are a few examples of physical/ecological barriers. Overcoming these systemic barriers that routinely prohibit some groups from accessing adequate health care treatment lies mainly on those disadvantaged, predominantly rural older persons.

2.1.1.2 Financial Barriers

Accessibility is the degree to which individuals are inhibited from or facilitated to enter and receive healthcare from the healthcare system. Factors influencing accessibility or lack thereof may include geographic, financial, social, and organizational considerations related to the healthcare provider and the consumer (Dassah et al., 2018). Access to healthcare can be defined in various ways, and in its narrowest sense, it refers to the geographic availability of healthcare services. Literature on the status of access to and use of healthcare services in developing countries identifies cost, distance, and education as the principal factors influencing the utilization of such services. The problem of cost deprives people with low incomes of access to healthcare facilities, while distance impedes utilization by those who do not have access to adequate transportation. The need factor in utilization is subsumed by the predisposing, enabling, and restrictive factors like distance, travel, and waiting periods. Insurance has been found to improve utilization by the few with access to healthcare facilities. Unfortunately, the insurance system is poorly developed in developing countries.

Financial capability is one underlying phenomenon influencing choices of healthcare utilization (Dou et al., 2015). Older persons are one of the population groups facing the most challenges, such as poverty. The gradual decline in physical capacity, activities of daily living (ADLs), and economic engagements among the aged population fuel poverty among older persons. Many older persons live in chronic poverty, which worsens the degenerative effects of ageing and their ability to seek healthcare support (Help Age International, 2008). Socioeconomic disadvantage or poverty decreases the affordability of healthcare services, irrespective of availability and greater healthcare need (McMaughan et al., 2020). Financial affordability is one of the leading barriers preventing older persons from accessing healthcare services. Older persons often work critically low-paying jobs and receive zero or minimal income from pensions (Amente & Kebede, 2016). In 2002, Uganda's Ministry of Gender, Labour and Social Development and the Department of Disability and Older Persons reported that 64% of older persons lived in poverty compared to 38% of the general population. Empathetically, low-income and inadequate or unavailable pensions have been identified as the primary cause of illness and death among older persons (UNPD, 2015; Leet al., 2015).

A study conducted in Namibia demonstrated that geography, long distance, transportation problems, logistical issues, and time are responsible for significant problems affecting rural, remote areas in terms of access to medical care (Van Rooy et al., (2010). These issues become more acute for older persons as physical access to healthcare centers becomes costlier. Such costs can prevent older persons from following through the required referral pathways and accessing regular treatment for chronic conditions, with significant implications for the adequacy and quality of health care being received. The cost of health care is a concern for older persons living in both rural and urban areas. Primary health care is free in government health service systems, but the cost of accommodation, medicines, and travel pose significant constraints, barring older persons from receiving healthcare services. According to Anderson and Perrin (2017), medical costs sometimes rise due to the application of sophisticated medical technologies and new drugs, which can only be met by those with higher income levels. Older persons receiving income support can access tertiary-level health care available in urban regions. Older persons are vulnerable and marginalized, often excluded from mainstream social, economic, and healthcare services and educational opportunities needed to meet their full potential (Eide & Loeb, 2006; Loeb et al., 2008; UN, 2006).

2.1.3.3 Distance as Deterrent of Healthcare Access

Accessibility to healthcare services is an essential determinant of the utilization of healthcare services, particularly in developing countries. In most rural African areas, older persons live more than five kilometers from the nearest healthcare facility (Help-Age International, 2015). For example, a study conducted in Burkina Faso suggested that transport costs accounted for 28% of the total costs of using hospital services (Ensor & Copper, 2004). Other studies have revealed that household use of healthcare services tends to decline as the distance from healthcare facilities increases (Help-Age International, 2016). Older persons in developing countries are a highly vulnerable group of society and are exposed to hardship, malnutrition, poverty, and old-age-related diseases (Fouad, 2004). Health is a primary concern among older persons since it determines their ability to care for themselves and undertake other societal roles (Charles & Sevak, 2005). An increase in age is also related to higher morbidity, higher use of healthcare services, and greater demand for

specialized services (Crimmins, 2010). These have led to increased healthcare and social support demand among older persons.

Geographical access and the distance that must be traveled to use healthcare services are often overlooked (Kotavaara et al., 2021); however, these present barriers such as cost, time, and inconvenience. Evidence suggests that an increase in distance from healthcare services inhibits access to healthcare services, resulting in poor health outcomes. Furthermore, measures of geographical access can be challenging to compare. Rurality has often been used as a proxy for the inaccessibility of healthcare services (Chinyakata, 2021). It has a dichotomous categorization, such as the presence or absence of a service provider in an area (Honda et al., 2015). There are complex measurements such as the straight-line distance between populations (for example, demand points) and health service providers (Gregory et al., 2000) or 'network distances' (which can include both road distance and travel time), which have added complexity. However, the relationship between these measures is not clear. Geographical accessibility to healthcare services measures the extent to which such services are available and accessible to the population. This is linked to the distribution of healthcare infrastructure in a region and the actual offer of healthcare services and facilities. Inequalities in spatial accessibility to health care are pronounced in many developing countries, but they are also prevalent in developed countries where rural areas are medically underserved.

Accessibility, as perceived by Penchansky and Thomas (1981), as cited in Black et al. (2005) and updated by Oliver and Mossialos (2004), also as cited in Black et al. (2005), is measured by availability, acceptability, and addressability (socio-economic, ethnic, age, sex, costs) and geographical or spatial and physical accessibility of service. Geographical accessibility measures the level at which services are available and accessible to the population, linked to the distribution of healthcare infrastructure in a specific region and the actual offer of the services and facilities. Geographical accessibility varies depending on local transport conditions; it is calculated as the distance (kilometers) between the residence and the nearest medical service, including the nearest hospital or ambulance station. These distances are calculated in line with the existing line access routes (roads, highways, paths). It is the time a patient uses to accede to a medical facility. There is no consensus on what constitutes "away" in healthcare service. However, it is usually considered that an optimal

distance from a primary healthcare service should not be more than 5-7 kilometers and 25-35 kilometers for a larger hospital (Jordan et al., 2004). A distance to a medical facility may adversely affect people's health status (Corden et al.,2021).

The location of a healthcare facility is essential insofar as it influences healthcare utilization and health outcomes. Although the accessibility of a healthcare facility may be more critical for those in rural areas than those in urban residences, this factor is worthy of exploration as older persons live in rural areas. For those living in rural areas without access to or the ability to own or drive a private car, the absence of trustworthy transportation options provides significant barriers to people intending to travel to their workplaces, see a healthcare practitioner, and visit stores selling groceries with a high possibility of having adverse effects on health outcomes (National Advisory Committee on Rural Health and Human Services Policy Brief, 2017). Accessibility is an essential social determinant of healthcare utilization among older persons. Proximity to healthcare facilities may promote healthcare utilization while traveling a long distance to a healthcare facility may be a barrier. Irrespective of the urgency and criticality of the aging process, an inverse relationship between distance or travel time to healthcare facilities and healthcare service utilization has been identified as an essential barrier to access to and utilization of healthcare services (Hjortsberg & Mwikisa, 2002; Hjortsberg, 2003).

2.2.1 Socio-cultural Barriers

Older persons in rural areas have been characterized as having a distinct culture, and health differences by residence have been well documented. While there is evidence of poor health among older persons living in rural areas, research has done little to examine how they perceive and define health. Culture has received increased recognition among researchers, both domestically and abroad, as an essential determinant of health. People's beliefs and perceptions of ill health are influenced by the socio-cultural context and indigenous healers, who form an alternative health service in many societies and may compete with biomedical health services, especially if they are perceived as the best way of addressing specific health concerns (Yehya & Dutta, 2010). Older persons hold different beliefs about the origin of diseases or ailments. What may be considered a symptom of a disease or illness might vary from culture to culture? Older persons are relatively committed to traditional beliefs about health and illness and might prefer their traditional healthcare practices to modern ones. In

every culture, care for older persons has its cultural constituency. To foster access to health care among older persons, culture-congruent care can help provide advantageous and appropriate health care among this vulnerable group through a supportive and enabling environment that is tailor-made to meet their needs and institutional and cultural beliefs. Against this backdrop, the current study seeks to investigate access to and use of healthcare services among older persons in CSD.

Culture involves norms that affect human behavior, interactions, beliefs, values, skills, and how people view themselves in their environment (Ibeneme et al., 2017). It goes beyond the individual and is a way of life for a group. It is passed on from generation to generation, affecting help-seeking behavior, communication styles, and how an individual relates to helping systems (Samantrai, 2004). Culture is an aspect of human life that encompasses health and illness and is not limited to ethnic and racial differences (DeSantis, 1994). For example, "culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups" (Cross et al., 1989, p. 3). Numerous environmental factors existing in many rural communities can ultimately influence rural culture. Rural residents often face structural barriers to healthcare access due to a lack of general and specialty providers, transportation challenges, and limited employment opportunities (Ginsberg, 2011). Global trends have eroded traditional African values, particularly family solidarity (Fox, 2015; Cleveland, 2012). The underlying reasons for emphasizing cultural competence in the healthcare arena include a worldwide change in demographics as many countries are experiencing an expansion of the ageing society. It is crucial for practitioners who implement healthcare policies to recognize that older persons may enter a healthcare setting describing their illness with an explanation different from that found in the modern medical model.

The concept of culture has been described as a set of guidelines (both explicit and implicit) that individuals inherit as members of a particular society or group (Helman, 1994). The role of culture as a determinant of health is not as well developed as our understanding of many socioeconomic factors. However, culture should be considered separately from social determinants. For many groups, particularly ethnic groups, culture is central to their health and well-being, which differs significantly from socio-economic factors. An understanding

of access to health care must consider culture as a central determinant of and strategy to improve healthcare provision among different groups must be cognisant of the influence of culture. Cultural factors can have both a positive and a negative influence on healthcare access. Cultural competency has been identified as a critical consideration in addressing disparities in access to healthcare. Although information on culture exists for various populations, little specifically exists for individuals living in rural environments based solely on geographical location and not on other defining characteristics (for example, race, ethnicity, age, beliefs, attitudes, and knowledge can affect people's lifestyles).

The assumption underlying the cultural explanation is that individuals may attribute a lack of seriousness to certain health situations because they may consider such conditions as usual based on their cultural understanding and experience of that condition (Azevedo et al., 1991; Betancourt et al., 2003; Ashton et al., 2003; Brach & Fraserirector, 2000). Although it accepts the logic of the characteristic's explanation of the use of healthcare services, the cultural hypothesis assigns equal importance to the independent role played by cultural factors in shaping decisions such as seeking health. The general argument advanced by the cultural perspective is that as societies modernize, individuals' decisions on health-seeking practices depend on the enduring models of their cultural origin and their current involvement in modernizing experiences. Socio-cultural barriers, which include stigma and lack of knowledge about health conditions and services, prevent many older persons from accessing healthcare services (Maharaj & Pillay, 2012). Culture can influence access to healthcare through inequalities inherent in the social system. Gender also affects access to healthcare, pushing women into gender-specific roles that negatively influence their health or force them to seek permission to obtain healthcare services. Other researchers have measured access using cultural beliefs, communication between patients and doctors, patient waiting time, and modes of transportation to and from healthcare facilities (Wyss, 2003).

Culture plays a role in influencing health-seeking behaviours (Caroll et al., 2007; Omu & Reynolds, 2012). The importance of cultural beliefs regarding health and healthcare-seeking behaviour has been well-documented (Bailey et al., 2007; Caroll et al., 2007; Legg & Penn, 2013). Different cultural groups have vastly different perceptions of the causes of diseases, which influence their health-seeking behaviours (Bailey et al., 2007; Caroll et al.,

2007; Legg & Penn, 2013). Health-seeking behaviour is significantly influenced by culture, religion, and an individual's socioeconomic status. Culture has norms, expectations, accepted practices, values, and beliefs that constitute the foundation of health-seeking behaviour (Hayden, 2013). In addition, there appear to be cultural aspects to the remoteness of access to healthcare services. Cultural access describes, among other things, access to user-friendly and culturally appropriate services, covering such issues as access to the same gender healthcare providers and an assurance of confidentiality. Cultural appropriateness is an issue that policies and healthcare interventions must address to improve the experiences of older person patients. to address to increase. It is important to note that the potential consumers' background and ethical and value systems are considered (Rosenfeld, 1997). Elliot-Schmidt and Strong (1997) reiterate the same point, stressing that healthcare service providers in rural areas adequately understand such differences.

Studies have suggested that a prevailing ''rural culture,'' characterized by a sense of independence and a suspicion of change from the outside, may affect people's propensity to use services (Van Rooy et al., 2015). While the literature has identified these factors, it remains unclear how elders living in rural areas perceive barriers to healthcare access. An enormous proportion of the world's older persons live in rural areas and show wide variations in health status. Many, particularly those in developing countries, are vulnerable to greater socio-economic and health-related marginalization, mainly due to inadequate services and economic deprivation.

Studies that have explored the phenomenon of access to and utilization of health care services by older adults tend to be randomized trials such as health behavior (smoking, physical activity), risk (fall), or disease (diabetes or heart disease) specific (Byrne et al., 2012; Jorgensen et al., 2012). These studies have demonstrated success with small sample sizes and unknown long-term effects. Studies have revealed that access to health care makes the most difference in slowing down functional decline and reducing the risk of death among older persons with no functional limitations (Zhang & Zeng, 2009). A study conducted in Nigeria concluded that socioeconomic indicators (particularly poverty) and the nature of illness were the most persistent determinants of healthcare utilization among older persons. This study also established that the nature of illness and the quality of service

provided were the primary determinants of healthcare-seeking behavior among older persons (Abdulraheem, 2007).

Furthermore, one's place of residence is an essential determinant of health-seeking behavior, particularly in Africa. Studies show that living standards, employment, consumption patterns, and access to health care and social services differ considerably between urban and rural areas (Gebre & Gebremedhin, 2019). An estimated one-third of rural residents live in extreme poverty compared to one-tenth of urban residents living in Africa (United Nations, 2016). In rural areas, infectious diseases and malnutrition are the significant causes of mortality, whereas in urban areas, chronic diseases and other health problems associated with industrialization are the dominant causes of mortality (Smith & Goldman, 2012). Under-financing of health systems, over-stretched healthcare workforces (from doctors to community health workers), poor management of health information systems, unreliable supply of medicines, physical barriers to access to healthcare, and distance-related barriers are other factors that contribute to older persons' poor access to healthcare (Help Age International, 2013).

2.2.1.1 The concept of disease and illness in Africa

In Africa, health and healthcare are greatly influenced by the laws of ancestral harmony and atonement, which suggests that disease originates from a spiritual imbalance between people and their ancestors. From an African worldview, illness transcends biological and tissue problems. Disease and poor health are closely related to one's destiny and ancestral spirit in the traditional African context (Omonzejele, 2008). Dime,1995 described the disease as "two-fold," with both physical and metaphysical origins of disease/ill health; he provided more specifics. Therefore, he said, a diagnosis is a two-step process. First, the medicine man must carefully examine the patient and interrogate them to determine the organic or physical cause of the illness. This goes in addition to determining the illness's mystical or spiritual root. The dual understanding of illness in Africa sets it apart from the Western concept of illness. According to WHO (2013), combining traditional and modern medical approaches can coexist in harmony within the realm of PHC, utilizing the finest aspects of each system and making up for some of its shortcomings.

The concept of sickness and culture frequently significantly impact how medicine is practiced, which is also true in African culture. The conventional medical procedures of a different culture may appear unsettling and unusual to an outsider. Many who practice it view it as rational and logical since it accords with their personal and cultural views on health and healing. It is crucial to comprehend the culture to understand how traditional medical practices are carried out (Freierman et al.,1992). How sickness is treated will demonstrate the consequences of the communal side of African culture and the idea of contamination. The way indigenous people deal with health and illness has been subsumed under various names, which signifies the complexities of understanding traditional medicine.

2.2.2.2 Conceptualizing traditional/indigenous and alternative medicine.

WHO defines traditional medicine as knowledge, skills, and practices based on indigenous theories, beliefs, and experiences for maintaining health and preventing illness. Complementary medicine encompasses healthcare practices not part of a country's tradition or conventional medicine (WHO,2013). Traditional, complementary alternative medicine (TCAM) refers to a set of healthcare practices (indigenous or imported) that are delivered outside the mainstream healthcare system (WHO,2014). TCAM is a form of alternative medicine practiced since 200 B.C. The ancient medical systems of China, Korea, Japan, India, and Vietnam each have distinctive variations (Tabish, 2008). Traditional medicine is mainly used in LCIM to bridge unequal access to healthcare. On the other hand, health is a process of adaptation, the result not of instinct but an autonomous yet culturally shaped reaction to socially created realities (Chipfakacha, 1994). Differently conceived medical systems coexist in each community.

Traditional medicine (TM) is described by the World Health Organisation (WHO) as "the body of knowledge, skills, and practices based on the theories, beliefs, and experiences that are indigenous to different cultures, whether explicable or not, that are used to maintain health as well as to prevent, diagnose, improve, or treat physical and mental illnesses" (WHO, 2008, page number). African traditional medicine (ATM) would be the TM native to the various African cultures as a result. Traditional medicine continues to meet most of the world's population's healthcare needs today despite having been used by humanity to

treat numerous diseases long before the development of orthodox medicine. The WHO reports that there have been rising trends in the use of TM and complementary medicines (WHO, 2013). Complementary medicine (CM) and alternative medicine (CAM) refer to a broad range of medical procedures not part of a nation's customary medical practices or its dominant system of conventional medicine. In some nations, the phrases are used interchangeably with TM.

TCAMs are often used alongside conventional medicinal treatments, and it is a critical social phenomenon. Social, cultural, and political values and socioeconomic factors influence TCAM use in industrialized societies (Eskinazi, 2001; Astin, 1998). The affordability and accessibility of healthcare services influence individuals to opt for traditional medicine rather than conventional medicine. In developing and poor-resourced countries, affordability, availability, and cultural familiarity contribute to the continued use of TCAM, and importantly, primary care services may not be available. Indicators of human development in Africa consistently show low performance compared to the rest of the world, including deeply ingrained and gendered poverty, high rates of infant mortality and total life expectancy, and lack of access to social infrastructure.

2.2.3.3 Prevalence and Use of TCAMs

The health practice known as traditional and complementary medicine (TCM) has deep historical and cultural roots and is widely accepted and applicable (WHO, 2013). The medical procedures included in the broad category of TCM can differ from nation to nation and area to region. Since the Alma-Ata Declaration in 1978, TCM has been acknowledged as a part of achieving "health for all" and is a valuable PHC resource for many communities. The World Health Organisation (WHO) recognizes the value of TCAM for health, wellness, people-centered care, and universal health coverage. The WHO works to integrate traditional medicine "into the mainstream of health care, appropriately, effectively, and above all, safely" (Bodeker & Kronenberg, 2002, pp. 238-252). Since the 1970s, it has been argued that integrating 'established' conventional practices into national health systems will increase access to primary care and enhance health outcomes by providing more options for point-of-contact (WHO SEARO 2010; WHO SEARO, 1990). This acknowledges that traditional healers are frequently the first point of contact and the

only available healthcare providers in some regions and that traditional herbal treatments are used for primary care (WHO SEARO, 2010).

Exploring the potential of TCAM in promoting healthy aging is now more critical than ever due to the higher NCD burden associated with ageing and the growing appreciation of TCAM's role in health care. While the philosophical underpinnings of the various medical systems' approaches to illness prevention and treatment may vary, they have some things in common. These approaches are predicated on the idea that the body can heal itself. Utilizing various strategies that affect the mind, body, and spirit is frequently necessary for healing. Treatment is frequently customized and based on the current symptoms. Hence, biomedical dominance continues to frame our language in health, illness, and healing. A study done by WHO in Malaysia in 1986 showed that 29% of older persons use traditional medicine to cure ailments such as hypertension. TCAM usage is widespread throughout numerous nations on the planet. T&CM was used by more than 60% of the population in Australia, China, and the Republic of Korea, and more than 30% of the population in Brunei Darussalam, Malaysia, New Zealand, Singapore, and Viet Nam, according to the Regional Strategy for Traditional Medicine in the Western Pacific 2011-2020 (WHO, 2012). Older persons or any other population group can use TCAM services independently or combined for any health need in a comprehensive healthcare system.

2.2.3.4 The role of traditional medicine in Africa

The World Health Organisation claims that local healers have helped with various healthcare needs, such as managing, preventing, and treating non-communicable diseases and mental and geriatric health issues (WHO, 2001). Over 80% of the population in SSA still use the services of traditional healers (Green, 1997). Traditional medicine is a fusion of ancient myths, customs, and beliefs that vast segments of the population around the world still cling to today (Mothibe & Sibanda, 2019: Fokunang et al.,2011). It creates a medical system that identifies, treats, and prevents diseases with many aetiologies. Because their approaches are more culturally acceptable and holistic than "modern medicine"(Feierman, 1985, p. 106). It is thought that traditional healers can help advance health care in a community. Depending on their cultures, these individuals are referred to by their native names in particular cultures, such as *Sangoma or inyanga* in South Africa, *n'anga* in

Zimbabwe *akomfo, bokomowo* in Ghana, *niam-niam, shaman, or mugwenu* in Tanzania, *nganga in* Zambia, *shaman or laibon* in Kenya, and *babalawo, dibia, or boka*, etc., in Nigeria (Abdullahi, 2011).

TCAM use in Africa is predicted to be 58.2% on average, with a range of 4.6% to 94% (Nsagha et al., 2020; Gari et al.,2015). Dissatisfaction with traditional healthcare is one of the fundamental driving forces behind adopting TCAM (van Staden & Joubert, 2014). This includes problems including travel distances to healthcare facilities, prescription shortages, barriers to care, unequal access to care, unfavorable attitudes of healthcare professionals, protracted wait times, drawn-out procedures, and anxiety over receiving a critical illness diagnosis (Aziato & Antwi, 2016; Rutebemberwa et al.,2013). TCAM use is further encouraged by conventional medicine's failure to effectively treat patients' diseases, manage their symptoms, and manage drug side effects, all of which are thought to be caused by a lack of information about the possible risks of using TCAM concurrently with conventional medications (Mwaka et al.,2015; Peltzer et al.,2009). Additionally, healthcare expenses are considered excessive even at state-run hospitals and clinics, where consultation and treatment are presumed to be subsidized (Fokunang et al.,2011). Numerous health-oriented ministries are now promoting the use of local medicinal plants for illness treatment to partially address the issue of a medicine shortage or high cost. Rural areas lack adequate health care systems, forcing locals to self-medicate.

In Africa, alternative remedies are frequently founded on local belief systems, knowledge systems, and customs. The oldest and maybe the most varied medical system is traditional medicine. Regarding therapeutic methods, Africa's great biological and cultural diversity is evident (Gunrib- Fakim, 2006). Africans have a holistic understanding of health and disease as an integrated concept that considers the body's biological faults and the influences that religion, morality, politics, and the economy have on the body. Africans also see health as more than the absence of disease, understanding that both the body and the mind must be in harmony, acknowledged, and accepted by the person and society. Ndege acknowledged that this idea of health partially resembled that of the WHO. Still, he said that although the WHO's definition of health primarily focuses on the individual, the African sense of health also considers society as a whole (Ndege, 2001). Given the shortage of healthcare, medical

resources, and personnel, traditional medicine and healing serve as a crucial conduit between rural Africans and primary healthcare.

2.2.3.5 The Role of TCAM in Zimbabwe

Traditional medicine is one of the significant alternatives to modern medicine in Zimbabwe and other underdeveloped African countries. Traditional medicine is the first port of call for most people in Zimbabwe. When faced with disease, the Shona, Zimbabwe's largest ethnic group, typically seek conventional (science) medical care (Chavunduka, 1978). Traditional healers are most active in more remote rural communities when access to contemporary medical care is difficult or nonexistent. About ten percent of the more than 5,000 plant species that grow in Zimbabwe have medicinal qualities and are utilized in traditional medicine (Gelfand et al.,1985). Traditional medicine remains the most accessible and affordable option in Zimbabwe's primary healthcare system for populations with few resources (Maroyi, 2013). In a study conducted by Maroyi (2013) in south-central Zimbabwe, 93 plants treat different ailments. Plants such as Hypoxis vigidula (*nhindiri*) are used to treat the whole body, Crossopteryx febrifuga (*mukomberwa*) in the treatment of bowel problems, and Vigna unguiculate used as an inflammatory disease which is most common in older persons (Maroyi, 2008). Traditional medicine has also been managed by establishing oversight bodies such as the Zimbabwe National Traditional Healers Association (ZINATHA) and collaboration with the MOHCC.

2.2.3.6 Integrating TCAM and Biomedicine

The Alma-Ata (in Kazakhstan) conference of 1978 on making health care available to people with low incomes further strengthened the development of traditional medicine. The Declaration of Alma-Ata called for a new emphasis on primary healthcare and the participation of locals in the design and management of health systems (Nkwi, 2006). The use and the inclusion of TCAM in health and illness have been invoking debates among biomedical and TCAM discourse. The Alma-Ata movement ("Health for all by the year 2000") aimed to call attention to the biomedical paradigm's neglect of various social influences and indicators on health and healthcare. However, it has received harsh criticism for allegedly being subverted by political forces and "by the bacteriological emphasis of the

late nineteenth and early twentieth centuries" (Mckenna, 2010, p. 7). The emphasis on bacteriology also obscures the critical impact of socioeconomic inequalities on health worldwide.

The current attempt to establish collaboration between the two systems has been severely hampered by the relationship between traditional healing and biomedical systems, which is marked by mistrust, tension, and conflict (Wreford, 2005). On the one hand, biomedical professionals are outspoken in their criticism of traditional healers and the lack of scientific evidence supporting their use; on the other hand, THPs find it challenging to comprehend the biomedical professionals' lack of understanding of their contribution to health and wellbeing as seen through the indigenous knowledge lens. Missionaries have historically converted people, many of whom possessed conventional worldviews, to Christian worldviews through biological structures (Zimba & Tanga, 2015; Thornton, 2009). Ultimately, coexisting worldviews cause a clash of values and interests between patients and health professionals, both biomedical and conventional. However, the excessive social power of practitioners may undermine patients' beliefs and values. The coexistence of several healthcare systems needs to be acknowledged, and these systems need to be optimized so that patients can benefit the most from them. This remains the case even if so-called objective medicine is significantly influenced by the dominant values of time and place (Foucault, 1975).

Since traditional medicine is not based on biology, several authors have discussed the difficulty of studying it from a purely biological perspective (Flint, 2015; Van Niekerk, 2012; Wreford, 2005). Wreford (2008;2005) suggested that THPs must acknowledge the biological paradigm's alleged dominance before any genuine discourse is relevant to collaboration. As a result, the difficulty in forming a partnership between biomedicine and conventional medicine partly results from the knowledge's hierarchical classification (Nyika, 2007), in which biomedicine's scientific information is positioned above other types of knowledge. The Western colonial powers wanted to change the culture of the Africans under their control by eliminating traditional medicine. In addition to attempting to alter African culture, they also believed that their civilization was better than that of Africa. When their efforts to "civilize" Africa met with opposition, they retaliated by demonizing African culture. They viewed the Africans as a cheap labor supply and as having barbaric

cultures and ancient healing methods. Many colonial works demonstrate this superiority complex, which persisted into the late 1900s (Memel-Fote, 1999).

The ability of patients to seek care from both conventional healers and modern medical professionals demonstrates their desire to exercise their right to make independent decisions and the connections between the two systems. The patient's best interests dictate that both systems appreciate one another's unique viewpoints because they are complementary. If patients are to gain from both systems, cooperation rather than conflict or confrontation is required. Twumasi (1988) summarised it by noting that there are few hospitals, numerous ailments, and societal issues, and people shop for assistance. The more diverse the treatment facilities with various healing modalities, the better for the therapeutic customers. Traditional healers meet four goals of primary health care. It is acceptable and available to the general public. It identifies the population's medical needs that may be avoided, adjusted, or treated and makes the best possible use of the workforce and resources to address those needs (Chipfakacha, 1994).

2.2 Socio-economic as Healthcare Determinant of Older Persons

Access to social resources can operate as a buffer against the negative impacts of inequality on healthcare. For example, the availability of support (financial, travel assistance) information (providing pertinent information for a health problem) may provide some resources that would otherwise be inaccessible to disadvantaged older persons. Older persons in LMICs are vulnerable because of the nature of labor and migration; the traditional extended family system is no longer the dominating social structure (Kalideen et al.,2022). Older persons' assistance from their family members determines how well they can adapt to changes in their health and end of life.

According to the CDC (2019:7), these social determinants are "economic and social conditions that influence the health of people and communities" and are shaped by the amount of money, power, and resources people have. The CDC (2019) itemizes these factors as early childhood education, employment, the type of work a person does, access to food and health services, and their quality, housing, income, discrimination, and social support. Currently, the social determinants of health (SDH) are broadly defined by the

World Health Organization (WHO) as “the conditions in which people are born, grow, live, work and age” (CSDH, 2008:5).

The socioeconomic status of individuals and different age groups is vital in determining healthcare status. Socioeconomic status is a strong determinant of health, both within and across countries (Mackenbach et al., 2003). Hence, there is a need to establish the social determinants of health care for older persons. The actors related to social and structural determinants of health can further worsen the challenges affecting the management of complex health issues for older persons. Rural adults suffer disproportionately poorer health and worse health outcomes than their urban counterparts (Jaffe, 2015). Limited resources and access to health care negatively impact rural adults’ ability to receive timely management for both chronic and acute conditions (Gamm et al., 2002). Identifying perceived social determinants helps promote quality health status for older persons. Also, it helps implement social protection policies that support the needs of older persons. In rural communities, identifying specific social determinants that may contribute to cognitive health in rural-dwelling adults may provide critical information that improves this underserved group's long-term cognitive health.

2.2 Access to Healthcare and Older Persons

The current global population is 7.6 billion people, of which older persons aged 60 years and over account for 13%. This figure is projected to rise to 21.2% by 2050 and 27.5% by 2100 (United Nations, 2017). The average percentages of older persons projected by the United Nations for developed countries are 29% by 2030, 33% by 2050, 34% by 2075, and 35% by 2100 (United Nations, 2017). For the South Asian region, the projections are 11%, 18%, 27%, and 35% by 2030, 2050, 2075, and 2100, respectively (United Nations, 2017). This trend prevails worldwide, although some countries still enjoy demographic dividends. Population ageing is now a global phenomenon and not an emerging trend limited to the higher-income world. Societal ageing is accelerating in virtually every country, regardless of wealth. While Sub-Saharan Africa is often thought to have young populations, population aging is expected to accelerate in the region, increasing from 46 million in 2015 to 157 million by 2050 (WHO, 2015).

Globally, many rural residents, including older persons, face considerable challenges in accessing appropriate healthcare services. Most older persons face fundamental problems, such as poor financial support, senile diseases, no medicines, proper healthcare and medical facilities, exclusion and negligence, deprivation, and socioeconomic insecurity (Islam & Nath, 2012). Ageing is associated with a shrinking workforce and higher demand for healthcare services, social care, and social pensions (Beard & Bloom, 2015). Ageing comes with changes that range from infectious to non-communicable diseases such as diabetes, cancer, and cardiovascular diseases (Arora, 2015). With their more significant healthcare needs, older persons put considerable pressure on healthcare systems and provide additional urgency to research to find solutions (Gutiérrez-Robledo, 2002). Healthcare services are a prioritized demand, but in many developing countries, healthcare systems are not prepared to meet the burden of diseases and disabilities brought by ageing populations. Current health challenges and existing policies act to hide the situation of older persons. Research has described the process of ageing using contrasting perspectives: demographic characteristics, physical health, cognitive impairment, disability, and self-perceived health of older persons in developed countries (Sudharsanan & Bloom, 2019). Studies on population ageing in developing countries have focused primarily on Asia and Latin America.

An alarming increase in the population of older persons and projected increases have an overwhelming implication on healthcare cost and utilization, given the varying health conditions associated with ageing (Garza, 2016). Older persons may become irresistibly dependent, more likely to develop chronic diseases, and spend more on medicine and treatment (Maserova et al.,2019; Palangkaraya & Yong, 2009). Based on evidence-based research outputs on ageing, older generations, in comparison with other age groups, usually need a higher amount of healthcare services because of their declining quality of health, which may result in disability, mortality, increased morbidity, healthcare utilization, and burden of care (Hou et al., 2018). A statement extracted from the WHO (2016) at the 69th World Health Assembly confirms that social determinants greatly influence healthy ageing and have implications for proper exploration to contribute to the global efforts of improving healthcare services. Unfortunately, the availability of healthcare services and their

utilization by older persons in most SSA countries have been reported poorly (Jaleta et al., 2019).

2.2.1 African Situation of Older Persons and Access to Healthcare

Obtaining data on the health situation of older persons in Africa is often very difficult. Despite this fact, this section reviews the situation in Africa. As the population grows older, the demand for healthcare services also increases. In Africa, data on providing healthcare services for older persons residing in rural areas (Kelly et al., 2019). Studies suggest that older persons are more likely to experience malnutrition, chronic physical and mental conditions, hearing and sight difficulties, depression, and dementia (Fávaro-Moreira et al., 2017; Furukawa & Tanemoto, 2015). In SSA alone, the number of individuals aged 60 and older is projected to reach 163 million in 2050 (World Bank, 2019). Despite this demographic wave, most of Africa's older persons have limited access to quality geriatric health care (World Bank 2017). Studies conducted in Kenya, South Africa, and Pakistan identified lack of finance, absence of family support, physical inaccessibility of healthcare service providers, and practicing quacks as the significant factors deterring older persons from seeking healthcare services (Ladha et al., 2009; Paxton, 2008; Waweru et al., 2003). Developing countries are characterized by the under-utilization of healthcare services (Gordon et al., 2020). In many cases, clinics located in rural areas often lack adequate equipment or trained health personnel and require patients to pay before receiving healthcare services (Maphumulo & Bhengu, 2019). Without health insurance, rural people often cannot afford all healthcare services. Although foreign aid and capacity-building efforts can help to close this gap over time, it is likely that failure to understand the unique context of Africa's older persons, many of whom are marginalized, will lead to inadequacies in service delivery and poor health outcomes. As the need for culturally competent care for older persons gains recognition in the developed world, research in geriatric care in developing countries should progress in tandem with developments in the developed world.

Meanwhile, access to healthcare and its subsequent utilization are significant to rural development because they are vital for well-being and human capital (Braverman, 2014). Accessing healthcare in rural areas is compounded by problems such as insufficient

healthcare infrastructure, chronic diseases and disabilities, and socioeconomic and physical barriers (Azevedo, 2019). Patterns of seeking and using health care in later life are determined by several factors that affect older men and women differently. Access to and use of healthcare services are also related to socio-economic conditions in later life. Poor access to health care is one of the significant impediments to balanced growth in rural communities worldwide (Kruk et al., 2018). An assessment by Appiah-Denkyira et al. (2013) revealed that in rural areas, a lack of access to skilled healthcare service providers or human resources and financial obstacles mainly prevent critical health services from being adequately delivered to and accessed by those who need them the most. This results in hampered healthcare outcomes.

Good roads in poor areas are not only required for people to reach healthcare facilities but also to ensure the distribution of drugs and other supplies as a means of geographic access (Kruk et al., 2018). These authors further emphasized that governments' ability to allocate and sustain financial accessibility to their healthcare systems highlights some strategies towards facilitating access to healthcare, especially in developing countries. The accessibility premise is based on the assertion that access to healthcare facilities and personnel is equally vital in healthcare services, especially in developing countries (Azevedo, 2017). For instance, a study conducted by Adedoyin and Watts (1989) in Nigeria has shown that accessibility significantly determines greater use of healthcare facilities and improved health conditions. Accessibility to healthcare services is an essential determinant of the utilization of healthcare services in developing countries. In most rural areas in Africa, most older persons, for instance, live more than five kilometers from the nearest healthcare facility (Weiss et al., 2020). For example, a study conducted in Burkina Faso suggested that transport costs accounted for 28 percent of the total costs of using hospital services (Ensor & Copper, 2004). It is not surprising to note that utilization of healthcare services by households tends to decline with distance. This is why urban citizens use healthcare services more than their rural counterparts.

Studies on health care and utilization for older persons tend to be randomized trials that are centered on health behavior (smoking, physical activity), risk (falls), or disease-specific (diabetes or heart disease) (Byrne et al., 2012; Jorgensen et al., 2012; Van Hoecke et al., 2014; Zbikowski et al., 2011). Some of these studies have succeeded with small sample

sizes and unknown long-term effects. A study conducted in Nigeria by Abdulraheem (2007) concluded that socio-economic indicators (particularly poverty) and illness were the persistent determinants of healthcare utilization among older persons. This finding was also corroborated in this study, which confirmed that the nature of illness and quality of service provided were the significant determinants of healthcare expenditure.

2.2.2 Access to Healthcare by Older Persons in SSA

The current situation of older persons in SSA is relatively poorly known, and micro-level data are available only for a limited number of countries. Older persons in SSA (SSA) usually retire and settle in rural areas characterized by poor infrastructure and acute problems of essential health care service provision. Access to and use of healthcare services are also related to socio-economic conditions in later life. Poor access to health care is one of the significant impediments to balanced growth in rural communities worldwide (Strasser et al., 2016). An assessment done by Appiah-Denkyira et al. (2013) established that in rural areas, a lack of access to skilled healthcare service providers or human resources and financial obstacles mainly prevent critical health services from being delivered to and adequately accessed by those who need them the most. This results in hampered health outcomes. World Bank (2020) suggested that good roads in poor areas are not only required for people to reach healthcare facilities but also to ensure the distribution of drugs and other supplies, thus enhancing geographic access to healthcare. Furthermore, these authors emphasized that the ability of governments to allocate and sustain financial accessibility to their healthcare systems highlights some strategies that could be adopted to facilitate access to healthcare, specifically in developing countries. Although the population of older persons is increasing in Africa, older persons are becoming increasingly vulnerable due to urbanization, breakdown of family structures, and rising healthcare costs, resulting in most African countries being deprived of social health protection for older persons.

A study conducted in Kenya shows that the effects of age can be due to differences in socio-economic status, as defined by employment, education, and income (Mishra et al., 2002), as well as greater economic dependency, poor housing, loneliness, and lowered self-esteem (Waweru et al., 2003). Older persons often cannot access adequate health care, contributing to poor health status (Waweru et al., 2003). This can concern developed and less developed countries (Wiet, 2005; Waweru et al., 2003).

> *Examination of the older persons' incomes, health status, and social support shows… There have been persistent inequalities in age, gender, and social class regarding resources, access to informal and formal care, and value accorded to later life. These inequalities are due to differences in status and resources… [and] raises the questions of the health status of the oldest generations, income distribution among generations and genders, of access to informal and formal care and adequacy of the latter for the frail older persons* (Henrard, 1996, p. 667).

Older persons may more likely resort to informal health care, home and folk remedies, traditional healers and traditional medicine, and faith healers (Mashobela et al., 2017). This is not just because of economic reasons, although often traditional medicine can be more expensive, but as likely out of habit, tradition, or personal beliefs and attitudes. However, changes associated with development and modernization can weaken traditional social values and networks that stress the vital role of older persons in society and reinforce traditions of intergenerational exchange and reciprocity. These changes include increased formal education and migration of young people from rural to urban areas, leaving older family members behind. Studies have investigated older persons' health status in SSA, WHO SAGE, and the IN-DEPTH network in 2010. Studies from the IN-DEPTH sites include South Africa, Tanzania, Vietnam, Uganda, Indonesia, and Bangladesh. However, few studies have investigated inequalities in healthcare access among older persons (Gomez-Olive et al., 2010; Kowal et al., 2010).

2.2.3 Accessibility Challenges Faced by Older Persons in Rural Settings: Zimbabwe

Access to health care by older persons can be defined as the ability to get the required medical care from health service providers when needed. It is a comprehensive measurement of access to health care and requires a systematic assessment of physical, financial, and socio-psychological access to services. Access to health care by older persons has long been a concern for public health administrators, health service researchers, and policymakers. Much of the extant literature focuses on subpopulations at risk of confronting barriers to health care. For several reasons, older persons residing in rural areas are often considered especially vulnerable. Rural areas are frequently characterized by poorly

developed and fragile economic infrastructures, resulting in poor access due to physical barriers, including a lack of public transportation, rugged terrain, and long distances (Murphy et al., 2018).

Mohatt (2000) categorized access to rural healthcare into three spheres which are physical, financial, and psychological. Physical access in rural areas includes difficulty accessing relevant healthcare services due to geographic distances, widely dispersed healthcare services, or lack of needed services within the community (Johnson et al., 2006). For older persons, financial status can further impede access to healthcare due to dependence on family and gatekeeping systems where patients must pay extra fees for chronic illness, which often characterize older persons. In most African states, lack of access to reliable health care financing in old age poses serious development challenges, and it is detrimental to healthy ageing, mainly because older persons often battle various health challenges, which attract substantial financial costs. In his notion of structuration, Giddens (1984) stated that just as an agent can alter the prevailing structure, the structure can also change an agent. Structuration theory suggests that the poor health practices of the community residents are as important as the absence of health facilities in the community in understanding why health outcome is poor in the given community (Oppong, 2014). The absence of health facilities has the potential to lead to a situation where the community residents will engage in poor health practices; this could be the driving force that will ensure health facilities are constructed in the given community.

Kaseke et al. (1998), cited in Dhemba (2014), expressed concern about older persons' access to health services, arguing that while older adults have a right to free health care in public hospitals and clinics, these are always overcrowded and medical services are usually inaccessible due to drug and medical personnel shortages. This leaves older persons with no choice except to contact private service providers, whose user fees are too expensive for those without health insurance. Other challenges that older individuals experience include a lack of knowledge and long distances traveled to receive services. The fact that most social services are concentrated in cities while 82% of older individuals live in rural regions is cause for concern.

Fee waivers in health care have not produced much since public health institutions lack the necessary pharmaceuticals and personnel to meet the unique needs of older adults. Zimbabwe's experience with overpriced, unavailable health care is comparable to that of other Sub-Saharan African countries. Age International (2017) discovered underinvestment in the resources needed to detect, treat, and care for older persons in a four-country study of Ethiopia, Mozambique, Tanzania, and Zimbabwe.

Challenges such as insufficient retirement pension, social marginalization, lack of access to essential services, health care, and food insecurity characterize older people's poor quality of life for older persons in Zimbabwe (Dhemba, 2014). Unacceptable' health care can negatively impact geriatric health by determining access to and provision of healthcare services. Dessa et al. (2018) aver that the acceptability of healthcare providers to the clients is an indicator of the utilization of services along with the capability of accommodating clients in a service structure and affordability, availability, and accessibility issues that are necessary for measuring the strength of the connection between healthcare providers and healthcare seekers. Matching patients' preferences (acceptability) and needs for health care with the ability of services to meet them must be considered together to avoid unintended consequences. The dimensions of access are not an independent construct. In rural Zimbabwe, the government mainly focuses on the issue of geographical access and the proximity of clinics within rural settings to alleviate some of the accessibility factors. However, this could inadvertently impact service delivery if these provided services do not meet the needs of the older persons population. Reducing geographical barriers to healthcare service alone can fail to guarantee acceptability to the users (older persons). Most of the studies on access have focused on one aspect of access (mainly geographical access to and availability of services.

2.3 Conclusion

This chapter evaluated the general terminology and concepts many writers use in diverse geographic contexts to explain access to primary healthcare services. Because there is no globally acknowledged standard for defining and assessing access, regularly used access variables were investigated, eventually leading to the development of a model for measuring and evaluating total access to healthcare provision for older persons. This helped

to shape the conceptual foundation for this study. Although this study focuses on evaluating various dimensions of access to healthcare, a review of different phases and aspects of healthcare outcomes, such as healthcare utilization, quality of healthcare, and health-related equity issues affecting older persons. Healthcare systems differ significantly amongst countries, with just a few offering universal healthcare. Public healthcare is often underfunded, overloaded, and unprepared to care for older persons, while private care is too expensive. It also dwelled on how TCAMs can prevent NCDs in older populations on a primary, secondary, and tertiary level while fostering well-being. African notions of health, disease, and therapy are best understood within African metaphysics, ethics, and cosmology.

CHAPTER 3

THEORETICAL FRAMEWORK

3.0 Introduction

The previous chapter located the study within empirical and conceptual literature on access to health care and its social determinants. The chapter shed light on contemporary

theoretical models of access to health care and the socio-cultural and socioeconomic dimensions of health care from a rural setting. It presented an overview of the study's relevant literature on accessing healthcare for older persons. This chapter examines the theoretical framework underpinning this study. The chapter is divided into two parts; the first part examines the Penchansky and Thomas model of access to health care developed in 1981, while the second part discusses Giddens' structuration theory, drawing insights on the relevant tenets used in the study. Bourdieu's structuralist-constructivism is an essential complement to the current understanding of health inequalities for indigent older persons and access to healthcare. The selection of these two philosophies was grounded on the pretext that the former provides a more sociological explanation of macro and micro influences of structural properties on day-to-day actions. Alternatively, the theory offers abstract lenses, though, with agents acting and responding to constraining or enabling structures. The latter offers strategic conceptual tenets that provide a complementary approach to the Structuration Theory. Within this model, the notion of access, as often used in discourses of healthcare systems, reflects the relationship between the characteristics of the study participants (agents in the Giddesian perspective) and expectations of the service providers, thus rendering the model suitable for this study. Medical sociology holds that every "option" of health practice should be influenced by both organizational structures (i.e., socio-cultural milieu) and individual agency factors (Kelly & Field, 1996; Cockerham, 2005).

3.1 Theories Ageing

Ageing is a lifetime process that involves maturation and change on a physical, psychological, and social level, as Riley (1978) points out. Ageing theories seek to clarify how we age. In order to contextualize ageing in this study, age stratification, cumulative disadvantage/advantage, and phenomenological theory will be briefly analyzed to give a sociological perspective and place this study into the geriatric discourse. In order to improve the sociology of ageing, there is a need to distinguish between individual ageing as a biological and social process as structural aspects of social struggles over limited resources, including access to healthcare. Perceptions and views on ageing are particularly relevant to the ageing process because they impact health and policy implementation. It is

also helpful to counteract the stereotypes about the ageing process. It also assumed that the country understudy (Zimbabwe), since the Older Person Act was enacted in 2012, is not yet in force and has not been given attention. Could this be because of the political will, unavailability of resources, or the lack of understanding of the ageing phenomenon?

According to Riley et al. (1972), age stratification is an essential aspect of both social structure and social dynamics influencing- and influenced by the behavior and attitudes of individual members of the society. It parallels class stratification in specific economic, social, and political resources. With increased longevity, the global uniformity of healthcare access is unparalleled between developed nations and LCIMs. Access to healthcare among older persons in SSA is dire due to higher poverty levels and low policy coverage, and the majority are not as well catered for as those in the developed nations. It is arguably factual that socioeconomic status influences use and quality of life regarding health. The older population in SSA is vulnerable due to antecedent factors such as poverty, a lack of adequate health infrastructure, and inadequate social welfare and support systems (Rahman & Ali, 2007). All of these sociocultural elements, along with others, can be used to explain why older persons in Africa are in a unique situation regarding the use of health and healthcare access and utilization. This lends strong credence to earlier research showing how socioeconomic status, money, and resources influence health-related quality of life and usage (Saeed et al., 2016; Li & Chi, 2007; Somkotra, 2013). A significant risk factor for sickness and death in older people is low income and insufficient or inaccessible pensions. Financial accessibility is one underlying factor affecting older persons' decisions on healthcare use.

The cumulative advantage/disadvantage theory of aging is characterized by the systemic propensity for interindividual variation in a particular feature (such as wealth, health, or status). The concept of cumulative advantage was introduced by Robert Merton in 1988, and it is concerned with "how initial comparative advantage of trained capacity, structural location, and available resources make for successive increments of advantage such that the gaps between the haves and the have-nots... widen" (p. 606). Social welfare systems are established in developed nations, but developing nations are unprepared to care for the elderly outside traditional family structures. Many African nations, including Zimbabwe,

lack social security systems, leaving older persons vulnerable. Good health depends on adequate income; the link between health and wealth cannot be ignored.

Phenomenological theory explores the subjective experiences of aging, highlighting how individuals perceive and make meaning of the ageing process based on their perspectives and interactions (Tuohy et al.,2017). Theories of aging should consider diverse perspectives on aging, including gender, culture, health, and identities. Non-Western nations may prioritize familial ties over autonomy and personal responsibility; not all individuals have equal access to resources. Narrative or life history research can examine perceptions of ageing and health to help understand ageing among older persons. This knowledge helps older persons adapt to life challenges and develop alternate interpretations of the aging process, known as biographical ageing. According to Mark and Twiggs (2018), the ageing body is essential to older people's daily lives and is hardly ever discussed in gerontological or sociocultural discourses. According to Brooks (2010) and Chonody and Teater (2018), ageing is a socially created phenomenon shaped by culture, societal expectations, and personal experiences. The phenomenological theory helps put into perspective how illness/disease is constructed and localized in different cultural groups. Acknowledging individual life stories promotes diverse explanations of aging, challenging the notion of a single "successful" aging standard for all older persons. Chapter 5 of this study will offer insight into how older persons in Zimbabwe construct and navigate healthcare in modern spaces, though biomedical and traditional medicine.

3.2 Theorising the Penchansky and Thomas Model of Access to Healthcare

This section provides an insightful analysis of the framework of access to health care as applied to the context of this study. In particular, this section discusses the critical elements of the Penchansky and Thomas model of access to health care and reiterates its relevance to the study. Penchansky and Thomas's (1981) model of access to health care provides the framework that guides this research. According to Penchansky and Thomas (1981), although access to healthcare is relevant to the advancement of health policies, legislation, and services, the concept has not yet been adequately defined; in reality, it is a condition that promotes inequality in healthcare distribution and widens the gap in healthcare outcomes between the rich and poor, which is particularly evident between urban and rural populations. According to Penchansky and Thomas (1981), access to healthcare does not

generally refer to the use of a healthcare system or the factors that influence that use, nor does the clients' health measure it. Instead, access to health care refers to the compatibility of a person and the health care system available to them. It is measured by factors enabling or constraining an individual's access to healthcare services.

Although studies on access to healthcare have applied Penchansky and Thomas' (1981) perspective in their analysis, very few have utilized all the components, such as rurality and ageing. To this effect, the current study seeks to utilize Penchansky and Thomas' five dimensions of access to health care, which are availability, accessibility, acceptability, affordability, and accommodation, to investigate access and social determinants of healthcare services for older persons in Chivi South, a rural district in Zimbabwe. This investigation was conducted after a collapsing healthcare system in Zimbabwe. Penchansky and Thomas' (1981) model of access to healthcare provides a framework that explains the multi-dimensionality of access to healthcare. Central to this model is perhaps the idea of constructing an analytical tool that facilitates the study of and research on access to health care and stimulates dialogue among the various dimensions of this model to present a comprehensive argument on healthcare access. The proposed conceptual model recognizes access as the outcome of a process involving the interplay between the characteristics of the healthcare service system and older persons in CSD. As Levesque et al. (2013) described, access encompasses five dimensions: approachability, acceptability, availability and accommodation, affordability, and appropriateness. Saurman (2016) argued that awareness should be another dimension of access and modified Penchansky and Thomas's (1981) Theory of access to health. Access to healthcare is decided by the spatial accessibility of healthcare services, which is a primary factor that determines healthcare utilization.

This section presents an in-depth access analysis, incorporating five components of Penchansky and Thomas's access to healthcare framework. This allows the study to focus on specific healthcare access problems among rural older persons in CSD. Against this backdrop, the model is appropriate, as it enables the access concept and its pertinent dimensions to be put into proper perspective when assessing the healthcare access situation in a specific national or regional context. On this note, Kullgren et al. (2011) conducted the first study using the Penchansky and Thomas' (1981) model to identify the population prevalence of non-financial barriers in adults in the United States of America and quantify

the multidimensional access challenges faced by adults facing difficulty affording health care. Their findings showed that non-financial barriers were not limited to the inability to secure an appointment when convenient, long wait times, lack of transport, long distance, and non-availability of geriatric healthcare services.

According to Penchansky and Thomas (1981), the access to healthcare model recognizes the five interrelated dimensions, including entry points and the factors influencing the choice to access healthcare. The five dimensions may seem vast and disjointed, but they suggest that improving access to health care is complex and needs to be tackled simultaneously from more than one angle. Thus, for policymakers to achieve comprehensive healthcare access, they ought to look at a broader picture and comprehend how factors that fall outside their direct control affect or impact users of healthcare services. The authors argued that the assumption held by policymakers that poor access can result in people receiving less appropriate care is not always the underlying factor. Foundational thinkers, such as Donabedian (1988), agree with Penchansky and Thomas (1981) on the need to provide an insightful view of the concept of "access" and how it intersects with the notion of social determinants of health. Penchansky and Thomas (1981) are theorists that more explicitly conceptualize access. Autonomous access to health care may occur if segments of the population, homogenous in terms of age, sex, or other characteristics, are considered separately. This approach assumes that dissatisfaction with a particular dimension of access may be salient for some groups of patients but not others, and it is consistent with the view that patients' beliefs and perceptions are important determinants of health behavior (Penchansky & Thomas, 1981). Individuals are the main components of the 'population;' they should be considered a part of society and the culture they belong to when implementing healthcare programs and interventions.

In addition, older persons have medical, financial, and social needs, some of which are common to all older persons. In comparison, others are unique to older persons residing in rural areas. The constraints that prevent older persons from getting access to health care are not only related to accessibility but to availability as well. In particular, older persons(those aged 70 years or more) living in rural areas cannot move quickly to district hospitals due to physical limitations. Moreover, they cannot afford expensive healthcare services without financial support. In Zimbabwe, the healthcare sector almost collapsed due to a persistent

economic meltdown and the absence of effective accountability by the responsible ministry and the State to provide adequate healthcare to vulnerable people, including older persons.

Furthermore, some obstacles should be eliminated to ensure that older persons in Chivi South District can utilize or benefit from healthcare services. These obstacles refer to the dimensions of access to healthcare as well. Travis et al. (2004) classify the constraints that hinder access to healthcare as financial (such as payment difficulties and informal payments) and physical barriers (such as long-distance travel to access healthcare facilities). According to Khan (1992), two of the factors determining access to health care (namely availability and accessibility) indicate the spatial dimension, and the remaining three factors present the non-spatial dimension of access to health care (Delamater et al., 2013). The spatial dimension emphasizes the significance of distance as an obstacle to or facilitator of access. In contrast, the non-spatial dimensions relate to income level, culture, ethnicity, age, and sex. In the related literature, the spatial dimensions (availability and accessibility) of access are combined, and the concept of 'spatial accessibility' is commonly used (Luo & Wang, 2003; Guagliardo, 2004).

3.3 The model underpinning and guiding the study: Penchansky and Thomas

Since the 1970s, access to healthcare has been conceptualized in different ways that encompassed demand and supply facets (Donabedian, 1972; Aday & Andersen, 1974; Penchansky, 1977; Gulliford et al., 2002; Oliver & Mossialos, 2004; Peters et al., 2008). This thesis focuses on the demand-side conception of access as propounded by Penchansky and Thomas (1981), who conceptualize access or utilization in terms of financial accessibility (the price of healthcare, income) and geographical accessibility (distance to healthcare facilities). The study's primary objective is to investigate access to health care and its determinants, focusing on the older persons living in Chivi South District in rural Zimbabwe. By exploring the accessibility of healthcare services in modern rural spaces, the proposed study seeks to contribute to the contemporary debate on the sociology of older persons. Penchansky and Thomas' (1981) access to healthcare model will be utilized to unpack access to healthcare among rural older persons. As the dimension of health care provided to people changes and increases with age, it can be said that older persons are the group of people that needs to be included in a proper healthcare structure where accessibility, availability, affordability, accommodation, and acceptability of the healthcare

services will be ensured through the consideration of their needs and barriers. Subsequent reviews point to additional dimensions that operate at various scales to determine access to health care.

Although attempts to describe the roles of different dimensions of access have generated several conceptual frameworks, little is known about how different dimensions of access influence the utilization of healthcare services in different geographical settings. Levesque et al. (2013) called explicitly for empirical research to test the relevance of each dimension in different contexts**.** Availability and accessibility are related constructs that pertain to the adequacy of the supply of healthcare providers and the location of providers for patients. Acceptability is the interaction between the patient and healthcare provider's attitudes and preferences towards acceptable personal and treatment practices, focusing on patient trust in the current study. Accommodation refers to how well the providers' operations are organized to accommodate patients' constraints and preferences. Affordability refers to the relationship of prices of services to patient income, insurance, and overall ability to pay. Finally, the conceptual model suggests that latent barrier class membership shapes respondent health service utilization behaviours**.** Access to healthcare services constitutes a crucial aspect of social determinants.

According to Penchansky and Thomas (1981), access to healthcare does not generally refer to the use of healthcare services or the factors that influence that use; neither is it measured by the population's health being studied. Instead, access to health care refers to the compatibility of a person and the healthcare system available to them. It is measured by assessing patient satisfaction or preventing them from using healthcare services. Access to health care remains complex, exemplified by the different authors' varying interpretations. In most remote African rural areas, the existing disparities in health care result from the inaccessibility and unavailability of healthcare facilities and human resources as well as poor road infrastructure needed to facilitate the utilization of healthcare services.

Penchansky and Thomas's (1981) healthcare access model underpins this study. Specifically, this study utilizes the five dimensions of access: approachability, availability, affordability, acceptability, and appropriateness. To illustrate this point, the first research question seeks to explore participants' responses about the dimension of approachability,

particularly how older persons perceive healthcare services in the Chivi District. The second research question seeks to understand the two dimensions of availability and affordability (ability to reach and pay for healthcare services). Against this backdrop, Penchansky and Thomas' healthcare access model provides an interpretivist understanding of the phenomenon under study. The study borrows from Sauzman's (2013) appropriateness premise, which stipulates how healthcare interventions must also be considered within the current social and cultural context and the justice of resource allocation, hence being accessible to older persons. In a nutshell, the five dimensions of healthcare access outlined above will be used to investigate access to healthcare services and social determinants of healthcare access for older persons in the rural area of Chivi District.

3.3.1 Accessibility

The relationship between the location of supply and the location of clients must be considered, reflecting on the client's transportation resources and travel time, distance, and cost. Compared with urban dwellers, rural people are more likely to travel long distances to access healthcare services, particularly specialist services. This can be a significant burden in terms of both time and money. The lack of access to healthcare services in rural areas mainly revolves around geographical accessibility, financial accessibility, and acceptability. Even where healthcare services are available and affordable, access to healthcare facilities is crucial and imperative. In Zimbabwe, the transport network system has broken down in some areas due to poor road maintenance, thus leaving many of the rural population unable to access healthcare facilities. Rural communities also have more older persons and residents with chronic conditions requiring frequent outpatient healthcare facility visits than urban communities. This becomes a challenge without reliable public transportation. This premise will seek to answer Objectives 2 and 4. A study conducted by Fiestas et al. (2019) found that low income, lack of healthcare supplementary insurance, and old age are other factors barring older persons from accessing healthcare services. This scenario is worse in countries like Zimbabwe, where most older persons have never worked and have no insurance or pension access. The economic meltdown that culminated in 2008 eroded the savings of the Zimbabwean population, thus aggravating the vulnerability of many older persons. A study by Okoroh et al. (2018) recommended an improvement in access to health

care for uninsured older person patients, highlighting different issues such as lack of transportation, insurance, family support, perceived complications in receiving health care by older persons, poverty, perceived dissatisfaction with the communication procedures with doctors, as playing an influential role in decreasing the accessibility of healthcare services by older person patients.

3.3.2 Availability and Accommodation

Availability and accommodation refer to the fact that healthcare services (physical space or healthcare workers) can be reached physically and timeously. Availability constitutes the physical existence of healthcare resources with sufficient capacity to produce services (existence of productive facilities) (Peters et al., 2007). Essentially, availability results from characteristics of facilities (for example, density, concentration, distribution, building accessibility), urban contexts (for example, decentralization, urban spread, and transportation system), and individuals (for instance, duration and flexibility of working hours). The southern African country is experiencing major socioeconomic troubles, which has resulted in several challenges in health facilities, including critical shortages of pharmaceuticals and staff such as physicians and nurses. UN declared Zimbabwe's healthcare system among the finest in the developing nations in 1985. However, most improvements made after independence appear to have been erased due to a lack of people and general poor administration.

In a study by Wilson and Nhiwatiwa (1992), Zimbabwe faces ageing issues due to inadequate institutional and national support for the elderly population. Despite the unpredictability of the AIDS epidemic's impact on the future population of older persons, there are compelling demographic reasons for Zimbabwe to plan for and execute geriatric services. Poverty increases, and older persons' lives are jeopardized due to insufficient, poorly targeted, and underfunded social safety nets and social care services (Hungwe, 2022). Access is restricted if available resources are unevenly distributed across a country or levels of care (with specialty care being developed at the expense of primary care).

An essential component of a country’s health structure is reflected in the availability of healthcare services and making them accessible to the country’s general citizenry (van Gaans & Dent, 2018). In this regard, older persons are vulnerable because making the

services available and accessible to the older persons is more complicated than doing the same for any other age group. The availability of healthcare services depends on a country's healthcare structure, the country's approach to providing healthcare services to the older persons population, and the arrangements made based on the prioritized issues and identified vulnerabilities. In ensuring increased availability of healthcare services, the development of the health status can be seen in the older persons population, which ultimately impacts the perceived satisfaction with health and healthcare services provided to older persons with health issues. Saurabh et al. (2013) found a relationship between increased life expectancy and healthcare delivery options. They identified different challenges impacting the availability of quality healthcare services, which, according to this paper, need a joint approach and strategies to be diminished. Fernandez-Olano et al. (2006) also consider the availability of healthcare services as a factor influencing an individual's decision to utilize healthcare services positioned within multiple linked issues related to self-perception about health. The study conducted by Fernandez-Olano et al. (2006) also established the importance of the availability of healthcare services, such as chronic diseases care centers, as this paper considers them crucial in the management of the perceived poor health status and the subsequent poor health outcomes such as increased morbidity, shorter life expectancy or disability as they relate to ageing issues.

As the age and diversity of the population increase, so does the potential for patients, including older persons, to experience barriers to healthcare access. A population may have access to healthcare if an adequate supply of healthcare services is available. The availability and accessibility of services and barriers to the utilization thereof must be evaluated in the context of diverse healthcare needs and the material and cultural settings of diverse groups. Evidence suggests a significant mismatch between professional expectations, patients' health needs, and patterns of uptake of healthcare services. This is exemplified by some groups' low uptake of preventive services, for example, the rural older persons, the delays in accessing care for severe conditions, or over-utilization of emergency services for what is deemed medical 'trivia.' The inadequacy of healthcare services to community needs impacts patients' use of a healthcare facility (Ladipo, 2009). These factors result in delays in seeking health care or obtaining required services at the most

appropriate time, thus adversely affecting the healthcare use and health-seeking behaviours of a country's rural residents (Cham et al., 2005).

3.3.3 Acceptability

Cultural and religious factors, including age, gender, education, race, and ethnicity, influence *acceptability* in healthcare services. It depends on social acceptance, religious preferences, shared language, and personal perceptions. There is a relationship between clients' attitudes towards personal and practice characteristics of providers and the actual characteristics of existing providers and provider attitudes towards acceptable personal characteristics of clients. Evaluating this dimension considers the beliefs and expectations of different groups. Providers may either be unwilling to serve certain types of clients (such as older persons) or, through accommodation, they may make themselves available. In rural areas with little anonymity, social stigma and privacy concerns are more likely to act as barriers to healthcare access. Residents may be concerned about seeking care for issues related to mental health, substance abuse, sexual health, or even common chronic illnesses due to unease or privacy concerns. The attitude of healthcare professionals was found to have a negative and statistically significant effect on healthcare utilization (Ameh et al., 2014; Liu et al., 2007). Ameh et al. (2014) highlighted that in South Africa, the attitudes of doctors and nurses at the first visit (a barrier reported by 6.7% of older persons) were significantly associated with the use of healthcare services in subsequent visits. Rural older persons expressed dissatisfaction with how doctors and nurses treated them in several low-income countries, including South Africa, Ethiopia, and India. Experiences of mistreatment included receiving no or little attention and a perception of receiving incorrect medical treatment (Sharma et al., 2013). This negatively impacted rural older persons' subsequent access to healthcare centers.

Health services attitudes can hinder access among older persons. Poor remuneration has affected service delivery in Zimbabwe. A certified nurse in Zimbabwe makes approximately 33,000 Zimbabwean dollars ($165) per month, which is insufficient for many who are now on the move to seek better living conditions abroad and in neighbouring countries such as South Africa, Botswana, and Namibia. Nurses in Namibia earn an average monthly income of 22,000 Namibian dollars ($1,472), while nurses in South Africa earn R28,470 ($1,887). Such enticing wages in neighbouring nations have only fuelled the flight

of Zimbabwean medical staff. According to the Zimbabwe Medical Association, the African country has about 3,500 doctors for a population of 15 million.

3.3.4 Affordability

There is a relationship between the prices of services and providers' insurance or deposit requirements and the client's income, ability to pay, and existing healthcare insurance. The clients' perception of worth about the total cost is a matter of concern here, as is their knowledge of prices, total cost, and possible credit arrangements. The affordability issue also determines the perceived level of satisfaction with older persons' health status. From the works of Giddens and Bourdieu, access to affordable healthcare depends not only on individual, household, and agency but also on broader social, cultural, and structural factors of a given social system. Affordability results from direct prices of services and related expenses, in addition to opportunity costs related to loss of income. The ability to pay for health care is widely discussed in health services and economics literature (Caner & Cilasun, 2019). The term also describes people's capacity to generate economic resources through income, savings, borrowings, or loans acquired to pay for healthcare services without the catastrophic expenditure of resources that are otherwise required to procure necessities (examples of such expenditure include home sale). Poverty, social isolation, or indebtedness would restrict people's capacity to pay for needed health care.

Funding for healthcare in Zimbabwe has been eroded, leading to costs of healthcare services, especially at rural health facilities charging user fees. The unaffordability of healthcare services for older persons: "lack of insurance or money to meet treatment fees," older persons and their families sell their possessions to cover medical bills (Kakongi et al.,2020). To save money, some older persons seek out local traditional healers with "negotiable fees," or they stay home praying and engaging in other religious rituals (Kakongi et al.,2020; Kibuga et al.,2009). Others reported purchasing drugs without prescriptions or formal medical consultation to save money on medical treatment, likely increasing their exposure to medical problems and other disorders (Waweru et al.,2005). The emergence of costly, unregulated private-sector healthcare providers is responsible for the decreased affordability of healthcare services among older persons. The introduction of neoliberal reforms has led to profound changes in global healthcare systems, as they emphasize the free market rather than people's right to health. Such reforms have

particularly disadvantaged older persons due to their increased healthcare needs and lower socio-economic status. The principle extended into welfare, education, and even pensions. In developing countries such as Zimbabwe, the shadow of the neoliberal reforms and the pressure to reduce government expenditure on health and to reorganize the health sector to bring in private provision and payments for service has been seen as a significant threat to the affordability of healthcare services for many.

A study conducted in India by Sbhojit et al. (2012) states that the adverse effect on affordability regarding older person issues can emerge from the individual's level of socioeconomic status. A study in Kenya suggested that affordability, because of the interaction of different demographic factors, such as sociocultural and institutional factors, determines how older persons perceive access to health care (Waurika, 2014). Andersen (1995) considers affordability as knowing about and the means to access healthcare services as well as the ability to make use of them, adding that some important parameters that measure affordability include income, health insurance, a sustainable source of income, and communication costs, which should be facilitated by available health care service structure. Apart from individual-level socio-economic issues that adversely affect affordability, several systemic factors underpin people's reduced ability, mainly older persons, to pay for health care services. Income security could be guaranteed through robust pension systems or State welfare schemes. Most African countries have neither of these. In cases where they do exist, welfare and social security systems face serious sustainability challenges. Healthcare affordability constraints include limitations in income, employment, and assets, as well as limitations in financial protection offered for health expenditures in a healthcare delivery system. The perceived barriers and needs of older persons foster an understanding of the multidimensional perspective of the older persons themselves based on their socio-economic condition and their respective accessibility, affordability, and acceptability of health care.

3.3.5 Appropriateness

Appropriateness refers to the societal perception of appropriate health care that reflects older persons' changing social and cultural values. This is centered on the effectiveness and efficacy of the *available* health care (Krishnan, 2000; Frenk, 1992). The ineffectiveness of health care is compounded by the skewed resource allocation by the government, which is

considered provisional, partly because of the unexplored social and cultural diversity of views and the uncertainties surrounding the aspect of disease construction, which can be a significant stumbling block between the service provider and the consumers (rural older persons). In Zimbabwe, vital machinery, such as dialysis machines and incubators, remained virtually inoperable at the substantial central hospitals (Baldauf, 2008). Zimbabwe experienced a socioeconomic crisis from 2001 to 2009, with acute recession and hyperinflation wreaking havoc on the national health system.

At the time of this study, the disease pattern in Zimbabwe was significantly dominated by communicable, maternal, perinatal, and nutritional disorders, which is similar to other Sub-Saharan African nations, even though Zimbabwe is plagued with an unusual economic crisis affecting healthcare delivery, and lack of human resources. There are inappropriate health provisions in Zimbabwe for older persons because rural health centers often lack appropriate drugs and diagnostic instruments, highlighting the inadequacy of health facilities for older patients. Non-communicable diseases like diabetes and hypertension are challenging to treat for older patients due to their high cost and demanding nature. Insufficient facilities may influence older persons' access to health services to meet their needs. Studies show that older women and men are often overlooked, and specialist care for common diseases like Alzheimer's is limited. Additionally, limited geriatric knowledge among health professionals affects the quality of care for older patients. Dispensaries are often far from older persons' residences, preventing them from receiving medical assessments. As a result, they may wait until severe health conditions require transportation to health centers. According to one research of physically challenged older Zimbabweans, the situation is as follows:

> *"Most interviewees claimed that if they became unwell, they would go to their local clinic; nevertheless, a few could not get there or could only get there with help." With age, one's ability to get to the clinic deteriorated. This issue does not appear sufficiently addressed by the local health worker system. Even though people living in townships were closer to their local clinic than those living in rural regions, the exact percentages reported trouble traveling to the clinic in both settings. Although more urban elderly people were using medication."* (Allain et al.,1997).

Governments neglect the elderly well-being, leading to the absence of social security plans and exclusion from other demographic groups. Data shows that most older persons in Zimbabwe are not covered. The economic decline in Zimbabwe has affected older persons in accessing and receiving appropriate healthcare. Financial crisis risks healthcare; fiscal austerity and weak social protection require controlling to reduce Zimbabwe's health crisis.

The different premises of access to healthcare summarised above present the difficulty of comprehending access by suggesting that access to healthcare cannot be generalized; instead, it must be examined thoroughly. Arguably, the general sense of these factors is that these metrics do not reflect the complete picture of access to health care because they are primarily defined by the demand side (patient) and the supply side (the healthcare provider); thus, the conceptualization of what is meaningful about access is mainly absent.

3.4. The Emergence of the Structuration Theory

The structuration theory was developed in the 1970s and 1980s by Giddens (Giddens, 1984; Fine, 1992; Cloke et al., 1991). Giddens (1984) developed the structuration theory in response to post-structuralism assertions that humans exist in predetermined structures that are either enabling or constraining. On this note, Giddens (1984) used distinctive terminology to explain dynamic relations that exist between the individual, which he calls "agency" and the "structure." Thus, the theory reflects on the relationship between agents and structures as reflexive, each playing an important role in effecting social change. The structuration theory provides insights into the processes of change and their impacts at the community level. At the heart of the structuration theory are notions of reflexivity, recursively, and the duality between structures and human agents. Cloke et al. (1991) posited that structures such as institutions, family, and the law enable human behaviour that ultimately influences and reconstitutes structures, thus giving the structuration theory conceptual validity. Giddens (1984) developed the structuration theory in detail, based on the premise that the gulf between naturalistic and interpretive traditions of thought needs to be bridged by a theory that reconceptualizes this taken-for-granted division. For him, dualism is always deeply embedded in social theory, a division between objectivism and subjectivism (Giddens, 1984). Giddens (1984) proposed to reconceptualize this division by presenting the idea of 'duality of structure.' For him, structure, which he defines as sets of rules and resources, has no existence without the 'knowledgeability' of agents in social life.

This implies that by reproducing rules (through habit and routine) and resources (institutions), agents reproduce the conditions that make such reproduction possible. In this sense, structure is both the medium and outcome of human agents' activities and is always constraining and enabling. Against this backdrop, it can be argued that the structuration theory is grounded on a philosophical principle that identifies the positive correlation between social forces that impact the individual's decision-making process. Thus, the essential objective of Giddens' structuration theory is the construction of the ontology of society. However, at a higher level of abstraction, the theory provides readers with a more sociological way of seeing human actions from the perspective of both the subjects and society.

3.4.1 Giddens' Structuration Theory

In order to provide a more sociological understanding of the phenomenon being studied, the study utilizes the salient features of Giddens' structuration theory. Giddens (1984) aims to integrate structuralism and functionalism. Giddens (1984) highlights the philosophies of social structure and human agency. The main thrust of this theory is to provide an understanding of how social practices are well-arranged across time and space. To reorganize the structure and human agency, Giddens (1984) reflected on agents' day-to-day actions that are produced and reproduced within a constraining and enabling structure. Giddens' (1984) view of agency denotes individuals' capacity to act and make independent choices. In this respect, the individual is the initiator with the ability to choose and make a difference, which Giddens (1984) foregrounded as 'transformative capacity.' Power plays a vital role in Giddens' notion of agency. On the other hand, Giddens (1984) conceptualized structure as recurring arrangements that influence or limit available choices and opportunities in different ways. In other words, Giddens (1984) views structure as resources or rules associated with social reproduction. The structure is both enabling and constraining. What is interesting in Giddens' theory is that rules and resources do not exist in isolation but in continuous practice in social systems.

Giddens' (1984) structuration theory will be applied in this study to understand better the relationship between the older persons in Chivi South District and their access to healthcare services. In so doing, the duality of structure and agency will be utilized to understand the phenomenon under study better. Building on Giddens' structure principle, a set of rules and

resources associated with facilitating older persons has far-reaching effects that might affect their access to healthcare services. Applying this theory in the context of this study, it can be argued that there are recurring relationships between older persons(agency) and structural conditions that affect access to healthcare services. Such relationships suggest that people create environments (structures) that shape the older persons' (agency) ability to access healthcare services.

The rationale for using Giddens' (1984) structural theory in this study is the theory's attempt to bridge the gap between naturalistic and interpretive traditions. Studying the dynamic relationship between cause and effect could help design and implementation decisions to achieve desired outcomes better. Giddens (1984) proposed that human agents and social structure are a mutually interacting duality instead of independent conflicting agents. Human agents produce, reproduce, or modify social structures through their actions, and in turn, social structures enable or disable human actions. The main argument herein is that the theory attempts to determine a central division in the field of social sciences between academia who argue that social phenomena are determined by the impact of objective external social structures and those who view them as a reflection of the 'agents' in light of a subjective understanding of the social world. Building on Giddens' (1984) theory implies that structure and agency are not conflicting elements but a commonly interacting duality. Such proclamations provide consciousness-raising on the lived experiences of rural older persons and provide knowledge that addresses the structural and healthcare practices of the phenomenon being studied. In this way, rural health is not solely produced in rural areas but through a complex process of relations in specific rural places (time-space distanciation) and more urbanized, social, cultural, political, and economic and health arenas. This means that the structuration theory explains how rural health manifests in geographically isolated spaces and is also the product of connections between actions in rural locales with macro-level policies, funding, health systems, social determinants, and broader processes.

In this study, the structuration theory will be used to understand access to healthcare services and its determinants in the case of older persons living in rural areas of CSD in Zimbabwe. In addition, Giddens' (1984) structuration theory best fits this research because it clearly explains the connection between agency (what people do) and structures

(established rules and understandings that either enable or constrain repetitive actions). The significance of such a philosophical thought to this research is that it connects what happens in rural spaces to broader structures and actions, integrating health policy, community action, political decisions, and rural service delivery or management. Theoretically, the structuration theory provides a sociological description of what people observe in healthcare delivery. Older persons in CSD are entitled to use institutions such as clinics daily. However, their actions are controlled by rules and resources available in the opportunity structure, particularly healthcare providers. This research thus explores how structure enables or constrains the study participants.

3.2.2 Key Elements of the Structuration Theory

The structuration theory was applied in this study to provide a sociological understanding of rural older persons' practices concerning their access to healthcare systems. The main aim is to show how social and belief systems affect how the study participants interrelate with healthcare structures to access healthcare facilities. For this reason, only those principles pertinent to this research, namely agency, structure, the duality of structure, and time-space distanciation, will be discussed. These four principles provide a nuanced explanation of participants' lived experiences regarding access to healthcare services and its determinants, focusing on the older persons living in CSD of Zimbabwe.

3.4.2 Structure and Agency

Structure and agency form an enduring ontological debate in social theory. In this context, 'agency' refers to the capacity of individuals to act independently and make free choices, whereas 'structure' refers to factors that limit or affect individuals' choices and actions (such as social class, religion, gender, ethnicity, and so on). Giddens' (1984) structuration theory suggests a social structure (traditions, institutions, and moral codes) that guides human behaviour. However, these structures themselves can be modified by human agency, for example, by reproducing them differently, interpreting them differently, or replacing them. Giddens (1984) has attempted to recast structure and human agency as the structure and human action duality through the structuration theory. In other words, social structure is drawn upon by agents in their day-to-day actions and is therefore produced and reproduced by these actions.

For Giddens (1984), the structure does not exist outside of the individual but encapsulates practice patterns. As practices change, the structure also changes, and vice-versa. The structuration theory bridges the dualism between objective and subjective social worldviews. It introduces the notion of dependency between human actions and structure in organizations. Anthony Giddens, an influential 20th-century thinker concerning the structure-agency debate, made the most important contributions to sociology through his structuration theory. The theory was developed in response to claims by past structuralists that the structures that humans find themselves in are determined for them, and volunteerism suggests that humans are entirely free to create their lived environment. The structuration theory has several unique nomenclatures explaining human 'agency' relationships with institutions or 'structures.' Giddens (1984) claims to have developed his theories not as a metanarrative but as a means of bridging the distance between political economy approaches and humanistic ones, avoiding the overly deterministic structures of political economy on the one hand and the overemphasis on the role of human agency in social change on the other. The structuration theory is based on the idea that both agencies, defined as the ability to deploy a range of causal powers, and structure, objectified as the rules and resources in society, give rise to people's social practices, which are the activities that make and transform the world in which we live (referred to by people in public health as behaviours). Using the heuristic of collective lifestyles (Frohlich et al., 2001), it has been argued that an adequate tackling of inequalities in health should address all three aspects of the structuration theory (agency, social structure, and social practices) rather than structure or agency alone. Underutilization of preventive healthcare services in rural areas is another concern. Casey et al. (2001) found that after controlling for demographic factors, rural residents are less likely than urban residents to obtain certain preventive healthcare services. Structures in rural health care (such as the physical healthcare facilities), the policies, and the processes that govern services and human resources are thought to impact the population's health by determining access to resources and healthcare services.

According to Giddens (1984), agency is when an individual can observe his or her own experience and then be able to give reasons for their action. The agency should be identified with reasoning and knowledge (Turker, 1998). According to Giddens (1984), agency involves a notion of practical consciousness, such as all the things known as social actors,

and hence must be known to make social life happen. Further, Giddens (1984) sees the relationship between structure and agency as the duality of structure, whereby individuals reflexively produce and reproduce their social life (Turker, 1998). Giddens (1984) re-configures the hard-edged dualism of agency and structure. Agency refers to how we decide to shape our relationships with other people to have a degree of autonomy in our actions (such as self-determination or control), which means that we have the 'power to do otherwise.'

Structure refers to the rules and resources used to govern the scope of our agency, and our actions are shaped by larger forces of society, be it organizational, cultural, social, political, or religious. Integrating the subjective and objective aspects of health and ageing into practical, cost-effective interventions for delivering healthcare services to older people is little understood. A healthcare programme design requires understanding how older persons define their health and well-being and the programmes they might consider helpful to support their efforts. The utilization of healthcare and social services is seen to be more closely related to age than to other socio-demographic characteristics. Many health problems are known to increase with age, and this demographic trend may lead to an increase in the absolute number of health conditions in this population.

Healthcare responses are also apparent in urban areas. However, rural and urban populations are impacted differently. For example, in the rural context, the lack or under-utilization of healthcare services is mainly impacted by geographical isolation. The structures that frame rural healthcare provision ultimately function as critical determinants of the nature and scope of healthcare service utilization. The rural locale is a particular 'setting in which social relations are constituted' and where rural health outcomes occur (Bernard et al., 2007). Rural locales incorporate all types of social relations, including conversations between health consumers, individual behaviours, the actions of community groups (such as fundraising for their hospital), relationships with the natural environment (through farming, mining, bushwalking), networks between individuals and power relations within the community (who are the decision-makers). While the focus is essentially 'local,' the 'local' is also shaped by connections with non-local people.

Broader social structural circumstances influence and shape health conditions, contributing to healthcare disparities between rural and urban populations (Pauly et al., 2009). This is especially significant in rural settings where social conditions such as poverty, chronic health conditions, unemployment, and low literacy and education impact health outcomes by limiting rural older person's ability to access health care. Existing rules, resources, relations, and social organizations are maintained to reproduce political, social, cultural, and economic behaviours and understandings (Giddens, 1984). The historical, social, and economic arrangements of society significantly impact the lives of rural people, resulting in their unequal health status.

A synthesis of the structuration theory's central assumptions and beliefs gave this study the necessary guidelines. The theory posits that structuration is a two-way process where individuals are shaped by society. At the same time, people are intrinsically involved in society because they can change or structure it. What people do in terms of health-seeking behaviour is, therefore, related to their structure and the way they have been socialized within their surroundings. The barriers that impede access to health care for older persons in rural Zimbabwe have much to do with the structure that shapes their day-to-day lives. Structure, which refers to the rules and resources that agents draw upon as they produce and reproduce society, can be written or unwritten, thus enabling social actors to go on in their social situations. Such resources as education and knowledge of older persons' healthcare services affect how Chivi residents react in situations of sickness and health. These aspects can either delay health-seeking or influence failure to seek it.

3.4.3 The Duality of Structure

The duality of structure refers to existing social structures constraining an individual's behaviour; however, this behaviour simultaneously constitutes social structures by rectifying or challenging the status (Giddens, 1984). Power is understood as the capacity to make a difference, to transform something from one state to another, either as an individual action or as an outcome of a more extensive system (Miller, 1992). In this way, power constrains an individual's ability. However, it also prescribes protocols for what is expected and provides opportunities for individuals and groups to act, thus enabling action to be initiated (Giddens, 1979 and 1986). Giddens (1984) argues that power accompanies action and proposes that the actor and structures are integral aspects of power analysis and are

mutually dependent. The structuration theory explores power and control within the social context and explores how the exercise of power can manifest itself in the dialectical interplay between agency and structure (Giddens, 1984).

3.5 Time-space distanciation - An empirically supported integrative framework for Access to Healthcare in Rural Areas

Giddens (1984) used the concept of 'time-space distanciation' to trace the historical trajectory of different societies, such as tribal societies that are characterized by low levels of time-space distanciation, class-divided societies with increasing levels of time-space distanciation, and industrialized societies with much higher levels (Johnston et al., 2000). Giddens (1984) defined "time-space distanciation" as "the stretching of social systems across time-space, based on social and system integration" (Giddens, 1984, p. 181). He further defined "time-space edges" as "connections, whether conflicting or symbiotic, between societies of differing structural types" (ibid). There is a close link between the concept of distanciation and power. Coordinating social systems across time and space involves the resources that, in combination, create structures of domination (Giddens, 1984). It is this concept that gives rise to the process of structuration, which, in turn, both constrains and enables human agents to effect change.

Specifically, structuration theory suggests that the poor health practices of older persons are as important as the absence of health facilities in CSD in understanding why health outcome is poor in the district understudy (See figure below). This suggests that poor health practices may lead to poor health outcomes, while poor health outcomes may limit an individual's capacity to engage in good health practices. Similarly, a lack of health facilities can lead to older persons engaging in poor health practices. In contrast, poor health practices could be the driving force to ensure the district's health facilities are constructed.

Giddens' Structuration Theory applied to health (Grooves et al.,2011)

3.6. Habitus, Field, and Capital: Incorporating Bourdieu's Structuralist Constructivism

Pierre Bourdieu' is one of the essential sociologists whose work is crucial in understanding the dynamics of healthcare access. His theory, often called structuralist constructivism and constructivist structuralism, sought to overcome the structure-agency dichotomy by proposing an integrated approach to understanding the iterative nature between structure and agency. He does this by giving three concepts, i.e., habitus, field, and capital. The idea of habitus, which encompasses internalized structures guiding behaviour can be used to understand older persons' construction of disease and the ordering of their world of healthcare. Several factors make up that habitus. They include belief systems, traditions, decades of socialization, and interaction that create a cognitive lens through which older persons conceptualize and interpret health and illness. Apart from habitus, Bourdieu proposes the concept of field, which he views as being dominated by competition and conflict, and individuals must navigate this social field. Health care can be considered a field, and older persons navigate this field by relying on several forms of capital. In this study, how does the concept of capital aid in the refinement of understanding of older persons' access to healthcare? The concept of social capital is fundamental, which Bourdieu defines as "the accumulation of actual or potential resources connected to the possession of a lasting network of more or less formalized mutual acquaintance and recognition" (Bourdieu, 1986, p. 248). An individual's social network can be used to acquire health

information and assistance, speed up access to healthcare, or get suggestions on good quality healthcare providers when using healthcare services. The social environment in Zimbabwe is characterized by constraints that limit how older persons access healthcare and social protection nets. The social environment has exacerbated poverty, inequalities, and other barriers such as HIV and AIDS, stigma and discrimination, isolation as a result of witchcraft accusations, weak implementation of legislative frameworks such as the Older Persons Act (17;06), the Social Welfare Assistance Act (17: 11), the erosion of social insurance, and the collapse of extended family institutions, among other issues (Chikoko et al.,2022). As a result, it is difficult for older persons in Zimbabwe to live a dignified life since the social context hinders rather than enables it. The social environment makes older Zimbabweans more vulnerable to various issues like illness, desertion, and neglect. Older persons can have a dignified life if social protection challenges are addressed.

In general, Bourdieu's theoretical orientation situates health behaviors within the family and social environment, with a particular emphasis on the components of individual capital structure, which include economic, cultural, and social capital, having complex effects on health behaviors at the same time (Paccoud et al., 2020). In other words, the many forms of capital that individuals own create the action resources that can be mobilized when there is a desire to enhance one's health. As a result, the qualities of these resources together may aid in predicting individuals' health behavioral tendencies. Older persons in Zimbabwe depend upon the declining tax-supported public health system of clinics and hospitals for essential health services. Kornadt and Rothermund (2022) added that treatment sources older persons seek when symptoms occur include socio-cultural factors like beliefs and household decision-making to seek care, social networks, and economic status.

Bourdieu’s approach is intriguing because it considers the monetary dimension of capital and other forms of capital (social and cultural), as represented in the symbolic dimensions of class relations, such as social relationships. This method allows us to make specific forecasts based on the possession of various types of capital. I hope to contribute to a deeper understanding of the class-related mechanisms of healthcare access for older persons in Zimbabwe by investigating the relative contribution of each capital and the consequences of different capital compositions.

Bourdieu never did health research, but his social capital theory can be used to investigate health inequality. Each kind of capital and its interaction can be crucial in gaining or sustaining excellent health (Abel & Frohlich, 2012). The use of this framework has various advantages. It gives a theoretical foundation for evaluating health disparities rather than simply creating them (Abel, 2007). Second, it allows us to account for the assertion that understanding health inequities requires various resources (Grineski, 2009). Third, Bourdieu's approach provides insight into commonly overlooked social structural variables that influence health, such as cultural factors (Veenstra, 2007). Finally, Morrow (1999) emphasizes the importance of this paradigm in avoiding the deficit theory syndrome, which refers to approaches that emphasize the resources that unsuccessful individuals lack. Bourdieu's theory emphasizes people's resources rather than the resources they lack, making it a theory of privilege rather than a philosophy of inadequacy.

3.7 Conclusion

As shown in this chapter, Penchansky and Thomas' access to healthcare contributes significantly to improving access to a regular source of care. More can be learned from Bourdieu and Giddens' work than has been done so far in the sociology of health and health research, especially when understanding daily routines and how they affect health and wellbeing. Interventions focusing on social practices rather than individual attitudes, behaviors, and choices will improve population health and foster good social change. Thus, the duality of structure and agency has been utilized to understand better the phenomenon being studied. Building on Giddens' structure principle, a set of rules and resources associated with facilitating older persons has far-reaching effects that might affect their access to healthcare services. Applying these theories in the context of this study, it can be argued that there are recurring relationships between older persons(agency) and structural conditions that affect access to healthcare services. Such relationships people propose create environments (structures) that shape older people's (agency) ability to access healthcare services.

METHODOLOGY

4.0 Introduction

This chapter describes the methods and techniques to address the study's key research questions. The study explores access to and social determinants of healthcare services for older persons in Chivi South District in rural Zimbabwe. It describes the critical aspects, including the research paradigm, design and approach, sampling method, data collection method, data collection tool, data analysis techniques, trustworthiness, and ethical considerations. The researcher describes the motivation for choosing such methods. All the critical aspects of the methodological approach are a culmination of the nature of the questions the study seeks to answer.

Furthermore, this chapter describes the study setting, entry into the study site, and the data collection process. The data collection procedures and processes comprise (i) data collection method (in-depth interviews), (ii) data collection tools (the researcher as the vital instrument in qualitative research and interview schedule), and (iii) pilot study. The last parts of the chapter comprehensively describe the data analysis and presentation processes. Furthermore, the chapter reflects on ethical considerations and how trustworthiness was ensured, mainly on data collection and management procedures.

4.1. Research Paradigm

Various scholars hold different understandings of the term 'paradigm.' MacNaughton, Rolfe, and Siraj-Blatchford (2001) contend that a research paradigm comprises three elements: a belief about the nature of knowledge, a methodology, and criteria for validity. Neuman (2000) and Creswell (2003) refer to the term 'paradigm' as epistemology, ontology, or research methodology. Mackenzie & Knipe (2006) demonstrate various understandings of paradigm and classify the variable theoretical paradigms as positivist (post-positivist), constructivist, interpretivist, transformative, emancipatory, critical, pragmatist deconstructivist, postpositivist, or interpretivist. In the post-positivist paradigm, the philosophy is determined by cause and effect (Creswell, 2003). In contrast, interpretivist

researchers seek to understand "the world of human experience" (Cohen & Manion, 1994, p. 36).

Cohen and Manion's (1994) views echo those of Creswell (2003) and Yanow and Schwartz-Shea (2011), who claim that interpretivist researchers discover reality through participants' views, backgrounds, and experiences. The interpretive model has a long history, from its roots in the Nineteenth Century to Dilthey's Philosophy, Weberian Sociology, and George Herbert Mead's Theory of Social Psychology. In sociology, the interpretivist paradigm is linked to the work of Marx Weber's Verstehen approach. Understanding phenomena in their contexts has elements of sympathy not in a psychological sense as an intuitive and non-conscious feeling but as a reflective reconstruction and interpretation of the actions of others (Platt, 1985). This study does not aim to investigate all sorts of research approaches and methods; instead, it mainly focuses on the interconnection between interpretivist and qualitative methods in the sociology of older persons. Therefore, this interpretivist paradigm was relevant because individuals experience healthcare services differently. The researcher sought to explore the uniqueness of experiences, hence the interpretivist paradigm. The paradigm influences the data collection method. For example, the interview method allowed the participants to explore the phenomenon in depth.

4.1.1 The Rationale for choosing the interpretive research paradigm in this study

The study uses an interpretivist paradigm. It derives its constructs from the field through an in-depth investigation of access and social determinants of health care services for older persons in CSD in rural Zimbabwe. It is suitable as it allows the researchers to view the world through the perceptions and experiences of the participants. Issues of access to health are not only influenced by the availability of physical infrastructure but depend on an appreciation of the social construction of disease since this ultimately determines health-seeking behaviour. Hence, how older persons access healthcare should also be contextualized in constructing meaning about health and illness. In seeking the answers to the study's key research questions, the investigator follows the interpretive paradigm and uses participants' experiences to construct and interpret their understanding of the gathered data. This paradigm is essential to fulfilling the main aim and objectives of the study.

Specifically, interpretivism supports scholars in exploring individuals' interpretation and understanding of their world.

Interpretivists believe that reality is not objectively determined but is socially constructed (Husserl, 1965). The underlying assumption is that placing people in their social contexts gives them a greater opportunity to understand their perceptions of their activities (Hussey & Hussey, 1997). The social construction of illness examines how social forces shape the understanding of illness, highlighting its social origin and individual responses within a sociocultural context, influencing cultural perceptions. By its nature, interpretivism promotes the value of qualitative data in pursuit of knowledge (Kaplan & Maxwell, 1994). Essentially, this research paradigm is concerned with the uniqueness of a particular situation, contributing to the underlying pursuit of contextual depth (Myers, 1997).

According to Burrell & Morgan (1979), interpretivism is not a single paradigm; it is, in fact, a large family of diverse paradigms. The philosophical base of interpretive research is hermeneutics and phenomenology (Boland, 1985). Creswell (1998) contends that a phenomenological study describes the meaning of the lived experiences of several individuals about a concept or phenomenon. In the human sphere, this translates typically into gathering "deep" information and perceptions through inductive qualitative research methods, such as interviews and observation, representing this information and these perceptions from the perspective of the research participants (Lester, 1999). It is, therefore, critical for others to understand the subjective perceptions of the researcher(s) from their social and cultural context. It was used to gain an in-depth insight into the twenty older persons in CSD experiences and perspectives on access to healthcare. The essential motive was the desire to join the participants' social environment to see how they build their reality from their perspective and synthesize the findings to contribute to the development of empirical knowledge (Glaser & Strauss, 1967). Thus, for interpretivism, what the world means to the person or group being studied is critically essential to good research in the social sciences. Interpretivists favour qualitative methods such as case studies, in-depth interviews, and observation because these methods better understand how humans interpret the world around them.

4.2 Research Design

Scientific research must be conducted within the confines of a stipulated research design. To select the appropriate research design, the study's purpose and critical research questions are the point of departure (Wahyuni, 2012). The current study sought to establish an in-depth understanding of real-life experiences in a natural context related to access to healthcare services by older persons in CSD. Therefore, it used a phenomenological research design, which dovetails with the qualitative approach described above. A phenomenological design was appropriate for this study because it focused on exploring humans' lived experiences through the description offered by those who went through those experiences.

Often, qualitative research emanates from real-world or direct experience; hence, phenomenology is an approach to qualitative inquiry that dwells on the participant's lived experiences. Daher, Olivares, Carré, et al. (2017), drawing from a Husserlian (Edmund Husserl:1910-1911) philosophy, argue that ignoring or defying the experience of the person who lives the phenomenon is simply impossible. This study investigates access to healthcare services by older persons in Chivi South District (Zimbabwe) and this sample's inherent social determinants of health. A phenomenological approach was deemed the best fit to elicit rich, thick data. Phenomenological studies approach research from a perspective where participants are asked to describe their experiences as they perceive them (Hancock et al., 2009).

4.2.1 Research Approach

The study's main objective is to investigate access to and the social determinants of healthcare services for older persons residing in Chivi South District in rural Zimbabwe. The perceptions and experiences of older persons concerning access to healthcare services cannot be measured quantitatively; therefore, a qualitative design was chosen. The qualitative approach is best suited for the study because it allows the researcher to explore the perceptions and experiences of older persons concerning their access to healthcare services. Adopting a qualitative research design empowers the participants by incorporating them as active contributors to research, thus making their voices heard.

4.2.2 Rationale

Qualitative research considers a particular characteristic of human experience and facilitates the investigation thereof (Creswell & Poth, 2017). People can access much of their experience, which may not be publicly available. Thus, data gathered to study such human experience must consist of first-person narratives or self-reports drawn from participants' experiences (Schwandt, 2001). This qualitative viewpoint can provide an invaluable perspective of what older persons may need from their resources, families, communities, or support systems (including healthcare programmes) to maintain their health and well-being over time, thus making them successfully consider themselves ageing individuals.

Polkinghorne (2005) emphasized that qualitative research is committed to the natural logic of language as a preferred medium that fosters an understanding of human affairs. The primary purpose of qualitative research is to describe and clarify experience as it is lived and constituted in awareness. Studying human experience is a challenging academic undertaking, as it is multi-layered and complex; it is an ongoing flow or "stream of experiences" that cannot be halted for the benefit of researchers (Polkinghorne, 2005, p. 137). The focus of qualitative research differs from that of statistical research; hence, it requires a set of principles that foster the selection of data sources. The focus of statistical research is to make claims about a population based on the studied sample of that population. Thus, it requires a random or representative selection of data sources from a population. On the other hand, a qualitative inquiry focuses on describing, understanding, and clarifying a human experience. It requires researchers to collect a series of intense, complete, and saturated descriptions of the experience under investigation. The unit of analysis in qualitative research is experience, not individuals or groups. Wand & Weber (1993) believed that numerically measured probability is only quantitative, and social science is merely concerned with qualitative inquiry. People being studied should be treated as human beings, and it is imperative to try to gain access to their experiences and perceptions by listening to and observing them.

Relevant data for this proposed study were collected from older persons and key informants from the Chivi South District. Qualitative research is an approach where the researcher is physically immersed in the study (Ehigie, 2005) to understand the participants' stories. This is important because "when people tell stories, they select details of their experience from

their stream of consciousness" (Seidman, 2006, p. 7). Furthermore, every word people use to tell their stories is a microcosm of their consciousness. In addition, qualitative research examines issues in depth and provides answers from participants' points of view (Denzin & Lincoln, 2003). On the other hand, quantitative research does not always adequately answer complex questions about the nature of human conditions.

Researchers using the quantitative approach are not inherently concerned about human interaction or feelings, thoughts, and people's perceptions in their research; they are merely concerned with facts, measurable behaviour, and the cause and effect of phenomena. Qualitative research offers rich and compelling insights into the real worlds, experiences, and perspectives of patients and healthcare professionals in ways entirely different from, but also sometimes complementary to, the knowledge that can be obtained through quantitative methods (Braun & Clarke, 2014). The qualitative approach was chosen to elicit the views relevant to answering the study's key research questions.

The trustworthiness of the conclusions drawn from a qualitative research study depends on a clear understanding of the purpose of the research and, hence, the form of the outcome it is intended to create. This informs the appropriateness of the research design and the robustness of the data analysis process (Thorne, 2000; Mays & Pops, 2000). Qualitative research is especially effective in obtaining culturally specific information about the study population's values, opinions, behaviours, and social contexts. It is valuable because it is suited to assess the validity of standardised measures and analytic techniques for use with diverse groups, thus permitting researchers to explore diversities in cultural and personal beliefs, values, ideals, and experiences. Qualitative interviews allowed us to gain an understanding and in-depth insight into the perspectives of older persons in CSD on this critical area of healthcare service.

4.2.3 Entry into the research site

The researcher's access to research participants is determined by a gatekeeper, an individual(s), an authority, or an organization that regulates the researcher's access to study participants (Neuman, 2016). The Ministry of Health and Child Care in Zimbabwe granted a gatekeeper's letter, permitting the researcher to access the participants and conduct the study. The University of KwaZulu-Natal's Humanities and Social Sciences Research Ethics

Committee considered this official permission to grant the researcher ethical clearance (HSS/0336/018D). While the gatekeeper's permission is critical, possessing this formal document and the ethical clearance certificate does not guarantee the researcher's cooperation or express access to participants. The researcher must negotiate with local traditional and informal gatekeepers (hospital personnel and kraal heads) to help the researcher gain access to the older persons' participants.

Another primary ethical consideration was that participants should sign the informed consent form. The research participants for this study were older persons. Since some could not read or write, informed consent was given orally, or assent was provided by literate relatives who assumed guardianship. Before the interviews, the researcher informed participants about the study's objectives. Researchers must abide by the principle of respect for the dignity of all human beings, which involves upholding the value of participants' privacy and the confidentiality of the personal information they disclose. The researcher informed participants that no incentives were given for participating in the study. Chivi South District is prone to drought and poverty; hence, the community would easily assume that the study offered avenues for them to receive donor aid. Therefore, to avoid such assumptions, the researcher had to clarify that there was no remuneration for participating in the study.

4.2.4 Study area: Chivi South District

Chivi is a district in Masvingo Province, southeastern Zimbabwe (KwaChivi). It is a semi-arid area which falls in agricultural regions 4 and 5. It is also the name of a mission station established in 1892 by Wedpohl, Neitz, and Dietrich Christian missionaries from Berlin, Germany. During colonial times, the district was known as Chibi, which was some form of corruption of the name Chivi. The Chivi South comprises 11 wards. The current study was conducted in wards 1, 19, and 22. These three wards were selected because they still hold quite a significant population, as some of the wards had communities dispersed due to the Tokwe-Mukosi flooding disaster in 2014. Its proximity to South Africa encouraged many residents to engage in cross-border trading, contributing significantly to the local economy (Ojong & Mhandu, 2018). Border jumping across to neigbouring South Africa is rife among the youths, most due to rampant unemployment in the entire country.

The Masvingo-Beitbridge highway is busy with long-distance buses and trucks plying the route. These provide a ready market for informal traders who sell by the roadside. This has helped people to supplement their meager income. Some residents have resorted to charging for the goods they sell using the South African Rand as the Zimbabwean dollar has lost value daily. This scenario makes life unbearable for residents who do not have access to foreign currency.

Owing to the scope of the study, this research does not entirely cover Zimbabwe. Its focus is on Chivi South, which is in rural Zimbabwe. To the researcher's knowledge, no empirical research focusing on older persons was done in the district in question. The situation in Chivi South is not any different from other rural areas. However, there is hardly any exhaustive data on older persons' health status and healthcare service accessibility, making tailored intervention difficult. A recent study on older persons in rural Zimbabwe was conducted in the Buhera district. Its focus was on the effects of excluding rural older persons in health education (Muchinako et al., 2017). No study has explored narratives bordering on access to health care and its determinants among people in CSD. Comparative studies are mostly gender-based, often based on the assumption that women's expectancy is longer than men's (Munyaradzi & Mhloyi, 2017).

4.3 Sampling (selection of participants

According to Polkinghorne (2005:12), the standard 'sampling process,' though used often in qualitative research, should be replaced by the phrase "selection of participants." This is so because sampling carries connotations of a quantitative orientation, especially since participants are chosen to be statistically representative. Polit et al. (2001) confirm that a portion that represents the whole population is selected in sampling, and sampling is closely related to the generalisability of the findings. However, Burns & Grove (2003) refer to sampling as selecting a group of people, events, or behaviors to conduct a study.

Sampling procedures in qualitative research are sometimes referred to as purposive, meaning that the theoretical purpose of the project, rather than a strict methodological mandate, determines the selection process. Purposive sampling is the technique mainly used in naturalistic inquiries or studies. It is defined "as selecting units (e.g., individuals, groups of individuals, or institutions) based on specific purposes associated with answering a

research study's questions" (Teddlie & Yu, 2007, p. 77). Sampling helps the researcher focus on key informants who are exceptionally knowledgeable about the issues under investigation (Schutt, 2006). Thus, purposive sampling allows decisions to be made by the researcher about the selection of participants (Ary et al., 2010; Bernard, 2000). In addition, it allows the researcher to justify their intention to use a specific category of informants in the study (Bernard, 2000). Besides, purposive sampling provides more excellent in-depth findings than other probability sampling methods (Cohen et al., 2011). Purposive sample sizes are often determined based on theoretical saturation (a point in the data collection when new data no longer brings additional insights into the research questions).

This study used the non-probability sampling technique, and participants were selected purposively. The participants were drawn based on their significant relation to the topic. The researcher selected 30 participants; 15 females and 15 males were selected and interviewed. Of the 30 participants, 20 participated in in-depth interviews, while 10 were key informants (one District Health Director and nine nurses were drawn from clinics based in rural areas. Patton (1990) argued that participants selected for a qualitative study are not selected because they fulfil the representative requirements of statistical inference but because they can substantially contribute to filling out the structure and character of the experience under investigation.

The reason for using multiple participants (a form of triangulation) is to provide accounts from different perspectives about an experience, thus enriching the data. By comparing these perspectives, researchers can notice outstanding features (Polkinghorne, 2005). The eligibility for participation was as follows: Older persons over 65 should be either male or female. The researcher selected those participants who had been residing in Chivi South District for five years or more when the study was being conducted, and participants were recruited mainly based on kraal heads that constituted the local administrative organs in rural communities. The kraal heads also served as key informants in the study.

4.3.1 Data Saturation

The question, 'How many is enough?' is critical in qualitative research (Fusch & Ness, 2015). To answer this critical question, a researcher can conduct research in a manner that enhances the attainment of data saturation (Francis et al., 2010; Gerring, 2011; Gibbert &

Ruigrok, 2010; Onwuegbuzie et al., 2010) by collecting rich (quality) and thick (quantity) data (Dibley, 2011). Although an appropriate study design must be considered, one could choose a data collection method that has been used before (Porte, 2013) that demonstrated attainment of data saturation; moreover, one would correctly document the process as evidence (Kerr et al., 2010). Interviews are one method by which study results can reach data saturation. Bernard (2012) argued that the number of interviews needed for a qualitative study to reach data saturation was not quantifiable but that which depended on what the researcher could get. However, scholars such as Guest (2006) and Bounce & Johnson (2006) propose that 12 participants are enough to reach data saturation among a homogenous sample. More importantly, stopping information gathering depends on the 'redundancy' of information or 'saturation.' Redundancy is "the process of sequentially conducting interviews until all concepts are repeated multiple times without new concepts or themes emerging" (Trotter, 2012, p. 399).

Unlike quantitative research, which aims to quantify or count the number of opinions, qualitative research aims to explore the range of opinions and diversity of views and collect "rich information." Therefore, the number of participants required depends on the nature of the research and the number of participants needed to answer the research questions. Generally, the focus is not on sample size but on sample adequacy because generalisability is not a priority in qualitative research. Hence, sampling adequacy is usually justified by attaining "saturation" (Bowen, 2008). Researchers use saturation to gauge the collected data quality (Guest, 2006).

Bowen (2008) argues that researchers are not transparent about how exactly saturation is reached and highlight the practical constraints in terms of time and resources that determine the number of participants that can be interviewed, and sometimes saturation cannot be reached. O'Reilly & Parker (2012) explain that this does not invalidate the findings; instead, it means that the phenomenon has not yet been fully explored, and this should be reported in the findings. This study attained data saturation at different points in the two samples. Among the older persons who participated in in-depth interviews, data saturation was reached during the 15th interview. However, the interviewing proceeded to the 20th interview as the researcher sought to ensure no new data would emerge. The other sample comprised key informants. This sample was predetermined; hence, the principle of data

saturation was inapplicable—the selection of key informants for participation in interviews aimed to ensure adequate representation. Therefore, the concept of data saturation was used to determine the size of the sample.

4.3.2 Data Collection Method

Qualitative research is usually multi-method in nature. Therefore, this study's principal data collection method is in-depth interviews involving participants and key informants. In-depth interviews are primarily advantageous because they provide the most detailed information in comparison with other data collection methods such as surveys (Kvale, 1996; 2006). Through in-depth interviews, qualitative studies investigate a variety of human experiences. These interviews attempt to understand the world from the subjects' points of view and through the meaning they attach to their lived world. They give voice to ordinary people, allowing them to freely present their life situations in their own words, thus enhancing a close personal interaction between the researcher and their subjects. During interviews, the marginalized, who do not ordinarily participate in public debates, can have their social situations and viewpoints communicated to a larger audience. In this study, the older persons are the marginalized, whose voices are erased from the main discursive spaces. Therefore, qualitative research adopts a social justice flair. Even though this data collection method has limitations, in-depth interviews are most valuable because they also provide a more relaxed and comfortable environment where participants can feel free to converse (Boyce & Neale, 2006). In this instance, older persons preferred to maintain privacy regarding their health; therefore, the interview setup provided an appropriate environment for privacy. The main aim of this technique is to provide insights into the perceptions and experiences of older persons concerning access to and availability of health care services, as well as the socio-cultural factors that influence the experiences of the study participants.

The selected method allowed for the study of a small sample through in-depth interviews. This helped the researcher to investigate, in greater depth, a small group of people as compared to investigating a large sample, which does not allow in-depth interviewing (Miles & Huberman, 1994 cited in Welman et al., 2005). The strength of a qualitative study is that first-hand experiences of the subject under investigation produce the best data (Welman et al., 2005). In this case, the researcher was in contact with the older persons of

Chivi South District, who provided her with first-hand experience on access to health care and its determinants. Like quantitative analyses, the qualitative investigational perspective can employ various forms of interview design to obtain thick, rich data (Creswell, 2007).

4.4 Data Instruments

The in-depth interview method is valuable not only because it builds a holistic snapshot, analyses words, and reports detailed views of informants but also because it enables interviewees to "speak in their voice and express their thoughts and feelings" (Berg, 2007, p. 96). Moreover, the in-depth interview, like other qualitative approaches to social science research, differs from quantitative methods in that it can analyze the resulting data, thus allowing participants to narrate their social life. According to Kvale (1996:174), an interview is "a conversation, whose purpose is to gather descriptions of the (life-world) of the interviewee" concerning the interpretation of the meanings of the 'described phenomena.' Similarly, Schostak (2006) adds that an interview is an extendable conversation between partners that aims to elicit 'in-depth information' about a specific topic or subject and through which a phenomenon could be interpreted in terms of the meaning interviewees attach to it. This section focuses on the two instruments used to gather the data: the researcher as the key instrument and an interview guide.

4.4.1 Researcher as an Instrument

In qualitative research, the researcher is the key instrument (Patton, 1990; Kvale, 1996). This characterization of research instruments makes the researcher inseparable from the research itself (Jackson, 1990). This has broader implications; for example, the credibility of the researcher is of particular significance in qualitative research, and it is so because the researcher is the main instrument of both data collection and analysis processes (Patton, 1990; Fusch & Ness, 2015; Shenton, 2004). The level of researcher involvement in qualitative interviewing embodies the researcher's unique and widely acknowledged role as an instrument of data collection in a qualitative study (Cassell, 2005; Rubin & Rubin, 2005; Turato, 2005). Because the researcher is the instrument in semi-structured or unstructured qualitative interviews, unique researcher attributes can potentially influence the collection of empirical materials.

Scholars often advocate for interviewer reflexivity (Ellis & Berger, 2003; Pillow, 2003). The researcher is the primary instrument facilitating the in-depth interview method in qualitative studies (Guba & Lincoln, 1981; Merriam, 2002). However, some notable exceptions exist (Pitts & Miller-Day, 2007; Watts, 2008). The qualitative interview is a collaborative enterprise, an exchange between two parties, the interviewer and the interviewee. The interviewer's role affects the interview's organization as a form of talk-in-interaction and the process of producing the talk. In readiness for data collection, the researcher prepared for an effective data collection exercise by conducting a pilot study, which benefited the researcher, whose interview skills significantly improved.

4.4.2 Interview Guide

The interview guide provides a framework detailing the questions that guide the interviewer to focus on areas covered within the framework. It outlines the questions or issues to be explored during the interview. It essentially serves as a memory aid to the researcher. According to Patton (2002), the guide provides topics for the interviewer to explore, probe, and ask relevant questions. The guide helps make interviewing several people more systematic and comprehensive by delimiting the issues to be explored. Questions included in the interview guide were generated after a thorough literature review was conducted to identify gaps and align the interview questions with the broader research questions.

4.4.3 Pilot Study

A pilot study is a preliminary study conducted to pre-test research protocols, data collection instruments, sample recruitment strategies, and other research techniques in preparation for a more extensive study (Lancaster et al., 2006). It is one of the most critical stages in a research project, conducted to identify potential problem areas and deficiencies in the research instruments and protocols before implementation during the whole study. The researcher conducted a pilot study for the current study, demonstrating the study protocols' feasibility. The pilot study had two components; the first was conducted with two key informants, and the second was conducted with five older persons. These participants were excluded from the main study because they had already been exposed to the questions, and their contributions could affect the findings. Conducting the pilot study allowed the researcher to improve the data collection tool (interview guide) and thus develop the researcher’s interview skills. Improving the researcher’s interview skills is essential because

the researcher is the key data collection instrument in qualitative research. Therefore, the pilot phase of the study was an important endeavor to generate rich and thick data.

Conducting the pilot study helped to illuminate several areas of interest to the study. At the onset of the study, the researcher intended to interview older persons and healthcare personnel; caregivers (who are in contact with older persons) were included in the research process. While the majority of wealthy nations have also constructed institutional social support systems, such as welfare programs and homes for the elderly, developing countries, notably in Africa, primarily only have an informal system of care. The younger family members are responsible for providing the care and support of older persons. The pilot study also assisted the researcher in revisiting the interview guide to incorporate issues such as health-seeking behavior issues with alternative medicine; it allowed the researcher to have a holistic approach to understanding their health-seeking (how they construct illness) among older persons.

4.5 Data Collection Process

The researcher conducted all the interviews with the aid of a research assistant. The research assistant was an undergraduate social sciences student trained to conduct interviews, capture field notes, explain issues of informed consent to participants, and to audio-record the interviews. The researcher would introduce the topic, and after signing the informed consent form (see Appendix B), the interview would proceed. While the researcher led the dialogic engagement, the research assistant would take field notes and ensure the interview was audio-recorded for later transcription. The interviews would last for approximately one hour. Examples of questions asked during data collection are (i) *What are the challenges you face in accessing healthcare services, if any?* (ii) *Based on your personal experience, what are the main factors and conditions determining your access to healthcare services?* The researcher would stop interviewing the participants when data saturation was achieved.

4.6 Data Analysis

The data analysis process started with transcription, which entails changing audio data to a word format. Data transcripts were generated. The data were manually coded; hence, the researcher employed thematic analysis, which involved analyzing transcripts and

structuring the themes of the interviews. Braun & Clarke's (2006) six-stage approach to data analysis, which entails familiarising with the data, generating initial codes, searching for themes, reviewing potential themes, defining and naming themes, and finally producing the analysis results, was used during the data analysis process.

4.6.1 Thematic Analysis

As qualitative research becomes increasingly recognized and valued, such research must be conducted rigorously and methodically to yield meaningful and valuable findings (Attride-Stirling, 2001). Therefore, thematic analysis was relevant to this study. To be accepted as trustworthy, qualitative research must demonstrate that data analysis has been conducted precisely, consistently, and exhaustively through recording, systematizing, and disclosing the methods of analysis with enough detail to enable the reader to determine the credibility of the process. Qualitative research is a valued paradigm of inquiry. The complexity surrounding it requires rigorous and methodical methods to create valuable results, and thematic analysis is a relevant qualitative research method. Data analysis conducted systematically can be transparently communicated to others (Malterud, 2001; Sandelowski, 1995).

The data analysis process started with the researcher listening to interview recordings. The researcher transcribed the recorded interviews and commenced the data collection process so that nuances or impressions would not be lost. Kvale (1996) teased qualitative researchers about being confronted with transcribing and analyzing 1000 pages of text, noting that unfocused interviewing probably results in texts becoming so large. Nevertheless, data analysis for qualitative study results in hundreds of 'languaged' data, but the advent of computer programming has made data management more efficient. It helps the researcher sort data quickly, structure and analyze text, and manage the resulting interpretations and evaluations. However, no computer-aided analysis was conducted in this study.

The researcher used thematic analysis, which Braun & Clarke (2006) describe as the best method of identifying, analyzing, and reporting patterns (themes within data) while also organizing and describing the data in detail and providing the opportunity to interpret various research topics. This method has, therefore, been used to analyze data from

qualitative interviews because of its usefulness in exploring contexts and meanings guided by specific themes.

4.7 Trustworthiness

Positivists generally question the trustworthiness of qualitative research, perhaps because their concepts of validity and reliability cannot be addressed in the same way as in naturalistic studies. Qualitative research is based on subjective, interpretive, and contextual data, thus making the findings more likely to be scrutinized and questioned. Therefore, researchers must ensure their research findings' reliability and validity (trustworthiness). The findings must be believable, consistent, applicable, and credible to be helpful to readers and other researchers. Issues of the validity and reliability of research instruments are significant to the findings of any scientific research. Dörnyei (2007) adds that the validity and reliability issues guarantee the results of the respondents' performances. In its broader context, validity refers to the degree to which a study reflects the specific concepts it aims to investigate and the accuracy or correctness of the findings.

On the other hand, reliability refers to the extent to which a research instrument yields the same results on repeated trials. However, Brewerton and Millward (2001:74) justifiably argue that interviews have poor reliability: "…due to their openness to so many types of bias, interviews can be notoriously unreliable, particularly when the researcher wishes to draw comparisons between data sets". In line with this observation, Creswell (2009) claims that the reliability of data obtained through interviews is 'elusive' and that no study reports reliable data. As such, Creswell (2009) added that researchers should use techniques that would help them maintain the validity and reliability of the interview method. These can be (i) avoiding asking leading questions, (ii) taking notes not just depending on tape recorders, (iii) conducting a pilot interview, and (iv) giving the interviewee a chance to sum up and clarify the points they have made. All these suggestions were adopted in the current study. The four essential parameters used to ensure trustworthiness are outlined below.

(i) Dependability

According to Bitsch (2005:12), dependability refers to "the stability of findings over time." Dependability involves participants evaluating the study's findings, interpretations, and recommendations to ensure that they are all supported by the data received from the study's

informants. Dependability ensures that the research findings are consistent and can be repeated. This is measured by the standard of the research being conducted, analyzed, and presented. Each process in the study should be reported in detail to enable an external researcher to repeat the inquiry and achieve similar results. This also enables researchers to understand the research methods and their effectiveness. In the current study, the researcher was committed to enhancing dependability.

(ii) Credibility

Credibility is the confidence that can be placed in the truth of the research findings (Holloway & Wheeler, 2002; Macnee & McCabe, 2008). For Trochmin and Donnelly (2008), credibility refers to the researcher's ability to establish the plausibility of research findings from the participant's perspective. In line with Tromich's (2006) and Trochmin and Donnelly's (2008) views, this study established credibility through lengthy engagements with the older persons during the in-depth interviews and providing a vivid description of the data. Credibility was also established by triangulating data collected from multiple sources (nurses, village healthcare workers, and older persons). Credibility is involved in ensuring that the results of the research are believable. This is a classic example of emphasizing 'quality, not quantity.' Credibility depends more on the richness of the information rather than the amount of data. Many techniques are used to gauge the accuracy of the findings, such as data triangulation, triangulation through multiple analysts, and member checks. The participants are the only ones who can reasonably judge the credibility of the results. The credibility criteria involve establishing that the results of qualitative research are credible or believable from the perspective of the participants in the research. From this perspective, the purpose of qualitative research is to describe or understand the phenomena of interest from the participants' eyes; the participants are the only ones who can legitimately judge the credibility of the results. The researcher conducted member checks, and participants were allowed to reflect on their contributions, making additions and corrections.

(iii) Confirmability

Confirmability refers to the degree to which other researchers can confirm or corroborate the results (Baxter & Eyles, 1997; Tromich, 2006). Confirmability is concerned with

establishing that data and interpretations of the findings are not figments of the inquirer's imagination but are derived from the data (Bowen, 2009; Koch, 2006; Lincoln & Guba, 1985). Confirmability questions how the collected data supports the research findings. This process establishes whether the researcher has been biased during the study due to the assumption that qualitative research allows the researcher to bring a unique perspective to the study. An external researcher can judge whether this is the case by studying the data collected during the original inquiry. To enhance the confirmability of the initial conclusion, the researcher kept an audit trail throughout the study to demonstrate how each decision was made.

Qualitative research assumes that each researcher brings a unique perspective to the body of knowledge. Several strategies can be adopted to enhance confirmability. The researcher can document the procedures necessary when checking and rechecking the data throughout the study. Another researcher can take a 'devil's advocate role concerning the results, and this process can be documented. The researcher can actively search for and describe *negative instances* that contradict prior observations. Moreover, one can conduct a *data audit* that examines the data collection and analysis procedures and makes judgments about the potential for bias or distortion. With the help of the research assistant, the researcher implemented all these strategies to increase conformability.

(iv) Transferability

Transferability refers to the degree to which the results of a qualitative study can be generalized or transferred to other contexts or settings (Trochim, 2006). According to Bitsch (2005), the "researcher facilitates transferability judgment by a potential user through 'thick descriptions and purposeful sampling. This means that the researcher must provide a detailed description of the inquiry and purposively select participants. Transferability refers to the degree to which the research can be transferred to other contexts, and readers of the research can define this section. The reader notes the specific details of the research situation and methods and compares them to a similar situation in which they are more familiar. The original research would be deemed more credible if the specifics were comparable. Transferability refers to the degree to which the results of qualitative research can be generalized or transferred to other contexts or settings. From a

qualitative perspective, transferability is primarily the responsibility of the one generalizing the results. The qualitative researcher can enhance transferability by thoroughly describing the research context and assumptions central to the research. Although the findings of this study cannot be generalized to other older persons in a different space and time, by providing a thorough and accurate description of the research methodology, processes, assumptions, and limitations, the person wishing to "transfer" the results to a different context is then responsible for making the judgment on how sensible the transfer is.

4.8 Ethical Consideration

Ethical issues are vital in social science research. Research projects should rigorously adhere to ethical considerations when dealing with human participants. According to Cohen et al. (2007), as interviews are considered an intrusion into participants' private lives regarding the time allotted and the level of sensitivity of questions asked, a high standard of ethical considerations should be maintained. It is essential to clearly distinguish between acceptable and unacceptable conduct, especially when human beings are involved in a study. Relevant to this study, four fundamental principles lay the foundation for healthcare ethics, which are: (i) voluntary participation, (ii) right to withdraw from the study without any adverse consequences, (iii) anonymity and justice ensure that patients are treated equally, and (iv) credibility, which was established through prolonged engagement with participants.

In the field and when providing a vivid description of the data, trustworthiness, fairness, impartiality, non-maleficence, not harming patients and autonomy, honour patients' right to make their own decisions. The principle of anonymity, which is directly related to confidentiality, suggests that researchers must ensure that participant data remains anonymous (Bless et al., 2013). Morrow (2005) perceives trustworthiness as a core criterion for quality and rigor in qualitative research. The trustworthiness of the data depends on the researcher's integrity and honesty (Haverkamp, 2005). In this study, the researcher was exquisitely committed to ethically conducting the research. During the data collection process, participant confidentiality was maintained in multiple ways. Participants were arbitrarily identified by letters of the alphabet, and their names were kept separate from all collected data during all the stages of data collection, analysis, and storage.

4.9 Conclusion

This chapter discussed the methodology of the study. It described the research methods, approach, sampling technique, and ethical considerations. This interpretive research paradigm was mainly associated with Max Weber (Crotty, 1998) and Alfred Schutz (Pring, 2000). Cohen et al. (2003) present the distinguishing features of the interpretive paradigm. Interpretivists state that reality is multi-layered and complex. They believe that people are creative and actively construct their social reality. The interpretivist paradigm is essential because it defines a researcher's philosophical orientation, which has significant implications for every decision made in the research process, including the choice of methodology and methods. Thus, a paradigm suggests how meaning is constructed from the data gathered based on individuals' experiences. The rationale behind the selection of a qualitative research design was adequately elucidated in this chapter. A consistent argument for using qualitative research in health care enables researchers to answer questions that quantitative methods may not quickly answer. The study utilized in-depth interviews to explore the accessibility of healthcare services among older persons living in rural CSD. The selection of participants, data saturation, data extraction, and analysis were methodically described. Ethical issues were considered in the fieldwork. The following four chapters present and discuss findings from the in-depth interviews discussed in the preceding sections.

CHAPTER 5

CULTURE, SOCIALITY, AND HEALTHCARE DYNAMICS AMONG OLDER PERSONS IN CHIVI SOUTH DISTRICT

5. Introduction

The previous chapter discussed the methodological procedures followed in this qualitative research. It located the study within an interpretivist paradigm and justified the ontological and methodological position of this study. Cultural determinants of health are critical to studying ageing and health, given that today's unprecedented number of older adults is rapidly increasing globally. It is imperative to understand how older persons construct health and illness. Culture, which plays a vital role surrounding individuals' and populations' lived experiences, shapes how people perceive/view ageing through which to consider the appropriateness of various policy options and how they will affect the well-being of ageing (Fries, 2012). Geertz's conceptualization of culture is a significant departure point in understanding how culture shapes older persons' disease and health-seeking behaviour. He notes:

> *The culture concept to which I adhere has neither multiple referents nor, so far as I can see, any unusual ambiguity; it denotes a historically transmitted pattern of meanings embodied in symbols, a system of inherited conceptions expressed in symbolic forms using which men communicate, perpetuate, and develop their knowledge about and attitudes toward life.* (Geertz 1993:89)

Culture, thus, has the primary function of driving perceptions and attitudes in individuals, thereby creating a systematic worldview. Health and illness cannot escape the totality of the cultural milieu in which they exist. This chapter discusses and analyses the findings of fieldwork conducted in May 2018 on the social determinants of health among rural older persons in Chivi. It addresses the following objective: Objective 1, which explores culture as a social determinant of healthcare access among older persons in CSD, Zimbabwe. Further, the chapter triangulates research findings, existing literature, and the researcher's reflections on conducting a sociological inquiry into how the (re)production of culture influences the uptake and health-seeking behavior of rural older persons in Zimbabwe. It

unpacks culture and sociality as integral social determinants that affect older people's experiences of health and illness.

It will draw from arguments (see Kruk 2018; Legg & Penn, 2013; Maharaj & Pillay, 2012), Penchansky and Thomas's Access to Healthcare Model discussed in Chapter 2, and Giddens' Structuration theory. The argument herein is that while other determinants of accessing health, such as removing monetary barriers and enforcing policies that promote free access to health, culture plays a much more significant role in accessing health services, particularly among older persons in CSD. Consequently, the argument in this chapter will be guided on the social construction of disease by older persons and alternative/traditional medicine as the first port of call when they become ill. A social constructionist approach to illness is built on the generally acknowledged conceptual distinction between illness (the social meaning of the state) and disease (the natural state) (Eisenberger, 1977). This difference has drawbacks and restrictions but is nevertheless a handy conceptual tool (Timmermans & Haas, 2008). Social constructionists emphasize how cultural and social institutions impact the meaning and experience of illness, in contrast to the medical paradigm, which holds that diseases are universal and independent of time and place.

The chapter thus argues for incorporating alternative/traditional medicine into modern healthcare systems as a complementary system to ensure adequate access to healthcare among older persons. It is essential to understand that alternative/traditional medicine still plays a salient role in the health-seeking behavior of older rural persons. It combines the geriatric arena's sociocultural dimensions, norms, and values. In this chapter, the researcher utilizes an emic perspective whereby participants are the key sources of information regarding their understanding of access to health care and its comprehensiveness. In so doing, the main thrust of this chapter is to put forward the argument that in the context of neoliberalism, global and national policies on health access have expended too much energy on the financial part of access to health care. Indeed, the entrenchment of neoliberalism has contributed to the marketization and commodification of social goods such as health care to the extent that those without money cannot access it. The welfare state has thus consumed itself too much in trying to eradicate the commodification of health, neglecting other

important determinants of health access, such as culture and social norms. There are far too many cases where governments construct access to health in financial terms.

5.0. Social Construction of Disease and Illness among Older Persons in CSD.

Diseases and illnesses are socially constructed. They are contextual and depend on communally shared understandings and interpretations. This ultimately influences the ways through which remedies to diseases are sought. How people attach meanings to diseases and illnesses has a far more significant implication on their health-seeking behavior. Several disease construction and interpretation aspects are crucial in older persons' healthcare patterns in the area under study. It determined how older persons sought treatment, including the timing and choice of treatment approach. Hence, it is critical to understand the interaction between local conceptions of disease and access to healthcare services by older persons since this is a critical determinant despite other factors such as availability and cost. I proceed to analyze some of the observations in terms of social constructions of diseases and illnesses. These include constructions of aging, religious beliefs, and long-standing traditional approaches to health and healing.

5.1 Cultures of Ageing and Illness

On the top of the list was the issue of how people under study interpret aging and illness. This largely influenced the older persons' choices to seek medical attention and the extent to which the support system was prepared to ensure that older persons access healthcare. Cultures of aging and illness are crucial in understanding how older persons experience health and illness. By cultures of ageing, I examine the ideas, perceptions, and attitudes towards older persons. These stem from family, community, societal members, and older persons. Older persons are viewed as having reached end-of-life stages, hence the limited investment in their healthcare. This can be seen from both the family level as well as the policy level. There is a prevalent culture of trivializing the illness of older persons. Klindworth et al.,2015, in a study done in Germany, concluded that older persons tend to downplay their illnesses and challenges as a process of adapting to end of life. The idea that one has reached the end of life creates an unintended neglect system towards issues relating to older persons' health care needs.

One of the conversations I had with an older man showed the deep state of internalization of the cultures of aging. The visibly ill man had been confined to his home for over two weeks. On enquiring why they had not sought treatment, he dismissively remarked;

> *Why should I trouble people by going to the hospital when you can see I only have a few days left on this earth? I have lived life to its fullness, and I do not think I should be heckling people to get me to the hospital. It is time that I get some rest rather than wasting people's money trying to get medicines. Do you think I can live another two years?* (Participant L, May 2018).

Pausing with the rhetorical question, the observations made by the man echoed through some of the respondents, who generally felt that they had seen better days; hence, it was pointless for them to extend their lives by trying to get healthy. There is an evident culture of surrender and acceptance that one is undergoing the natural aging process; hence, one should accept the accompanying aspects, such as age-related illnesses, and accept that the body is no longer at an optimal functional level. The cultural construction of aging hence views illness and disease as part and parcel of the aging process, which must be expected and embraced. This internalization and acceptance of aging resulted in most older persons resisting efforts to seek medical care and sometimes failing to address the healthcare problems they would face. Most caregivers and family members also noted that they had to go to great lengths to convince their elderly relatives to seek medical attention.

Some of the caregivers ended up accepting the mentality of the elderly constructions of disease, accepting the perspectives put forward by the older persons. One caregiver argued that they have to respect their relative's wishes and highlighted how difficult it was for them to understand how one will be feeling.

> *If my grandmother says she is fine, how can I argue? She says you are stressing me, so I should follow her instructions and act according to her wishes (*Caregiver 1 June 2018).

This hindered older persons from accessing health as sometimes the caregivers may not have the power to take them to the clinic against their will. Unlike in countries where institutionalized care creates mandatory health monitoring, the field under study showed how family-based care of the elderly also affected their access to health.

5.1.1 The Clinic and Cultures of Ageing

The cultures of aging were also evident in the hospital setup. Most medical professionals agreed with most ideologies and perceptions toward older persons. These perceptions influenced the type of medical care afforded to older persons. Several stereotypes about older persons could affect how medical professionals discharge their duties. Some stereotypes included viewing older persons as attention-seeking, nagging, and sometimes disguising other social problems using illness. In one scenario, an older lady was diagnosed with cancer at an advanced stage despite continued complaints, which both family and healthcare practitioners ignored. The healthcare sector also creates a culture where practitioners sometimes attribute certain diseases to old age. In the scenario of this old lady, the doctor assumed that these were general stomach pains that were characteristic of all persons and prescribed painkillers rather than launching an investigation into the causes of the complaints. Therefore, the study notes that it is essential to understand how cultures emanate as patterns of practices that accumulate over time. These patterns usually determine human responses to situations and sometimes can have life-threatening consequences, especially regarding healthcare.

Medical professionals are trained on biological elements that affect health but may not be aware of how social variables affect health outcomes. The social determinants of health are rarely extensively covered in conventional medical studies (Braveman, 2014). Cultural beliefs are based on societal views, practices, and ideologies; they are a well-known but under-researched obstacle to the accessibility of healthcare services in rural areas (MacLachlan, 2006). Biomedical care in Africa is influenced by culture because of different understandings of what ailment is and due to limited knowledge of health matters (Chukwuneke et al., 2012). Therefore, an evident co-production of cultures affects healthcare access among older persons. These cultures are built in the patterns of managing diseases and medical training practices, but that does not mean stream cultural belief systems. Some of these aspects of medical training and the professional medical care field are further discussed in Chapter 7.

5.1.2 Religion, Belief, and Disease Construction

The entire way of life is infused with Shona's religious beliefs. The position of the ancestors is crucial. Spiritual energy must be present for illness and death to occur among the Shona (Bosman, nd). According to Masaka and Chingombe (2009), even if the cause of death of a relative is evident and undisputed, the Shona would still want to know it. They think science cannot adequately explain a wide range of human problems.

a) Causes of illness in the African cultural context

Traditional Africans have a variety of ways to describe or comprehend the origins of illness. The initial point of contact is that attacks from evil or harmful spirits frequently cause disease. According to Mabvurira, 2016, people in Zimbabwe consider illness a manifestation of a spiritual disease that the patient or even another family member may have rather than merely a physical affliction.

- Angry gods; (Nyirongo 1997:159)
- Natural causes; (Nyirongo 1997:159)
- Illness caused by not appeasing the gods and ancestors;
- Witchcraft (Olupona, 2004, p. 113), there is the belief that those with bad powers might treat other people ill as a form of retribution for disrespect or as adversaries.

In light of the factors above that contribute to illness, we can conclude that in African culture, illness can be seen as a tangible indicator of discord between a person's relationships with influential people (including those with his family, community, ancestors, god, and immediate environment) (Mashau, 2006; Chavunduka, 2009).

5.1.3 Healing Conceptualized the Context of Zimbabwe

According to the traditional African worldview, the spirit world and the world of matter are not segregated. Spirit exists wherever the case does, and vice versa. Spirituality is not considered an element of life by Africans. They view everything as spiritual. All facets of reality, both the visible and invisible worlds, interact. People in Zimbabwe seek medical care from traditional healers, prophets from "Churches of the Spirit," hospitals, and clinics. Sickness or diseases are seen as having theological implications in addition to physical or psychological ones (Masiiwa & Gunda, 2007). Thus, the conventional forms of treatment heavily rely on religious ideals and beliefs. Herbal therapy, dreams, rituals, and symbolic representations are a few techniques that are essential to the traditional Shona healing

practice. The spiritual, transpersonal, and ecological dimensions of human existence are highly valued in addition to the physical, social, emotional, and mental parts.

i. The belief in witchcraft

However, when a cough or headache lasts too long or does not improve after receiving conventional or orthodox medical care, it qualifies as an atypical sickness. According to Shona, supernatural causes underlie abnormal ailments, which can only be recognized and treated by n'anga (Traditional healers). Examples include *munhikwi* hiccups are brought on by an angry ancestral spirit, an alien spirit, or witchcraft; *chitsinga,* pain in a specific area of the body brought on by witchcraft; *mamhepo*, a period of poor luck followed by madness; etc. According to Chavunduka, 1978; Gelfand, 1985, noted in their studies that Zimbabweans would not hesitate to switch to a different therapy approach if their first one proved ineffective. Alternatively, as Chavunduka points out, some people might use both systems simultaneously.

ii. The concept of God and healing

Psalm 41:3 **-** *The Lord sustains you to restore him to total health in his illness him on his sickbed; in his illness, you restore him to total health. 'A prayer is an important tool of healing.'* For thousands of years, healing has been connected to religious practices. People offer prayers for recovery from illness and good health. Through one or more of various processes, the power of prayer can bring about health and healing. Research on the therapeutic effects of prayer is riddled with assumptions, issues, and contradictions for various reasons, making the subject a theological and scientific minefield despite the availability of Western-style medical systems and Christian faith healing techniques (Andrade & Radhakrishnan, 2009). A spiritual assessment is crucial in exploring the religious strengths that older persons and the African view of prayer and healing embrace. The salience of their spiritual views must be acknowledged and respected as a form of treatment.

iii. The belief in the spirit world

The Shona people consider illness a manifestation of a spiritual disease that the patient or even a family member may have rather than a purely physical condition. According to Matolino (2011), the onset of illness is considered a sign of spiritual aberration. These are

called *zvirerwe zvinobva pasi* (diseases from the earth). Chirongoma (2013) contends that certain Shona people recognize natural causes of sickness. These illnesses have an unknown underlying cause. However, Shoko (2007) contends they are minor, transient ailments that typically go away independently. The Shona people, therefore, rarely attribute chronic illnesses to natural causes.

5.2 Local Disease Causation Conceptions Among Older Persons

Legg and Penn (2013) affirmed that one way to understand cultural influences is to explore how people understand causation and how disease or illness can be culturally constructed. Social and cultural constructions are non-medical factors that can inevitably influence one's health, especially older persons. This confluence of factors determines a person's experience and can also influence how health care is acceptable among older persons. One participant said:

> *"I understand that some of the diseases we are suffering from, such as diabetes and hypertension, are being caused by the food we eat nowadays. Most of the food we eat in this village is planted by us, and we know what we put in them. My grandson once brought me packed chicken, and the taste was different from what I was used to. I think people need to stop eating some food being sold in the shops; it is unhealthy. It takes six weeks to rear a chicken, but now you only need three weeks. This is not good food"* (Participant Z, May 2018).

The above narrative indicates that older persons have their own concept of illness, health, and diseases; this might have different reactions to the progress of treatment, which could eventually lead to misunderstandings between older persons and healthcare professionals. As a result, the view and construction of disease and illness may hinder how information on the causes of diseases is shared in different settings. In contrast to the medical model, which assumes that diseases are universal and invariant to time or place, social constructionists emphasize how cultural and social systems shape the meaning and experience of illness. Building on this assertion, Conrad (1987),

> "[A]sociology of illness experience must consider people's everyday lives living with and despite illness. It needs to be based on systematically collected and

> analyzed data from a sufficient number and variety of people with an illness. Such a perspective necessarily focuses on the meaning of illness, the social organization of the sufferer's world, and strategies used in adaptation. (pp. 4–5).

As a result, social constructionism challenges the deterministic logic of medicine in ways that can extend and enrich policy discussions and decisions and aid in promoting older people's health (Conrad & Barker, 2010).

> *"I believe cancer is evil because where does that aggressive disease come from? People who suffer from it die all the time" (*Participant L. May 2018*).*

The narrative above postulates that some illnesses, like cancer, are associated with specific social or cultural significance. These connotations relate to the condition and could affect individuals and healthcare separately. These cultural connotations influence how the illness is perceived and experienced, how society reacts to it, and the health-seeking behaviors of those affected by a particular disease. Giddens' (1984) original method for comprehending how human activity interacts with structural opportunities or restrictions to create the environment in which an action takes place. According to Giddens, behavioral results can be attributed to the actions or inactions of agents (in our case, older people) or the existence or absence of particular institutions or systems (primary health clinics). If the claim above is examined, it is possible to conclude that the inhabitant's (agents') actions and inactions, as well as the absence of the healthcare centre, are to blame for the poor health profiles of older people. The structuralist contends that social and economic structures over which an individual has no influence determine that person's behaviour (Voss, 1977). This implies that societal causes over which people have no control determine their behaviour. Because they lack access to healthcare professionals and facilities that could help them improve their health conditions, older people in this situation experience poor health outcomes.

The concepts of Giddens' structuration theory will be supplemented by Penchansky and Thomas' "acceptability premise." According to the acceptability of health care theory, identifying the concepts and discourses used to address age-related concerns requires investigation to uncover sources of truth. Participant acceptance is one crucial outcome metric that can be used to assess the effectiveness of an intervention (Sekhon

et al., 2017). Recognizing the importance of social and cultural contexts that help uptake or access health care is crucial for policymakers. Including these two variables can yield a nuanced understanding of how diseases are socially constructed among rural older persons. The experience drawn from the narration shows that healthcare acceptability among older persons in the rural areas of Chivi South District can be improved using a social and cultural lens, which can be shaped to suit the needs of those who use these services. Social and cultural dimensions inform how older persons value healthcare and can also influence their relationship with healthcare providers.

In Zimbabwe, bio-medical treatment does not address patients' cultural and spiritual needs (Chitindingu et al., 2017), which many consider expensive, inaccessible, depersonalized, and ineffective (Teuton et al., 2017). The preponderance of self-treatment chosen by older persons when sick can also reflect the traditional belief that illnesses are better treated with home remedies; hence, self-treatment is an alternative and supplement to proper health care. A study by Help Age International conducted in Zimbabwe (2010) concurs with the above analysis, as it established that rural older persons in developing countries are finding it hard to access health care when needed.

> *"I am an old man and have been using traditional medicine before I knew about this modern health. We had different kinds of medication for each disease, and it was a cheap method. It does not require money, only knowledge and energy; anyone could do it if they know about medicine use"* (Participant Z, May 2018).

The sentiments of Participant Z reflect how the lack of finances for health care interacts with culture and personal beliefs to influence people's health-seeking behavior, especially in most rural areas. Due to the expensive cost of mainstream medicine, some people prefer medical care from traditional healers or traditional African religious doctors. The above views show that some rural older persons use traditional medicine not only as an overall response to the unavailability, inaccessibility, or inadequacy of modern health care but also because traditional medicines, over generations, have shown to be effective and helpful in treating several illnesses (this will be discussed in greater detail in chapter 6 of the study). Thus, despite the earlier barriers, people in Chivi South District still seek care from traditional medical practitioners. Traditional medicines are being used in many countries for

different illnesses. This finding confirms previous research in Uganda, which showed that patients with diabetes strongly believed in traditional medicine's inherent efficacy and effectiveness in managing this ailment (Rutebemberwa et al., 2013). In rural Zimbabwean clinics, where there is often a lack of medical supplies and appropriate geriatric services, patients often resort to traditional medicine as an alternative practice. Commenting on medical supplies, Key Informant 2 said:

> *"When it comes to the acceptability and utilization of health care, older persons subscribe to the notion that there are cultural and religious effects. Culturally, some people believe that older persons tend to get sick. Some churches give people holy water when they fall sick. As a nurse, I was trained to treat a patient from the mindset of a biomedical undertone, which does not consider any of the cultural and religious views that some patients still uphold when seeking medical care. Some older persons are brought to the hospital by their children, who know their parents' problems. They only take medicine when they are at the hospital. Once they get home, they default because they might have visited a spiritual healer, only to come back with the same problem, insisting that they had been taking medicine; we tell them that if they had been taking medicine, they would not be coming back with a heart problem on top, but they should be recovering, instead*" (Key Informant 2, May 2018).

The above narration shows that older persons sometimes default on medication as they feel that old age is inevitable and comes with sickness. Culture and religion were prominent themes related to the challenges impeding older persons' acceptability of healthcare services. The critical informant's narrative reiterated the pivotal role cultural and religious aspects play in influencing healthcare provision among older persons. The nurses posited that culturally, people's values and customs are respected, but the agents also encourage the maintenance of some habits that are not adequate in health care.

This could be used in healthcare promotion to promote older persons struggling with illness. A factor behind the disconnection of the medical field and cultural and religious aspects is that many healthcare providers have been trained during their education and medical practice to look at things from a scientific perspective. Thus, healthcare providers

can incorporate religion and culture into their healthcare plans. To put this into perspective, it suffices to argue that there is a positive correlation between healthcare utilization and the acceptability premise in healthcare for older persons. They acknowledge that adding structure and agency to health research would help it move beyond methodological individualism and epidemiological concentrations on risk behavior, especially in understanding health inequalities (Giddens, 1984). However, from the account given by Key Informant 2, it is sometimes not about the acceptability of healthcare services among older persons but also about how the older persons interpret illness from a biomedical perspective. Healthcare practices within this cultural paradigm are not exclusively related to individual physical illnesses.

> *"I once went to the clinic and told the nurse that I did not want to take tablets for acids because they would damage my internal organs. I do not care that science has not proven it because I have had this problem for almost half my adult life. I never took any medication; I have my way of managing. For example, I drink ashes (dota) mixed with warm water every morning and manage them well. So, I do not need modern medicine since I can survive on the ashes. It is very unfair for medical personnel to challenge our culture and beliefs. The best way is for those in the health sector to incorporate biomedical science with the traditional way of managing ailments rather than to challenge us and tell us that we are not educated. We do not understand the disease, being told by a very young person (kuudzwa nemwana ane mukaka pamhuno).*" (Participant X, May 2018).

The narrative cited above shows the disrespect that some health personnel show towards older person patients, which ultimately bars them from seeking medical treatment at healthcare facilities. In some instances, they felt discriminated against. For any intervention, treatment, or healing to take effect, respect must be fostered (Amegbor,2014; World Health Organisation, 2013; Lakshmi et al., 2015). Respect for oneself and one's place in all the systems above are prerequisites for positive changes in one's health to occur. This respect will positively influence interactions and direct and guide efforts to improve health-seeking behavior. Such misunderstanding and failure to acknowledge the older persons' view on the use of traditional medicine can affect the optimal health goals (Pouliot, 2011; Sato, 2012a; Thorsen & Pouliot, 2015). The view held by nurses is that if a patient holds a different view

regarding disease management, is considered unintelligent, of differing intelligence, or irresponsible, this can marginalize the older persons within the healthcare system. This increases the prevalence of non-communicable diseases among older persons; hence, they resort to TMACs. A study in Ghana by Sato, 2012b; Aikins et al., 2014, though TMAC use is often associated with primary health problems, reveals its use is notably higher among patients with multiple acute and chronic health conditions. There are critical challenges that older persons face. The availability and accessibility of services and barriers to utilization must be evaluated in the context of the differing perspectives, the health needs, and the material and cultural settings of diverse groups in society. TMAC remains a vital healthcare resource for the poor and uninsured older persons in CSD. In order to avoid attending crowded, understaffed, and poorly equipped hospitals, many poorer citizens are turning to home remedies for their ailments instead. Indeed, an estimated 80 percent of the nation's population uses traditional herbal medicine for immediate health needs (WHO, 2019).

The social determinants of health do not view culture as a distinct and separate entity, like all other facets of an individual's life. The individual, the family, the community, and the environment are just a few of the more extensive systems connected to and dependent on health. These systems' imbalances are thought to cause illnesses, diseases, and conditions. By identifying the abnormalities in these systems and re-establishing the balance that naturally exists in them, treatments and interventions try to improve a person's health. The denigration of cultural conceptions of health and healing that are not found in biomedical or medical materialist models of health must be acknowledged in health promotion and interventions as one of the major causes of ill health in Indigenous communities and nations. This study also considers that a person is made up of more than just their physical selves. Emotional, mental, and spiritual well-being must also be considered. These techniques might include non-medical ones like healing circles, storytelling, prayer, singing, and ceremonies, as well as more conventional ones with a stronger medical foundation. This strategy should not be presented as an either-or choice that completely rejects biomedical therapies. Both systems have advantages and disadvantages. This strategy is being presented with the expectation that by identifying the benefits and drawbacks of each system, a better course can be found that will enhance the health of many of the participants in current services who are the most underserved.

5.3 Religion and Spirituality- traditional religious beliefs, local religious beliefs (independent African churches, Christianity), and Health-seeking Behavior among Older Persons in CSD.

Ageing continues to be some of humanity's most perplexing experiences (Gilleard & Higgs, 2014). Growing older is praised, on the one hand, as a sign of God's divine bounty upon humanity, while on the other hand, its physical effects are frequently terrible (Rozanova, 2010). On the plus side, ageing has been viewed as a learning curve from which older people emerge with more experience, wisdom, and knowledge. Many people still place a high value on religion, spirituality, and belief because they believe these things can help them overcome obstacles in life and provide their lives with structure, meaning, and insight. Literature suggests that religion, spirituality, and belief positively affect health and quality of life in general for older persons (Manning,2013).

Religious and spiritual issues are relevant to the older adult population and may positively influence sustaining health and recovery from a disease. Religion is a recurrent subject in health settings, though it is not only "researchable" but also of vital interest to healthcare professionals. Religion can empower individuals by connecting them to a community and to a superior force that might, in turn, give them psychological stability (Basu-Zharku, 2011). Older persons are nuanced in their beliefs that illness and diseases result from the will of God, and it shows that older persons' God is at the center of their conceptualization of health and illness:

> *When it comes to sickness, God is the only one who knows, and if I were meant to be sick, it would happen because it is God's will; I know that my prayers will be answered" (*Participant N, May 2018).

The view of Participant N shows that spirituality can boost a person's feeling of purpose and meaning in life, which is linked to greater resilience to stress, which is linked to diseases; it can be used as a coping mechanism for complex events in people's lives. Koenig (2006) notes that finding meaning in life and experiencing kinship with people and God appears to be a key component in coping with chronic illness, as reflected by the view of older persons.

"I think that only God can decide. God has the authority to cause illness. But some diseases can also be caused by witchcraft" (Participant M, May 2018).

Whenever I feel unwell, I go to church, and they give me 'holy water' This water is beneficial because it cleanses me, and when I vomit, I know that all the bile and toxins that made me sick have been excreted from my body" (Participant A, May 2018).

"I do tell myself I was not born with high blood pressure. I was not born with diabetes. I know God will heal me" (Participant B, May 2018).

In the narrative accounts of older persons, spirituality was a significant theme. According to the group understudy, 'God knows everything because He created the world, so He has the authority to determine the fate of each of us, whether we are in good health or not.' *"leaving it in God's hands" or "God will take care of me'.* This suggests that a person's physical and social environments are inextricably intertwined. Death is not seen as the end of life but rather as a change, a transformation (Baloyi & Mokobe-Rebothata, 2014). Instead of creating a rupture, it creates a new way to exist. The social network in such a cultural setting is highly structured and depends on these strong values, added to those of the family and community. It reduced the tendency to stigmatize and reinforced the encouraging attitudes frequently thought to be good for one's health. The separation of the body and rejection of subjectivity are two traits of modern medicine, according to Martnez-Hernáez & Masana (2022). Hence, when a strong focus is placed on the spiritual dimension, it can be challenging to combine biomedical explanations. Although attitudes are shifting, it is challenging to alter perceptions fundamentally. It is, therefore, essential to understanding the views of older persons' social construction as they may play a vital role in their utilization of healthcare services (biomedical). Furthermore, older persons' cultural beliefs and health practices significantly impact their well-being regardless of CSD's availability or lack of primary healthcare services.

Consequently, these health beliefs and practices affect the utilization of modern healthcare service delivery systems even when other barriers have been eliminated. Older persons' perceptions of their health condition and healthcare services may motivate or hinder them from accessing services. Moreover, older persons should not be treated as a homogeneous

group, as factors that act as enablers or barriers for a particular individual may not apply to other older persons. According to Penchansky and Thomas (1981), the foundation of acceptability depends on how patients regard healthcare treatments from their own social, cultural, and worldview perspectives. According to older person, religion plays a significant role in forming solid spiritual lives essential for overall health and well-being.

One of the main objectives of the healthcare system is to consider how and where patients heal. However, since so much self-perceived healing occurs outside the hospital and clinic, state programmes must acknowledge that the excessive reliance on metrics and outcomes to assess the country's health or illness ignores how individuals feel heard, heal, and live well. It is essential to understand the variety of ways people with various diseases live to see beyond clinical measures and understand how and why people rely on their families or organizations like the church to live well and maintain their health.

Older people who think their symptoms are ‘beyond human control’ will turn to faith-based and conventional healers rather than contemporary healthcare for guidance, care, or support (Guerchat et al., 2017). The finding in this study about the cultural perception that disability has a spiritual or mystic origin is consistent with findings from studies conducted in South Africa by Madden et al. (2013), the South African Department of Health (DOH) (2002), Carroll et al. (2007), and Bailey et al. (2000). All of these studies indicated that people in many cultures still hold the belief that their illness or handicap is a spiritual manifestation of a crime against their ancestors. Legg and Penn (2013) also noted that cultural attitudes significantly impacted how patients explained the origins of their post-stroke aphasia. This notion of the condition's origin negatively impacted the population's health-seeking behaviour. Designing sustainable interventions and health promotion initiatives would be more effective if we understood how older people view the crucial elements that affect their health and how local beliefs and perceived causes of sickness and death influence health-seeking.

It is essential to view older persons in a multicultural sense as this will play a significant role in designing culture-specific health interventions for them. Spirituality enables older persons to understand their illness experience and make value-based decisions regarding

what type of intervention they seek, either biomedical or spiritual help (Arora, 2020). Recognizing the significance of socio-cultural nuances, such as ritual and prayer, may not only help the physical and mental well-being of older persons (Mokgobi, 2013). In addition, spirituality has proven crucial in helping patients maintain their social responsibilities and connections despite their condition. As a result, incorporating socio-cultural nuances into biomedicine could provide older persons with more comprehensive care by fusing biological, psychological, social, and spiritual philosophies.

5.3.1 Self-perceptions of Ageing and Health

Self-perception of health is essential in older persons as it determines their health-seeking behavior. The idea of one's disease is drawn from the self-regulation paradigm, which characterizes humans as proactive problem solvers. Furthermore, this theory explains how individuals respond by noticing, coping with, and evaluating steps to narrow the perceived gap between present and ideal health. Thus, the impression of one's sickness is a self-declared view of one's health (Kwon & Kang, 2018). Understanding older persons' healthcare requirements is crucial before creating efficient solutions.

Illness and health perceptions for older persons are not statistically predictable; they vary according to the severity, length, cultural context, and doctor-patient interaction of the sickness. It is linked to biopsychosocial processes that influence how well a person perceives and comprehends a condition and knows what steps to take to enhance their health. The narratives below synthesize how older persons' self-perception of ageing, health, and illness:

> *"I have been experiencing problems with my back for a while; it comes with age. So, I do not need to go to the clinic because they will give me pills I do not want. As you grow older, my child, your understanding of illness differs. I do not believe you must seek medical attention when you feel pain. I am old now"* (Participant X, May 2018).

> *"Most of my agemates are sick. I think the primary cause of this disease is old age:" As you can see, she is a few years older than me, and I am sure I will be like her*" (Participant M, May 2018).

Participant M outlines that older persons see illness and disease in old age as usual; older persons often share this belief and do not seek help because they do not understand that they could feel better with appropriate treatment phenomenon: ‘life is completed and no longer worth living.’ It shows the process of withdrawal of an individual from society, giving up on life, and being ready to die. The views of Participant M resonate with the research done by Koenig (2012), which has shown that religion, spirituality, and beliefs are strongly linked to health and quality of life, mainly how people deal with poor health. Koenig notes that religion has only recently been disconnected from health care despite its influence on medical decisions, support structures available, and the ability to deal with health problems. The findings of this study conclude that a “narrative foreclosure” is the conviction that, even though one's life as such continues, in one's mind, one's life story has already ended. Participant M stated,

It can be argued that the discourse on access to health care among older persons in rural areas has reached far beyond what is stipulated in the “White Paper” (1988), *Planning for Equity in Health, A Sectoral Review and Policy Statement* the Government of Zimbabwe on removing financial barriers and offering free health care. Giddens’ Structuration theory asserts that structural and agentic approaches are genuine perspectives of health promotion. The importance of culture-centered aspects is integral in “achieving health for all,” which was enacted by WHO in Ottawa (1986) and looking beyond treating disease to health promotion. The Ottawa Charter advocates that health promotion occurs when people can improve and practice more successful control over their health. The Charter fosters health promotion in places seen as familiar by people from different cultural and socioeconomic backgrounds and as socially accessible, culturally appropriate, and non-judgmental. Giddens’ concept of agency aptly captures the importance of older people's agency as necessary for health promotion success, for instance, when interventions aim to improve people's (agentic) capabilities (for instance, personal skills that "increase the options available to people to exercise more control over their health and over their environments and to make choices conducive to health" (WHO, 1986, p. 17). How older persons perceive ageing can also influence their health status and how they access healthcare in case of illness.

The analysis of culture is essential since it exposes older persons' disease construction, thereby influencing their health-seeking patterns. How older persons view and perceive the medical problems they encounter determines the type of action they are likely to take to ensure that they correct the situation. It is something that becomes part of their habitus, to borrow Bourdieu's terminology. This habitus- an internalized structure- unconsciously directs behaviour (Bourdieu, 2004) and limits the available options to older persons. It determines whether they will go to a spiritual healer, a herbalist, or a biomedical healthcare center. Culture is an integral component of deducing and understanding the healthcare patterns of older persons and even the range of behaviours they are likely to adopt in addressing their health concerns. Older persons associate their health situations with socio-cultural and religious factors.

5.3.2. Sociality, Caregiving, and Older Persons' Health

Sociality is one of the markers of human life, as humans are usually considered social beings. Most African cultures promote sociality and communal living where the care of members is shared within the social group. This scenario informs even approaches to the welfare of older persons, where aging and death often occur within one's family and community instead of confined living. The Western models of putting older persons in care homes are largely untenable for most African communities. Consequently, the traditional cultural practice of older people depending on their children is no longer intact. Hence, the health and welfare of older persons is also primarily a shared responsibility of the family and community. This makes caregivers' attitudes, perceptions, and actions essential to understand as they create specific patterns of behavior that impact the experiences of health and illness among older persons.

> *"You do not relax, and eventually, you are very stressed. He harasses the children a lot. I feared l might come home to find he killed the children. I thought it would be better to stay and watch over him" (*Caregiver 2 May 2018).

Healthcare needs for older persons increase with age and may cause tensions with the caregiver (Waite & Das, 2014). Therefore, caregivers increase high levels of stress and burden, whether physical or financial.

"Since I am unemployed, my grandma does not always have access to the foods she prefers because she prefers fruits and vegetables" (Caregiver 1 May 2018).

Older persons are sometimes regarded as nagging, attention seeking, behaving like a child, or unaware of what they are doing. Coupled with experiences of memory loss, which sometimes afflict significantly older persons, there is often an issue of failing to conceptualize the illness experiences of older persons properly. CSD has no nursing homes, daycare facilities, or programming for housebound older adults. The absence of these facilities and services may factor into the carers' hopelessness and despair. The study deviates from the Western literature on the caregiving of older persons, emphasizing needs completely different from CSD's views. Caregivers in CSD express the need to meet basic needs such as food, shelter, and assistance from the government. Western literature, in contrast, emphasises the need for accommodating work schedules, psychiatric treatment, respite care, and the provision of supportive aid (Ploeg et al.,2020). Caregivers in CSD do not consider such needs as they struggle to meet their physical and survival needs. When it comes to the case of institutional care, the attention given to older person care centers is meager; currently, it is only available in Masvingo (the provincial capital)-located 80km from Chivi South, the place of study.

In Africa, family members are primarily in charge of caring for and supporting older persons. It translates to: "Because you [i.e., one's older parent] have taken care of me [the child] to grow teeth, I will take care of you until your teeth fall out"; this dependency is a reciprocating act (Apt, 1996; Scheil-Adlung, 2015).

"I had to abandon looking for work like my other agemates because I have to care for my grandmother" (Caregiver 2, May 2018).

"Living in the rural areas makes our situation worse because we do not have access to jobs or any other means of making a better living except for farming, which sometimes is unreliable because of poor rains" (Caregiver 1, May 2018)

The narratives for caregivers show their frustrations towards older persons. Living in a rural region was a strong indicator of having a care load. The fact that many young people leave rural areas for more excellent economic prospects may be connected to

this. Since not many people are left in rural regions, it falls to them to take care of older persons, which puts additional strain on them to care for themselves and their families (Nmadu et al.,2018). Economic difficulties may increase the burden on carers because many people live below the poverty line. There is also a paucity of information on the magnitude of the problems and implications of the population ageing shift in Zimbabwe and its impacts on caregivers. The Zimbabwean government has done nothing to ensure the care of older persons due to the syndrome and views this as the family's responsibility. Unfortunately, when they are eligible for a pension, it is usually not paid; when it is, it is frequently not delivered on time. The nation is rife with poverty, and older persons may be more vulnerable since they are no longer in the stage of life where they actively seek employment and because the national social security systems do not offer financial protection as they age (Dhemba, 2015). Due to the poor delivery of social services and economic hardship, most older Zimbabweans are exposed to poverty.

5.4 Medical Pluralism: Biomedicine and Traditional Medicine

Most Africans still consider traditional healing an essential part of their lives, connected to more inclusive belief systems (Mashau, 2016). Whether or not they can afford medical care, people consult with traditional healers. However, the problem extends beyond just access. Low-income people are unable to access healthcare due to prohibitive medical expenses. The public prefers traditional healers since they outnumber doctors and do not necessarily want payment upfront. According to Roberts (2001), conventional medicine is the primary source of care for almost 70% of Ghanaians. (Lekotjolo, 2009; Mander et al., 2007) Estimates suggest that 27 million South Africans, primarily black, use traditional medicine to treat various illnesses. In rural Tanzania, treating convulsions with conventional medicine has made a substantial difference, according to Makundi et al. (2006). Patients occasionally combine traditional and modern medical treatments to lessen the pain brought on by illness and disease.

According to Grobler et al. (2015), most African medical professionals work in metropolitan settings. There is no other option for many destitute Zimbabweans. Traditional healers are frequently the first and last line of defense against the contagious and crippling

diseases that plague their lives (Bhebhe et al., 2016). Africans largely accept Western medicine, nevertheless. Unlike doctors trained in Western sciences, traditional medical practices adopt a more holistic approach, primarily concentrating on the biomedical reasons for sickness. By throwing bones to interpret the will of the deceased ancestor, traditional healers in Zimbabwe are said to be able to determine the origin of a person's disease or social issues.

According to WHO (2008), traditional medicine is one of the primary healthcare resources. Against this backdrop, this section highlights how older persons with CSD use traditional medicine to cure their ailments. The narrative below outlines how older persons have become reliant on traditional medicine as part of their treatment. Culturally, they believe and argue that herbal treatments are effective as they have lived on such treatments in their early lives:

> *"Some people prefer seeking assistance from traditional healers to health centers because traditional medicine is cheaper; one can receive the treatment and pay for it later or until they are cured"* (Key Informant 2, May 2018).

The views above show that older persons consult traditional healers when healthcare facilities are available. According to specific reports, there are a few reasons why TMAC is so prevalent in sub-Saharan Africa. Traditional healthcare professionals are generally more easily accessible than modern Western healthcare providers. For instance, the population-to-traditional health provider ratio is 1:500, whereas the population-to-modern medical doctor ratio is 1:40,000. We also know that most urban areas have access to modern medical professionals, leaving rural residents with no alternative except to seek treatment from traditional healthcare practitioners in the event of disease (Abdullahi, 2011). These views are also consistent with that of Giddens 1984 p. 29, who argues that the "duality of structure the poor health profile to the actions and inactions of older persons (agency) or the nonexistence of health centers (structure)." Similarly, Lamsal (2012) presents this position as a macro-level analysis of external forces influencing the individual. This suggests that human actions are determined by the societal forces over which they have no control. The participants talked about the unfavorable effects on health caused by their economy, which

resulted in being unable to buy medications or prescribed drugs that were perceived as expensive.

According to Gerard et al. (2006), given the difficulty of accessing modern healthcare services, traditional and complementary medicine can be an alternative to primary healthcare services. Specific forms of traditional medicine, complementary and alternative, play an increasingly important role in healthcare and health sector reform worldwide. These views are complemented by Mander et al. (2010); their findings state that Sub-Saharan Africa is one region of the world in which Traditional complementary and alternative medicine (TCAM) has long been held to be widespread, with a considerable number of its population relying on it to maintain its health or prevent and treat communicable and non-communicable diseases. The economic circumstances and reduced quality of care at most health facilities (MHW, 2008) might have forced older persons in CSD to engage in TCAM and traditional healers as they could not afford the high cost of drugs. Like many other developing countries, Zimbabwe faces the "triple disease burden" (Kamvura, 2022, page number). Due to the collapse of the Western-oriented healthcare system, older persons in rural areas had no choice but to resort to traditional medicine. The economic cost, complications, and social consequences of NCDs among older persons are also enormous, particularly for low-income people. Hence, it is essential to understand that their habitus informs the agency (older person) thinking). Global population disparities in access to, affordability of, and availability of health care have increased.

Access to appropriate healthcare is increasingly acknowledged as a human right through international instruments such as the United Nations Human Rights Commission, Millennium Development Goals (MDGs), and the World Health Organization (WHO). In this context, there is a critical need to mainstream traditional medicine into public healthcare to achieve the objective of improved access to healthcare facilities. In Zimbabwe, as in other developing African nations, traditional medicine is a genuine healthcare alternative. Traditional healers are most active in the more isolated rural areas, where conventional medical services are unavailable or not easily accessible (WHO, 2000; Bannerman, 1983). One study found that traditional healers are considered more respectful and approachable than their biomedical counterparts (Munthali et al., 2014). Another reason for their popularity is their accessibility, as people in rural villages do not need to travel

long distances to see them (Courtright et al., 2000; Munthali et al., 2014). Traditional healers are also often cheaper than conventional medicine. For some, TCAM is a last resort after the failure of conventional medicine to cure them (Munthali et al., 2014).

> *I consult with a traditional healer (n'anga), and he has helped many other people in our community, alleviating their ailments, which include diabetes and hypertension, as well as the management of pain from cancer (gomarara). I grew up on traditional medicine; we did not have clinics but survived"* (Participant Z, May 2018).

The possible underlying structural factors that help explain the drivers of TCAM use include that Sub-Saharan Africa is host to the largest population of economically disadvantaged people, such as older persons, and access to conventional care is limited due to cost and distance. According to WHO (2018), traditional and complementary medicine (TCAM) is a health practice with strong historical and cultural roots, global acceptability, and applicability. Traditional healthcare practices vary from country to country and from one ethnic group to another. It is a vital resource that can complement primary healthcare and has been recognized as a component of achieving "health for all" since the Declaration of Alma-Ata in 1978 (WHO,1981). The World Health Organisation claims that traditional healers have aided in the prevention of disease, management of noncommunicable diseases, treatment of such conditions, and issues with mental and geriatric health (WHO, 2001). In many African communities, traditional medicines are essential to the healthcare system. Many people prefer them to conventional therapy due to their accessibility, availability, affordability, cultural acceptance, and spiritual, religious, and sociological values.

> "*Sometimes, we can spend more than three years without visiting the local clinic. If the disease is severe, we visit a traditional healer who, through his powers and the help of medicinal herbs, helps us fight the disease"* (Participant C, May 2018).

Traditional healers, with or without the support of the law, are already providing services within communities. In South Africa's black community, TCAM is "thought to be desirable and necessary for treating a range of health problems that Western medicine does not adequately treat," according to Mander et al. (2007: 190). Traditional medicine is produced and passed down from generation to generation and is based on the theories, ideas, faith,

and experiences indigenous to diverse cultures. This knowledge is primarily passed down orally, through custom, religion, and spiritual inspiration in the African Region.

5.4.1. Issues of Reflexivity and Illness in African Cultures

Understanding the common causes of disease among indigenous communities helps policymakers design effective integrated primary health care strategies for these communities. In African communities, illness has supernatural causes (e.g., Almighty God, spirits of nature, supernatural acts of humans) and natural causes (e.g., environmental and personal hygiene, poverty, biological and psychological factors). It is thought to have social causes (e.g., social trust, the experience of family support and harmony, violation of social taboos, etc.)

> *In our tradition, people believe* ***mudzimu*** *(spirit medium) protects them from illness and disease causes. To fulfill this role, the spirit medium must be recognized and respected through appropriate rituals, such as scaring goats and respecting local customs and values. The medium spirit protects loved ones from harm and helps protect and maintain good health* (Participant D, May 2018).

Participant D went on to say;

> *"I believe that one can incorporate both our traditional medicine and Western medicine; there is no harm in doing that; in the end, one needs to be healed and have a clean bill of health."*

The perceptions of Participant D show that supernatural forces can be the most significant cause of illness. They also clarified the role of natural causes and social relationships in maintaining health (Kickbush, 2008). Unfortunately, Zimbabwe's overall health education and primary care system focuses almost exclusively on hygiene and natural causes of illness, such as infectious diseases (Cuneo et al.,2017; Azevedo, 2017). As a result, the practical implementation of primary health care is hampered by the lack of consideration of the worldviews of indigenous communities. When Western biomedical scientists overlook or disdain the supernatural beliefs of group individuals, they risk distancing themselves from the very individuals they want to treat.

For believers of indigenous beliefs, happiness is constant without a connection between nature and spirit. Therefore, many indigenous peoples' attempts to restore well-being through biomedicine must include the usual confirmation of the intersection between nature and spirit as a hallmark of the recovery process (Mesfin et al.,2015). This seeks to bridge the research community's indigenous beliefs about supernatural causes of disease and modern science-based health education through health advisors who know both worlds. Health advisors may be best positioned to identify integrated strategies to improve health outcomes in their communities and provide guidance on making the most of limited primary healthcare resources. A conclusion can be given on the importance of understanding the cultural context in which this study reinforces new health-related interventions. It is hoped that the model of disease causality identified in this study will help improve health in rural areas, especially for older persons.

5.4. The Healing Process in the Context of African Culture

Understanding how social and cultural elements affect patients' health attitudes and behaviours and how these aspects are considered at various levels of a healthcare delivery system to provide quality healthcare is the definition of cultural competence in the healthcare context (Betancourt & Green, 2010). A paradigm shift towards a more proactive approach to health promotion of older persons is required to overcome these problems. The biological, physical, behavioural, environmental, and social determinants of health and SDH impact a person's perception of their health or illness. However, several factors, laws, and other circumstances that are primarily out of a person's control significantly impact how healthy they are and how well they perceive their quality of life. Therefore, efforts to enhance population health should focus on situations where people are born, live, work, and age rather than just the health care system. The existing formal health system structures can have limitations to accommodate the health needs of older persons. Traditional medical technology has kept many Africans alive for a very long period. Therefore, it is not advisable to disregard this type of medical care (Mufomadi, 2009).

A participant had this to say:

"You cannot separate traditional and cultural factors from your treatment, but you can do as much in the hospital. If the family decides to go and consult with a traditional healer, you can only advocate this much. I feel we need to be given autonomy to mix Western and traditional medicine" (Participant L, May 2018).

The view of Participant L reflects that every culture has a belief system about health that explains what causes disease, how it is cured or treated, and who should be involved in the process. The numerous components of spiritual, psychosocial, and psychological disorders cannot be detected, prevented, solved, or treated by Western medicine alone, according to Shizha and Charema (2012). The extent to which patients perceive health education as culturally relevant can significantly impact their assimilation of the information provided and their willingness to use it. Western developed societies regard disease as the result of a scientific phenomenon, advocating medicine to combat microorganisms and using advanced technology to diagnose and treat disease. Other societies believe that illness results from supernatural phenomena and encourage prayers and other spiritual interventions to counteract jealousy by supernatural forces. Cultural aspects play a significant role in patient compliance.

"As you can see in this area, villagers live close to this clinic but choose to visit it or consult a traditional healer. So sometimes it is not about accessibility or proximity of services but their choice" (Key Informant June 2018).

Participant L and the Key informant's views reflect that patients decide whether to use modern or traditional medicine. Supporting these two approaches could positively impact primary healthcare outcomes for older persons in rural areas. For example, Lidell et al. (2005) explore how sub-Saharan people's relationship with God takes the form of reverence and connection between nature and spirit, essential for maintaining family health. Liddell says these beliefs are central to indigenous peoples' distrust of government-run medical institutions that claim to maintain a purely secular biomedical approach to health and seek treatment. When medical practitioners ignore or ridicule the spiritual beliefs of their parishioners, they risk alienating the very people they seek to treat.

Numerous nations responded to the Alma-Ata Declaration on Primary Health Care (PHC) issued by the World Health Organisation (WHO) in 1978 by regulating and improving their

usage of traditional medicines. Traditional medicine and biomedical healthcare frequently coexist in distant areas of other nations as components of a pluralistic medical system, as is accepted (Vandebroek et al., 2004). Sharma (2016) complements the above narrative, arguing that culture and not biology dictates which illnesses are deemed contestable by the agency (older persons). This study advocates that the discourse of medical sociology be integrated into healthcare initiatives. Medical sociologists research health and illness' social, psychological, and physical aspects. The doctor-patient interaction, the organization and socioeconomics of healthcare, and how culture affects attitudes toward illness and wellness are essential subjects for medical sociologists. Based on the idea that reality is a social creation, the disease experience is socially constructed. In other words, only the agency's view of reality exists.

5.5. Conclusion

The arguments presented in this chapter show that culture and the attitudes of healthcare professionals can influence older persons' health-seeking behaviours. Acceptability has to do with the fact that some rural health centers do not meet the needs of the residents and are therefore avoided since they reportedly provide subpar services. The nature and scope of the population's perceived demands and obstacles to receiving healthcare services can be considerably influenced by this essential problem. To comprehend how older people in rural areas manage their ageing issues, policymakers and healthcare professionals must have a holistic understanding of how illness and diseases are constructed. Social and spiritual factors impacted the decisions that participants in this study made to achieve health or recovery. The current study aimed to identify and understand the function of spirituality in managing a chronic disease of older persons by considering spirituality as a component of human health and its impact on living with chronic diseases. Clinicians and other healthcare professionals must acknowledge the centrality of prayer and spirituality in healing to comprehend why treatments centered on self-care and physical restoration may not be successful. The complexity of African civilization, with its wide variety of religious and cultural practices, also affects how people view and comprehend health-related issues. According to studies, people in affluent nations tend to find rational explanations for their illnesses, such as diseases, stress, or environmental causes, whereas, in poorer nations,

cultural influences are more likely to affect how people view illness. Older and low-income people continue to rely on traditional remedies based on regionally accessible natural resources and cultural knowledge in low-income nations where modern healthcare is not easily accessible or inexpensive.

In public health, availability, accessibility, affordability, utility, quality, efficiency, and equity are relevant in promoting traditional medicine. From a utilitarian point of view, it is thought that knowledge of TCAM can be validated and absorbed to enhance current medical knowledge. It is believed that information from TCAM can be validated and assimilated to improve existing medical knowledge from a utilitarian point of view. TCAM is an integrated system that has been formally acknowledged and integrated into all facets of the delivery of healthcare, which means that the nation's national drug policy covers that suppliers and goods are registered and regulated, that therapies are offered at hospitals and clinics (both private and public), and that treatment is available. Several issues and obstacles must be overcome to realize the goal of regulating, standardizing, and integrating TCAM in Africa. The tendency of most stakeholders in modern medicine to showcase the ethnocentric and medico-centric tendencies of the dominant Western mentality is still a significant concern. In the medical community, there is a widespread perception that TCAM violates the principles of objectivity, measurement, coding, and classification. Even still, there are signs that it is possible to do scientific research on and analysis of the physical components of TCAM. To enhance the external validity of the results, the study should, to some extent, duplicate some participant narratives using a larger and more random sample size.

CHAPTER 6

NAVIGATING THE PHYSICAL AND STRUCTURAL BARRIERS TO HEALTHCARE UTILIZATION BY OLDER PERSONS.

6. Introduction

The previous chapter discussed how traditional medicine culminates all the skills, knowledge, and methods used to maintain health and prevent, recognize, and treat diseases. Sociodemographic and economic traits, culture, and the environment can influence the inclination for and practice of traditional medicine. The cost of healthcare interventions, preventative medicine, and self-healing will all be significantly impacted by accepting these practices as conventional healthcare options. This chapter builds on the former and extends the discourse of older persons' access to rural healthcare services. The chapter focuses on the structural barriers influencing access to healthcare in CSD.

The central question addressed in this chapter is how physical and structural barriers affect the provision of healthcare services for older persons in CSD. Three significant structural and physical obstacles are notable. Moreover, these include physical location dynamics, poor transportation networks, and the cost factor. Though these may not speak to the nature of healthcare services available, they are crucial for comprehensive healthcare for older persons. The chapter uses Penchansky and Thomas' theory of access to the physical and structural dynamics of access to healthcare services available in CSD. The researcher's primary observation is that several physical and structural barriers hinder effective healthcare provisioning for older persons. Most clinics are located in areas that are not conducive and convenient for most older persons. This is coupled with poor road network systems and poor transport services, which creates significant hiccups in older persons' access to healthcare services.

6.0 Contextualizing access: Policy and Development Issues.

Zimbabwe has robust legislation that promotes access to health care for older persons, and the government constructed many clinics in rural areas just after attaining independence in 1980. This was done under the Growth with Equity policy between 1980-1990, which addressed the dual goal of decolonization and social and economic growth. This was also in

line with the independent state's thrust on health care for all policy and decentralization of healthcare services. The government sought to dismantle colonial imbalances and ensure healthcare services were available for most black people, especially in marginalized rural areas. WHO-recommended distance of less than 5 km between the patient's dwelling and the nearest primary healthcare facility (WHO, 2013), whereas findings in this study reflect that walking distance to the outreach clinic in this article varied considerably from less than 1 km to more than 22 km, with in most cases in CSD, Zimbabwe. This notation is reflected in Figure 1—Health Centers in Chivi District.

It also availed resources, including the human resources for these clinics, as part of an elaborate public health system. This approach was in tandem with Mkandawire's (2007) call for a transformative social policy, which creates an interface between economic growth and social development. The policy emphasizes production, reproduction, social cohesion, and social justice (Mkandawire, 2007). Zimbabwe's healthcare policy landscape is also affected by its membership in regional and international bodies which regulate healthcare. These include the WHO, AU, and SADC. These offer acceptable standards for healthcare services and frameworks governing member states.

From the local legislative perspective, the Older Persons Act of 2012 is one of the significant pieces of legislation informing the protection of older persons. It provides for the conditions under which the welfare of older persons can be addressed. However, there seem to be few attempts to operationalize the law since none of its provisions have been implemented. The older person board and the older persons fund have not been implemented, leaving a considerable gap in coordinating efforts to secure the livelihoods and health of older persons. Some piecemeal social protection programs for older persons have primarily come through the Department of Social Development and NGOs.

Older persons are also entitled to health care, medical assistance, and financial help through the state's social security and welfare departments (Hungwe, 2022). This is guaranteed through the 2013 Constitution, the Social Welfare Assistance Act of 1990, the Disability Act of 1992, and the National Social Security Act, which gives a foundation for providing pensions and benefits to older persons (Hungwe, 2022). Ncube, Gutsa, and Price (2023) also noted that Zimbabwe has attempted to implement the Healthy Aging Strategy from

2017-2020 to provide care for older persons. However, most of these strategies have failed due to the state's inaction, failing to implement the infrastructure needed to care for older persons. This has left most older persons' welfare firmly in the hands of communities and extended families as the only significant place of care without adequate state support. Though in terms of policy formulation, Zimbabwe is one of the successful examples (Hungwe, 2022), its implementation side has always been piecemeal and ineffective. Successive economic failures have often affected the state's ability to implement policies. The findings from the study reveal that the government at the time of the study had a very minimal role in the operations of social welfare-related issues in the country. The Ministry of Social Welfare is failing to perform its responsibilities. The head of that department who was interviewed was quick to acknowledge that the social welfare malfunctions under such harsh economic conditions. All the government could do was provide care in a limited way, such as providing free health care in hospitals that were not functioning effectively due to the economic crisis.

The policies on health care for older persons are based on free access to health care for all older persons above the age of 65 (Hungwe, 2022; Ncube et al., 2023). This is a noble gesture and shows that healthcare costs are removed for older persons. However, the study noted that this policy was ineffective owing to several factors. The findings of this study reveal that the acclaimed system of 'free healthcare service' for older persons in Zimbabwe has failed to adequately provide free healthcare services to this group of people. Though older persons in Zimbabwe are entitled to free healthcare services, Kasere (1992) argues that there is almost a total absence of a healthcare delivery system specifically designed to cater to the healthcare needs of older persons. Older persons living in Chivi District face various barriers that impede their access to healthcare services. The older persons in Zimbabwe are not benefiting from the free healthcare service as clinics and hospitals have collapsed and are heavily congested, with a lack of drugs and health personnel being the most significant challenges (Dhemba, 2013). It is important to note that the contested free health care in rural spaces is not exclusive to this study.

Therefore, the reality on the ground presents a different picture from the policy prescriptions, as shall be explored in this chapter. There have been difficulties in translating policy into practice, with the existing services being a far cry from the policy prescriptions

of the state. Having a rural health center is crucial, although the most critical element should be the ability of the people to access these facilities. The decentralization of the healthcare system has also been established in line with the government's desire to ensure universal access to primary healthcare rather than tailor-made facilities for older persons. Hence, it is imperative to understand how these primary healthcare centers are designed to remove structural and physical barriers to accessing the facilities by older persons.

6.1 Distance, Infrastructure, and Healthcare Access.

The first structural barrier discussed in this chapter is the issue of distance. Most rural older persons in Chivi South travel long distances to access healthcare services in clinics and hospitals. This, however, contravenes the stipulation guided by WHO (2015) that the distance to the nearest health facility should not be more than 5 km to enhance access to healthcare. In Zimbabwe, people in rural areas walk more than 10 km, and some travel up to 50 km to the nearest health facility (Loewenson et al., 2014). Chapter Four, Sub-section 75 of the Constitution stipulates that every citizen has the right to have access to essential healthcare services. Geographical access is one aspect that has been overlooked in the literature on access to health care, especially in the context of older persons living in rural areas. The current study found long distances to be the most significant disadvantage experienced by older persons in Chivi South District. In this respect, this study argues that the distance travelled seeking healthcare services is one of the major causes of the discrepancies in access to healthcare between ageing populations in urban and rural settings. Traveling long distances was the most recurring theme during the fieldwork process.

The narratives of the rural older persons in CSD show that the long distance between homelands and healthcare services in their localities has far-reaching effects on the accessibility of healthcare services. Against this backdrop, this study submits that access to healthcare facilities in Chivi District is hindered by the long distances travelled to reach healthcare facilities. In this respect, distance is a critical element that significantly determines access to health care by older persons in this district. The increased travel times create barriers impeding access to health care, particularly in cost, difficulty obtaining transport, and enduring the rigors of traveling long distances. To provide a bona fide

analysis, this chapter draws insights from the narratives of three older persons staying in the Chivi District. The three recounts provide different perspectives regarding the distance travelled by older persons to obtain healthcare services in Chivi District.

> *"After three days of illness at home, I decided to go to Zivuku Clinic in Chivi South District. I walked three kilometers to the healthcare facility. After waiting more than four hours, I was diagnosed with typhoid caused by drinking dirty and contaminated water. However, I was told that there was no medicine. I am not the only one who walks such a long distance. Many people walk even more than three kilometers. Our clinics are very far, and transport sometimes poses a big challenge"* (Participant X, May 2018).

> *"We must pay for transport if we need to go to the clinic. As you know, my child's cash is hard to come by these days, so my money is in my Ecocash, and kombi drivers do not accept money from Ecocash. I am old, using the phone is very difficult, and my eyesight is so bad. The roads on this side are terrible during the rainy season. We hardly get transport to go to the nearest clinic. My neighbour died last week on her way to the hospital since they had to transport her using a scotch cart, which is very slow"* (Participant Y, May 2018).

> *"One other day, I had to walk to the nearest bus station. My leg was sore. I fell when I was doing my housework. It took me about two hours to get there. I waited another hour to get transport to the clinic, and by the time I arrived, it was late, and I had to find somewhere to stay for the night to get medical attention"* (Participant Z, May 2018).

The given narratives aptly give an insight into the realities of seeking healthcare services among older persons in CSD. The triple scourge of distance, poor infrastructure, and cost hinder effective healthcare utilization. Penchansky and Thomas' concepts of accessibility further illuminate the situation on the ground since it can be noted that healthcare access is ineffective in the absence of comprehensive mechanisms to ensure that they are accessible to the intended people. The barriers make it difficult for one to claim that the healthcare

needs of older persons are given importance in the area under study. Perhaps, to further elaborate on these barriers and other stumbling blocks to accessing healthcare, the chapter looks into other narratives and experiences of older persons seeking medical attention. The distance issue is addressed first as I try to paint a clearer picture of older persons' difficulties. Apart from the aspect of distance, the chapter will look at the '*curse of rurality'* and costs as part of the physical barriers to effectively utilizing health services by older persons.

I have sketched a map showing healthcare infrastructure distribution in CSD to understand distance dynamics. This is important in showing the number of public infrastructures designed to care for the community's health needs, including older persons. The following map seeks to contextualize the existing services by showing the physical infrastructure available and distances between these and the areas where older persons live in the area under study.

Chivi District Map

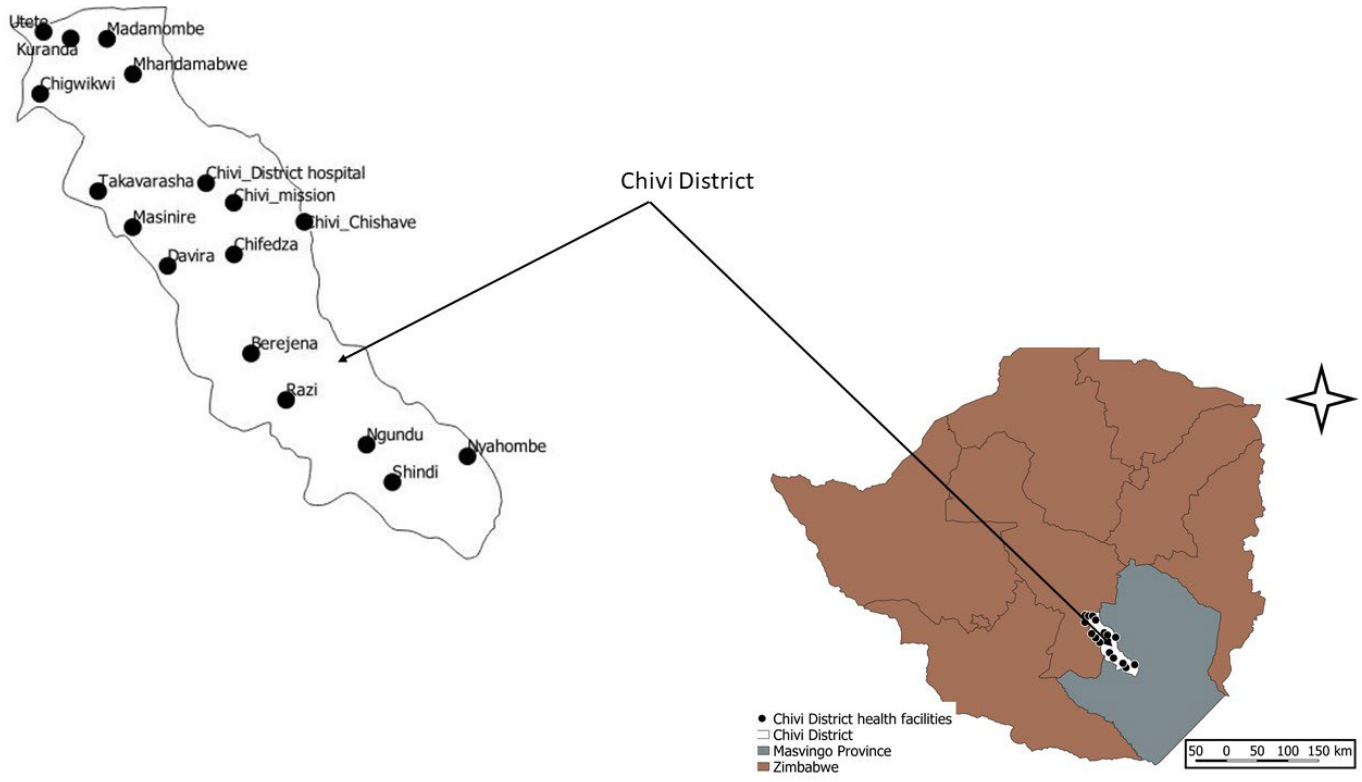

Figure 1. Health Centers in the Chivi District

Table 1. Distance between neighboring/proximate health Centers

Health Centers	Distance between health centers (km)
Shindi_Nyahombe clinic	15.7
Ngundu_Shindi clinic	10.1
Ngundu_Nyahombe clinic	20.1
Ngundu_Razi clinic	18.3
Razi_Berejena clinic	12.4
Berejena_Davira clinic	25.4
Berejena_Chifedza clinic	19.8
Chivi District Hospital	71.6
Davira_Chifedza clinic	13.7
Chifedza_Chivi (Chishave) clinic	14.9

A close analysis of Figure 1 and Table one shows the overview of distances people travel to access health care services in the district. Chivi South, the lower part of the district, was the study area. The clinics that are in the research area include Berejena, Razi, Ngundu, Shindi, and Nyahombe. The furthest part shows that people can travel for an average of 10km, showing that there is a considerable distance that older persons must travel in order to access primary health care.

The issue of distance is also best understood from the experiences of several older persons in CSD. One older woman clarified this issue when she said;

> *I fell sick last week and attempted to walk to the clinic to seek treatment. However, I just returned home after taking a few steps and thinking of how long the distance is; as you can see, at my age, it is painful to walk even a kilometer, what more of the long distance to Zivuku (one of the nearest clinics that are 8km from the sick person's homestead), (Participant B,21 May 2018).*

Due to these challenges, some participants were compelled to avoid medical examinations and suffer in silence in their homes under the mistaken idea that old age is accompanied by various illnesses (Joubert & Bradshaw, 2005; Dhemba & Dhemba, 2015). One of the caregivers also shared a harrowing experience where they had traveled to the clinic without the older person to try and get medications when his uncle fell sick. He said.

> *Sekuru did not wake up that day, and I could see he was in pain. However, I could not take him to the clinic because it was too far for him, so I tried to run to the clinic*

to plead with the nurses; perhaps they could give me some medications so that I could help him. However, by the time I returned after six hours, I found people already gathered and some wailing as it became evident that Sekuru had left us (Participant T, May 2018).

For the healthy young man, 2 hours was the minimum time one was expected to walk to the nearest clinic. For a sick older person, covering that distance was unimaginable without a mode of transport. Thus, the distance could be seen as one physical barrier affecting health services utilization by older persons in CSD. The distances older persons must travel to access healthcare affect their health outcomes. A distance of 8 km is recommended by the Ministry of Health and Child Care in Zimbabwe (MHCC, 2018; Patel & Ladusingh, 2015). The closer the health facility is to where people live, the less likely the distance will negatively influence healthcare access and-seeking behaviour. The results confirm research in other countries (Aboderin, 2012; Goins et al., 2005; Van Rooy et al., 2012), showing that older persons experience multiple barriers to accessing health care. Unlike the developed countries, a recent study done by Mangundu et al. (2020) in Zimbabwe concluded that in rural areas of developing countries, distance had been acknowledged as a critical factor in the utilization of health services, especially in vulnerable groups such as older persons.

The near absence of efficient public transport and road connection networks compounded the spatial scatteredness of rural health services. The rural villages in the area under study only have one major tarred highway that passes through the district. The hinterland does not have these all-weather roads, and usually, people travel up to 30 km to get to the only major highway in CSD. The remaining dust roads and community paths form the only existing road networks in the area under study. This creates a complex scenario for any attempts to bring older persons to seek medical attention. More resources are needed to address the infrastructure shortfall to upgrade the existing roads or construct new roads to bridge the distance between health facilities and people (MacKinnon & MacLaren, 2012). As alluded to by the participant below,

Most people walk to clinics, health centers, and hospitals. However, walking is not easy at a certain age, "I am old now, and I need someone to assist me in going to the clinic to get my medicine for high blood pressure (Participant L, May 2018).

The narrative above shows that distance and transportation hinder access to clinics for older persons because they cannot easily walk to health centers. Even a short distance to care can become an insurmountable problem. The opportunity for older persons to have a closer healthcare facility is significant in rural settings where distances are relatively plentiful, roads may be of poor quality, and public transportation is seldom available. Varela et al. (2019) identified inadequate healthcare facilities, long distances to healthcare facilities, lack of effective and efficient transportation systems, inadequate health personnel, and inability to afford the cost of healthcare services as major hurdles preventing rural people from accessing healthcare services. Access to healthcare services is confounded by the unavailability of medicines in healthcare facilities and low access to income for basic daily living, such as the inability to pay for transport costs to health facilities and payment of healthcare services at higher-level facilities due to severe socio-economic challenges affecting Zimbabwe.

In addition, the lack of adequate road infrastructure and reliable transport services, as seen in resource-deprived regions, particularly the Chivi rural area, is a significant barrier to access to health care. Rural health facilities require more time and finances, which may hinder older persons' quest for healthcare services. In this respect, longer travel times and greater distances to health centers in rural areas were the barriers to repeated visits. Given that geographic access is an essential determining factor for older persons' treatment-seeking behavior, it is crucial to study and develop measures of spatial availability and accessibility of healthcare facilities for rural areas where vulnerable groups reside. Physical accessibility to healthcare utilization can significantly impede older persons with limited mobility and those living in rural areas where poor transportation infrastructure and long-distance travel to healthcare centers or facilities may be unavoidable (United Nations, 2012). Buor (2003) emphasized that distance significantly influences healthcare service utilization among older persons in the Ahafo-Ano South District of Ghana. Terfa et al. (2019) succinctly argued that access to healthcare utilization among older persons is limited by their physical inability to withstand the long waiting time endured in most healthcare facilities or to take the strenuous journey to healthcare centres on public transport and being geographically isolated from healthcare services due to lack of public transport.

Older persons in CSD also encounter challenges accessing transport to ferry them to healthcare facilities. In some instances, they must walk long distances to the clinic. Due to such transport problems, older persons in rural areas sometimes use ox-drawn scotch carts, as shown in Figure 2. Figure 2 shows two older persons women using an ox-drawn scotch cart to access medical treatment in one of the rural clinics in Chivi District. Given that the ox-drawn scotch cart is a prolonged mode of transport, the older persons in these settings often wake up as early as around two o'clock in the morning, depending on the distance they travel. The use of ox-drawn scotch carts suggests a lack of access to private and public transport and high transport costs, which are attributable to the country's economic predicament. Moreover, the comfort needed to transport a patient cannot be achieved using the scotch cart.

Access to a healthcare facility in a rural setting incorporates the first point between the people, and the formal healthcare services should be the most accessible unit of the healthcare delivery system. Rural communities have long been struggling to maintain access to quality healthcare services. Besides the anticipated cost of traveling to a rural healthcare facility, there is also the likelihood of a referral to a hospital, which comes with extra transportation costs. The unique contribution of this study is based on how it utilizes Giddens' theoretical concept of time and space distanciation to enhance understanding of how older persons travel to access health services. Conversely, this theory acknowledges

that people can re-develop structures to improve practice, which is generated from a 'reflexive form of knowledgeability' (Giddens, 1984, p.3). Therefore, this theory informs researchers that knowing the barriers older persons face in accessing the health care system may contribute to policy formulation that allows greater access to health for all.

In this respect, the current study establishes that time travelled by the older persons in Chivi District exerts too much pressure and stress on this ageing population, ultimately affecting their ontological security. The relationship between travel time and transport cost variables affects older persons' ontological security differently. Dealing with traveling or walking long distances, high transport costs, and transport-related stresses would increase the overall cost of care, especially in a country like Zimbabwe, where a low dysfunctional national health insurance scheme compounds low incomes. However, the findings extend this scholarship by providing a fascinating view that compares distance with other factors influencing access to healthcare services by an ageing population. Evidence from the previously mentioned narratives shows that traveling long distances to access healthcare services would involve a long travel time and, in some instances, high transport costs, depending upon the nature of the road and availability of transport. The current study argues that these conditions can discourage older persons from accessing medical treatment.

The recurring idea of the long distances older persons traveled confirms the literature in comparable scholarship. Literature provided by Chinyakata et al. (2021) and Mangundu (2020) shows that long distance is a significant obstacle impeding access to healthcare facilities and, for this reason, older persons in rural areas become part of vulnerable groups. In addition, findings from the current study complement a study conducted by Schoeps et al. (2011) in Burkina Faso, which found that people in Burkina Faso travel almost six hours to access healthcare facilities. For this reason, an approximately doubled mortality risk was found compared to nearby people. The current study, therefore, augments its anecdotal evidence with those of Chinyakata et al. (2021), Mangundu (2020), and Schoeps et al. (2011), which consistently argued that the long-distance traveled to and from healthcare services impede access to healthcare services in rural areas.

In addition to inadequate transportation or lack thereof, the failure to access healthcare services in Chivi South is also exacerbated by long travel time, lack of public

transportation, and their economic status. Options such as walking, using wheelbarrows, or ox-drawn carts indicate older persons' desire to seek healthcare services from a healthcare facility. Access to a healthcare facility is inadequate because of the high cost of fares paid to reach the facility. Inadequate infrastructure or insufficient personnel resources may also be exacerbated by dysfunctional equipment and defective drugs at healthcare facilities. Hence, living close to a clinic and being able to afford healthcare services does not guarantee that citizens will get the medical attention they need.

6.2 Distance Decay: The Plight of Older Persons in CSD

Distance decay in the utilization of health services has been documented in many contexts, including Bangladesh (Rahaman et al., 1982), Papua New Guinea (Muller et al., 1998), rural Nigeria (Stock, 1983), rural Ghana (Buor, 2003), Namibia (Alegana, 2012), Kenya (Gething et al., 2004), Ethiopia (Okwaraji, 2012), and the United States (Nemet & Bailey, 2000). The concept of distance decay is used to explain how older persons must travel to obtain health care. Even when health services are provided free of charge, monetary and time costs of travel to a local clinic represent the price of access to health care. These costs may pose a significant barrier for vulnerable population segments, leading to poorer health (Mclaren et al.,2014). Understanding older persons' travel behaviour for seeking healthcare services is imperative as it is vital for equitable health resource allocation. Poor geographic access can persist even when affordable and well-functioning health systems are in place, limiting efforts for universal health coverage (UHC). The use of primary care decreases exponentially for populations living at increasing distances from primary healthcare centers (PHCs), known as the 'distance decay' effect (Feikin et al., 2009; McLaren et al., 2014; Gething et al., 2012; Noor et al., 2003; Stock, 2012).

The older persons in CSD measure geographical access to healthcare services using travel time and distance to these health facilities, considering physical barriers and poor road networks. When asked about the geographical distance traveled to access healthcare services, Participant Z (*23 May 2018*) recounts that if they walked through the mountains, it took four hours. However, owing to their age, they prefer using gravel roads because they can no longer walk in mountainous areas. They can use ox-drawn scotch carts; with this mode of transport, they take approximately six hours to reach healthcare centers. Based on

the accounts of Participant Z, the current study establishes that road networks and infrastructure in optimum condition are necessary for more accessible travel to healthcare facilities and timely referrals in emergencies involving diabetic persons. Distance is an essential factor influencing healthcare utilization in rural communities. Older persons in Chivi District suffer the most significant brunt in the distance they travel compared to their older counterparts in urban areas. This is mainly because there are few healthcare facilities in this district. Older persons can no longer walk long distances due to their declining energy and the effects of ageing. Thus, the issue of long-distance is detrimental to people's access to healthcare services. Older persons living in rural areas are the primary victims of the extreme spatial disparities between people's homes and healthcare services due to low living standards, making it difficult for many to go to health centers.

6.3 The Referral System and Distance

The previously discussed distance should also be conceptualized and understood within the framework of the decentralization of healthcare services seen through the referral system in the Zimbabwean health system. The health sector in Zimbabwe comprises central government hospitals, mission hospitals, municipal hospitals and clinics, and private hospitals and hospitals and clinics (McLoughlin, 1995). At independence, the government adopted a primary care orientation and organized public and mission facilities into a four-tier system, with primary care in the first level, district hospitals, health services at the second, provincial facilities in the third tier, and six central hospitals at the quaternary level. In principle, individuals are not supposed to go to higher-level facilities without being referred from a lower level. A key element of primary health care is its referral system, in which patients can access care at community-based health posts or health centers before accessing higher levels of care, such as secondary and tertiary hospitals. Zimbabwe has a referral hospital system where patients should report first at a rural health center or clinic and systematically be referred to district, provincial, and, lastly, central hospitals. Thus, central hospitals are at the highest referral level, offering the most specialist health services in the Zimbabwean public referral health system. The structure and nature of PHC are to provide at a low cost accessible promotive, preventive, and educative health services; prevent locally endemic diseases such as cholera and diarrhea; provide simple treatments of

conditions and diseases and local disease surveillance, family planning and home-based care services among other illnesses. Older persons usually require specialized care that might not be available in primary health care centers, which is explored in detail in the following chapter. However, regarding the referral system and distance, the study findings showed that the referral system worsened the issue of accessibility due to the factors of distances involved. It has already been established that local clinics are primarily located in places that are not central for everyone, requiring most respondents to walk longer distances. In the area under study, the next port of call for patients after primary health care is the district hospital located approximately 60 kilometers from the study area. This places immense constraints on the ability of older persons to access health care services. One older woman noted that;

> *Sometimes, you do not have money to go to the hospital. Look, from here to Chivi District Hospital is far, you can walk three hours, to find transport is difficult, sometimes we must wait for a lift, if the vehicle does not come you cannot go there. How can you do what they tell you to do? Besides, I have been instructed to see a doctor for my condition once a month till I get better, so I have to travel to the district hospital to see the doctor. If I had money, I could go to a private doctor at Ngundu, which is nearer (Participant K, May 2018).*

Older persons presented the distance to the healthcare facilities, lack of access, and transport costs as significant barriers. Older persons prefer services close to their homes or other providers, such as traditional healers. The above narratives are supported by Penchansky and Thomas' premise that accessibility (distances) and (affordability) financial costs created barriers to referral services at the health facility level. This situation aggravates the risk and vulnerability of older persons. The distance an older person must travel to access health care services is an important determinant, as a significant reason for unmet health care needs is that the health care services are too far away to access (Sbhojit et al., 2012; van Gaans & Dent, 2018). Loewenson et al., 2014, asserted that the higher the transportation costs, the less likely older people were to use healthcare services in Zimbabwe. This indicates that travel costs and distance are essential factors older persons consider when accessing healthcare services.

6.6 The Curse of Rurality, Disinvestment, and Rural Public Infrastructure.

Understanding the dynamics of the public healthcare system and the care available to older persons should also be done within the framework of Zimbabwe's general political and socioeconomic dynamics. The country's development trajectory is skewed such that there is an apparent inequality between urban and rural centers in Zimbabwe. Rurality is a structure that significantly contributes to how the health care available to older persons is structured. Rurality has come to be associated with underdevelopment, limited resources, and limited public infrastructure, making it difficult to find adequate resources for the health care of older persons. Gamm et al. (2010) note that rural communities are unique regarding their social, economic, and geographical characteristics and their residents' cultural, religious, and personal values. Mainly, some of the problems of access to health care can be understood within the general lack of access to resources that characterize Zimbabwean rural communities. Most of the narratives from the respondents pointed to issues such as impassable roads, lack of bridges, making it difficult for older persons to cross to the rural health care centres, and even poor infrastructure at the existing rural health centres. Giddens' structuration thesis is thus a critical framework that shows that access to healthcare services can also be interpreted within the broader framework of the structural constraint characteristic of the country's socioeconomic inequalities.

The concept of structure is also essential in understanding disinvestment in rural areas. Whereas the state has tried to ensure the smooth running of public infrastructure in urban centers where older persons generally live, there has been a significant absence of resource allocation to rural communities, resulting in the decline of public infrastructure. The primary healthcare centers in most CSD could be seen to be undergoing a significant decline due to a lack of essential maintenance and upgrading of existing facilities. Overgrown bushes collapsed bridges, and eroded roadsides often characterize impassable dusty roads. That is the scenario characterizing the lived realities of older persons where one expects the older persons to get adequate health care services. Some of the respondents lamented the futility of expecting to see better services at the hospitals when everything else is not working.

6.7 Counting the cost: The price for Access to Healthcare by Older Persons.

Healthcare costs are multi-layered and present a significant challenge to older persons. Cost included the resources needed to get to the health centers, access treatment, and purchase medicines for older persons. Several factors compounded the cost problem, including poor public healthcare infrastructure, an unstable economic environment, and diminished incomes of older persons. The study found that older persons living in rural areas of Chivi South District face unique challenges related to service delivery. It can further be established that the health of the ageing population in rural areas is strongly influenced by factors unique to the rural context, shaped by previously mentioned factors. An analysis of the distribution of resources shows that all the major referral hospitals are in urban settings, and older persons in rural areas must travel to access these resources. This issue is further discussed in the next chapter, focusing on the quality of health care services available to older persons. However, one should note that rural amenities may not be adequate for the health needs of an ageing population. Hence, accessing health care is expensive for most older persons with CSD.

The study shows that all healthcare facilities, including health posts, health centres, and district-level hospitals in rural and urban areas, are officially classified as primary healthcare facilities. As such, all healthcare services provided under these facilities should be free. It is understood that such services include drugs, consultation, laboratory, and other medical investigations, and an array of referral services. This policy eliminates standard user fees at the point of service; this can apply for all services, primary healthcare services, selected population groups, and selected services for everyone or services for specific population groups, usually those characterized by medical or economic vulnerability. Guided by the tenets underpinning the free-health policy, countries have implemented this policy to improve access to healthcare for vulnerable populations and help alleviate inequalities in the healthcare delivery system. Based on the above understanding, it can safely be argued that for Zimbabwe to implement this policy effectively, the economic situation must significantly improve. The government laid the groundwork for the failure of the Older Persons Act through the lack of statutory instruments, non-enforcement of the law, and lack of funding for awareness campaigns.

Another aspect of the cost that was seen in the area under study was the cost of transportation. As noted earlier, most older persons must travel longer distances to get to

rural health care centres, and most of the time, this may also mean paying for the transport. One respondent noted that they must travel about two kilometers to the nearest bus stop, where they get lifts from small cars that pirate in the area. He says;

> *There are no buses because of the bad roads, but some funcargoes (small popular Toyota fun cargo cars used as taxis) that pirate from the school going to the highway. At least we can use those to take us to the clinic, but we usually hire them because when you wait on the road, they take time to come since few people travel. So, you have to call the driver, and from here to the clinic, they charge me USD10, which makes it USD20 for the round trip (Participant X, May 2018).*

This showed that transport was a hidden cost that affected the ability of older persons to seek health care services. Some respondents noted that they would only go to the clinic when they encountered severe illness and endure when they felt their illness was not life-threatening. On probing their ability to pay, most respondents relied on their social networks for assistance and income to fund their travel and expenses. This showed a reliance on personal agency and social networks to overcome structural barriers characteristic of the health care options for older persons.

Key findings from this chapter offer a foundation for developing innovative interventions and workable public policy options that support the health of the ageing population in rural communities. Although CSD is not a homogeneous entity, the current study found that most older persons have standard views and experiences regarding access to healthcare services. The participants' narratives show that older persons experience challenges such as limited economic resources, long distances to the nearest healthcare facilities, inequalities in healthcare services, reduced health status, limited availability and accessibility of healthcare services, and a lack of social justice and health equity. Appropriate healthcare services must be available and obtainable promptly for older persons to have sufficient access.

Eliminating user fees in some African countries was driven mainly by politically motivated, for instance, vote maximization. In Zimbabwe, removing user fees in healthcare provision was done as ZANU-PF's political and campaign tool, which was done without proper planning and in an already collapsing healthcare system. Zimbabwe implemented this

policy under the preamble that exempted vulnerable groups such as older persons aged over 65 years from getting free health care. This policy became detrimental to economic development as the country could not fund free health care. Although the policy can effectively alleviate the plight of older persons, it requires a solid economic base supported by a well-functional taxation system. The removal of user fees at the inception of the policy was meant to improve and increase healthcare utilization; however, accessing healthcare is a very complex and multi-dimensional facet in which the removal of user fees alone will not improve the health and well-being of the population. This is a significant problem exacerbated by the macroeconomic drivel played by the State, thus destroying the healthcare system in all its forms and rendering the free healthcare schemes impractical and futile.

Free health care becomes free when it is offered comprehensively. In Zimbabwe's rural clinics, it is offered ad hoc. Even though Zimbabwe has put in place various programmes to cushion older persons from healthcare risks, the programmes are seriously affected by high exclusion errors given that only a small number of the older persons population is covered. Established in 1989, the National Social Security Authority (NSSA) only provides pensions, allowances, and other benefits to older persons who were formally employed. Commenting on the problems affecting free health care, Participant X had this to say:

> *"There is something wrong. I must go back home and die because I do not have money to buy medicine. So, I cannot say it is fine because even if we are made to get help from the clinic for free, they do not have the kind of medicine we need. We can only get free care in big hospitals like Masvingo General Hospital. They tell us to buy medicine, but we do not have the money, so that is how poor the country is. It is awful because I have to return home and die. I will not survive because I cannot afford to buy the medicine which can help me because I do not have the money"* (Participant L, May 2018).

> *"My son, the law states that anyone who is over 65 years of age (and I am 68) has the right to get free medical care service. However, nothing is happening here. It came to light when I fell ill, and I thought I would just*

> *be treated for the minor injuries I sustained from the accident and be discharged, but the doctors discovered that I was diabetic and hypertensive. Hospitals do not have the medication, so l am supposed to go and buy medicines from private pharmacies"* (Participant G, May 2018).

The sentiments of the above participants reveal that access to free health care, as directed by the free health policy, is still a problem among older persons. In some incidences, older persons who cannot afford health care have lost hope of getting treatment in public hospitals. Services are accessible in principle, but rural older persons still have to bear indirect costs in accessing healthcare services. Healthcare centres where older persons are supposed to get care unavailable at rural clinics are far away, so travelling to those centres is costly. For example, travelling from rural areas in Chivi South would require at least US$10 (ZAR150), and structural factors still threaten older persons' access to healthcare services. Most key informants averred that the country's economic quandary is the main limiting factor to providing free healthcare services. For this reason, older persons must pay for their medical prescriptions. Commenting on financial stumbling blocks, some of the critical informants narrated that:

> *"Older persons often face financial challenges. For example, even if one finds out they have diabetes, they get home and cannot keep buying medicine because they do not have money. So, they default, and when they return, their sugar levels will be very high, and they are given different medications or injections. They still cannot afford it; thus, diabetes becomes a big problem for them"* (Key Informant interview 1; May 2018).

Although the policy directs free health care to older people in government hospitals and health centres, it was found that only some medical services, such as doctors' consultations, are free. However, other services demand older people to cover at their own cost. Older people complained that health charges had placed their access to health care services in particular. This will result in older persons opting not to get treatment when sick due to the significant financial burden to the poorest older people with very little income. While the

government has removed all official charges, which were not always affordable to older people, the study found that "unofficial" charges are still in place, denying older people access to free health services. These findings also concur with Mutenga's (2016) and Chimhou's (2012) findings, which indicate that older persons incur high costs in purchasing essential medicines. These findings also correspond with Mhike and Makombe (2018), who assert that removing user fees for vulnerable populations can reduce financial hardship from healthcare payments, improving health outcomes and promoting health equity.

> *"We have a policy called 'free medical access to health care for older persons,' but the health system has many challenges. For example, sometimes, there is no medication. So, even if the services are free, there are no medicines, which means there are no services. We send some of the patients to provincial hospitals, and if they require further tests, they must travel and seek accommodation once they reach the main hospital"* (Key Informant interview 2; May 2018).

The above narratives show a consistent increase in out-of-pocket spending, which is of concern, given the increased burdens on households during severe economic difficulties. Fundamental economic theories suggest that removing fees increases service utilization if the fees represent a significant financial hurdle for households accessing health care. However, if the other factors, such as distance to health facilities, may act as constraining factors and lead to low utilization, removing financial barriers may have a limited impact (Lagarde et al., 2017). Free health care in rural Zimbabwe is meant to benefit and be accessible to older persons, but the country's volatile economy has severely strained rural clinics. Free health care is "money on paper" because the Government is not fulfilling its promises as the funds are never disbursed. Adopting the pseudo-currency (Ecocash, black market rating system Zimbabwean bond, and the United States dollar) in Zimbabwe makes the funding and implementation of the free health care policy complex. The medical system is in disarray, with nearly two-thirds of sick Zimbabweans being unable to seek the treatment they need because they cannot afford it.

> *There is a lack of government commitment to other laws, such as the Older Persons Act that enforce policy implementation. Without such instruments, the policy is not*

functional. We do not have outreach and educational programmes that target older persons regarding their right to free access to health care (DHA, May 2018).

Again, while it is possible for adequate resources to be available to meet the need for healthcare financing at a given point in time, the distance between the health seeker and the healthcare provider may be an essential constraint. This calls for the geographical conceptualization of access to reliable healthcare financing. Older people's access to reliable and sustainable healthcare financing requires sufficient, uninterrupted, and continuing funds to meet older people's healthcare needs without compromising or negotiating future generations' ability to achieve the same purpose. An essential step to achieving reliable healthcare financing for older persons is to ensure that adequate and satisfactory social support is provided, older persons have free access to funds or financial resources provided by the social support system, and that funding increases consistently over the coming years to meet up with the demand of demographic transition. Most private hospitals and doctors bill patients in US dollars for services. Due to the chronic nature of their medical ailments, older persons in Zimbabwe find this particularly challenging (Chikoko et al.,2022). This suggests that due to the current and constricting socio-economic and political climate, the majority in Zimbabwe do not have access to medical insurance. Raising and accessing reliable funds for healthcare financing for older persons is the responsibility of every country's household, community, state, and non-state actors. Providing access to reliable healthcare financing is crucial for any country that addresses the inevitable healthcare needs and challenges of older persons.

6.8 Conclusion

The study's findings indicate that rural older persons' healthcare needs or determinants extend beyond access to medical practitioners and the formal healthcare system. While having access to healthcare services was identified by many participants, there were aspects of older persons' support systems that underscore the influence of other healthcare determinants such as class, free healthcare, culture, geographical space (distanciation), and the economy. The research shows the need for more information on and awareness of existing services available in rural spaces, such as home and respite care. With limited housing options, no formal transportation services, growing financial concerns, and inadequate support, many older persons without economically stable families suffer more

than others. The results suggest that strategies outside the formal health care system are necessary for addressing rural older persons' health care needs. Rural populations experience lower access to health care due to affordability, proximity, and quality issues than their urban counterparts. Older persons in CSD and Zimbabwe require healthcare services more frequently and intensely; however, the lack of access to reliable healthcare financing challenges this group. With increasing healthcare costs, especially among the elderly population in Zimbabwe, providing reliable healthcare financing and removing possible barriers to accessing it is crucial for healthy ageing.

CHAPTER 7

REEXAMINING THE QUALITY AND APPROPRIATENESS OF HEALTH CARE SERVICES FOR OLDER PERSONS

7.0 Introduction

The previous chapter nuanced geography, distance, transportation, logistics, and time: remote areas have more significant problems with access to medical care due to distance, bad roads, and transportation problems. These issues become more acute for older people who cannot easily walk to health centers. There is a paucity of research in Zimbabwe looking at "triple vulnerability" culture, health decay, and rurality for older persons. Drawing from this research, it is not enough to implement healthcare policies but to make

primary healthcare available, accessible, and affordable. This chapter draws insights from healthcare services availability, appropriateness, and quality of care, focusing on older persons living in rural areas. The chapter analyses the available medical services and contextualizes them in terms of the needs of older persons. The main question in this chapter is how appropriate and adequate/or sufficient the services available in CSD are to the healthcare needs of older persons. It will argue that utilizing services also depends on the quality and relevance of services. The concepts of availability, effectiveness, and appropriateness as a unit of analysis to understand the quality of healthcare services available to older persons. Older persons living in rural CSD experience poor healthcare availability and effectiveness. Quality of healthcare, as it applies to the context of this study, entails reorganizing the delivery of care so that older patients receive specialized attention when they are seriously ill. This can be done directly by providing care by specialists in specialized units or indirectly by establishing policies and procedures for consultation and support to generalists who take on primary care responsibility. This includes improvement in health conditions or outcomes following the introduction of pertinent services, programmes, or treatment. Also, the availability of health care, as utilized throughout this chapter, is an aspect that refers to the comprehensiveness and physical presence of healthcare services that meet the minimum, appropriate, and acceptable standards available to suit the needs of older persons living in CSD. The argument presented in this chapter is that for healthcare services to be effective, they must comprehensively address the needs of those serviced, mainly older persons in CSD. The Chapter will also dwell on healthcare professionals' attitudes and how this can impede older persons' health-seeking behavior. In this respect, the chapter draws on the disproportionate and growing demographic of the ageing population and the lack of available, appropriate, and effective services to meet the needs of older persons.

7.1. Primary Health Care – The Quality of Care in Rural Zimbabwe

PHC was famously set as a global priority in the 1978 Alma-Ata Declaration. More recently, the 2018 Astana Declaration on PHC called for universal coverage of primary health care across the life cycle, essential public health functions, community engagement, and a multisectoral approach to health (Lancet Commission, 2020). However, LMICs,

including Zimbabwe, and PHCs services need to deliver on the promises of these declarations. In Zimbabwe, the continuing structural inequalities and the de facto lack of government support constrain the implementation of PHC. Despite being a signatory to the Alma-Ata Declaration, the country needs to catch up in achieving comprehensive PHC among the vulnerable population who reside in rural areas. PHC, in the context of Zimbabwe and older persons, needs to meet their healthcare needs. Muzvidziwa-Chilunjika and Chilunjika (2021) noted that despite government efforts to decentralize health care, many rural areas still need access to high-quality in Zimbabwe. Some of the commonly cited reasons in this study include but include more than inadequate communication and transportation systems, drug shortages, subpar equipment, inadequate health facilities, and a lack of senior experienced employees.

Public funding for PHC in Zimbabwe needs to be increased; access to PHC services remains inequitable, and older persons often must pay out of pocket to access healthcare in urban hospitals. As per the recommendations of Alma Ata (1987), PHC services need to recognize and fulfill healthcare needs for vulnerable groups such as older persons. It also notes that the growth of primary health care depends on the attitudes and capacities of all health workers and a health system structured to support and complement the frontline workers. A vicious cycle has undermined PHC in Zimbabwe; healthcare services are unreliable and underfunded, are of poor quality, and are not accountable for serving the needs of older persons. As discussed in Chapter 6, the shortage of drugs and medicine has undermined the PHC services in rural Zimbabwe. Given that PHC is viewed as ineffective, this circumstance has caused much public discontent. Additionally, hospital and clinic prices have increased due to cost-recovery measures and high inflation rates, but there has yet to be any discernible improvement in the standard of care. Some older persons shun primary healthcare facilities to seek higher-level specialist care. In tandem with this, one of the respondents said

> *Of late, I have been feeling unwell with constant palpitations; I cannot even think of going to our local clinic; there is no service. They have no resources to investigate what is causing those palpitations, so sometimes we go to Masvingo Hospital. Our local clinic needs qualified nurses (*Participant X, May 2018).

The main reasons for bypassing PHC facilities, from the findings of this study, were poor services (including lack of drugs and diagnostic services) and lack of trust in health workers at the bypassed facilities. Improving the quality of care at PHC facilities could also reduce delays in seeking appropriate care (Maphumulo, 2019). Hence, in a situation of scarce resources, strengthening already existing PHC facilities by upgrading them into hospitals to provide better quality services to rural populations should be prioritized before increasing the number of such facilities. The healthcare system must be decentralized, increasing the number of hospitals in the district. PHC may be used as a springboard to launch more hospitals. However, acknowledging that providing drugs and improving healthcare facilities alone may not increase service uptake. Other factors include structural barriers to accessing health facilities (i.e., physical barriers, facility accessibility) and health service delivery process barriers (i.e., feeling respected and health provider knowledge) (Loewenson et al.,2014). PHC services at rural clinics in Zimbabwe are minimal; hence, they must be more adequate to cater to older persons' healthcare needs. Thus, one respondent said,

> *Health workers in rural areas' incentives are impoverished, and the government does not care* (Key Informant 3, June 2018).

The lack of incentives or favorable compensation differentials for rural health professionals, considering the hardships and challenges they experience, shows the government's need for adequate support for PHC. Governmental support for PHC needs to be stronger because PHC is linked to several problems and challenges healthcare professionals face. The fundamental inequalities the PHC method in Zimbabwe has intended to alleviate make these challenges worse.

7.1.1 Older Persons and the Ailment Patterns in Chivi South District

Understanding the conditions affecting older persons is vital in determining the healthcare services' appropriateness. From the study, most respondents indicated they were affected by chronic illnesses closely associated with old age. It should be underscored that despite the marginal increase in the number of older persons in Zimbabwe (MCC,2019), the demographic composition shows a young population like many other developing nations. This trend means that older persons are not a priority population when it comes to the

allocation of resources and social policy. As stated in this thesis, the precarious situation for the older persons in Chivi is further compounded by the geographic location and the rurality.

Although there will probably be a rise in the need for medical services, more is needed to know about the health requirements of older people in the area under study. It emerged that the most common diseases affecting older persons were cancers of the prostate for men and cervix for women, cardiovascular diseases, diabetes, and stroke. Most respondents required daily medication for chronic illnesses such as diabetes and hypertension. Other problems were also linked to physical injuries arising from the fragility and vulnerability associated with aging. This usually resulted in cracked bones that needed treatment and attention. To support this position, one of the respondents had this to say

> *I now have difficulty walking, and sometimes I fall. If you look at our bones, they no longer heal fast, and though I must rest, I should ensure everything is in order at home* (Participant M, May 2018).

Another one also complained about the need to undertake daily household and livelihood chores since they are labor-constrained. Various scholars have noted the problem of labor, which continues to pressure older persons as they must do multiple livelihood and household chores (Gutsa, 2022; Matutu & Botchway, 2022). This also exposed them to physical injuries that require medical attention. The situation is worsened by rampant labor migration in CSD. Many younger persons migrated to South Africa, leaving an aging population. This, therefore, leaves the older persons to do all the work in this rural economy whose livelihoods are labor intensive. The district's proximity to the South African border makes labour migration a lucrative livelihood strategy for younger persons, primarily irregular migrants (See Gukurume et al., 2010).

Other related challenges raised included poor eyesight and increased incidences of physical injuries. Sight problems even resulted in some older persons requiring helpers to get around, thus making them highly dependent upon caregivers. In a study done in rural Zimbabwe, almost 57% of older persons suffered from sight-related problems, confirming the problem’s prevalence, especially in rural areas (Tagoh et al.,2020; Muruviwa et al., 2013). The shortage and inconsistent supply of medication at rural healthcare centers in

Zimbabwe seriously affect older persons suffering from chronic illnesses. These diseases and illnesses shape the health-seeking experiences of older persons. They are part and parcel of the conditions that create the need for healthcare services. Hence, to establish the efficacy of the healthcare system towards older persons, the study delves into the appropriateness and suitability of the procedure to address the challenges that older persons encounter.

7.2 Disengagement and Availability of Healthcare Services vis-a-vis the Needs of Older Persons from Health Services

The healthcare systems in CSD and rural areas in Zimbabwe are highly complex in structure, function, and administration. The complexity and diversity of the healthcare systems make their classification difficult, and this has been exacerbated by the fact that all healthcare systems are constantly evolving in response to ongoing political and economic forces. The other challenges include poor funding and infrastructure, limited medical resources equipment, and a shortage of healthcare experts (Kanyumba, 2022). Most Zimbabweans rely on the country's ageing clinic infrastructure for primary medical care, funded by taxes. Agrarian-based social protection programs like the input scheme, which could receive more significant budget allocations than any other social protection programs, appeared to be of greater interest to legislators from the ruling ZANU PF party (Chinyoka, 2018).

One of the factors this study established is that older persons are discouraged from seeking healthcare services by disengagement from healthcare services. This is mainly due to different attitudes that are widespread in their societies, even among healthcare professionals. The ubiquity of these barriers means that integrated healthcare services must be tailored to the specific needs of older persons. The current chapter maintains that this can be improved if services are provided without age-based discrimination. This is in line with the observations made by Osborn et al. (2014) that in older persons in eleven high-income countries, up to 41% reported problems with the coordination of care over two years. Similar lessons can also be learned from a study by Nolte and Pitchforth (2014), who noted that such fragmentation could result in healthcare failing to meet the needs of older persons and leading to substantial avoidable costs for older persons and the healthcare system.

Another essential factor that discourages older persons from seeking care, or that which results in their disengagement from health services, is the widespread ageist attitude in the societies in which they live. Most participants reiterated that ageist stereotypes, prejudice, and discrimination are potential barriers to equality in providing and accessing healthcare services. These stereotypes and discrimination against older persons negatively impact their health and well-being and are potential barriers to equitable health care (Wyman et al.,2018).

It also emerged in this study that the unfair distribution of health care service centers (See map in Chapter 6) is another inhibitive factor for the older persons' quest for health care service in CSD. Thus, there is an unwanted interplay of aging and distance for these citizens.

Commenting on this issue, a participant recounted that:

> *"There is no single clinic in our ward. We must travel long distances to access healthcare services. The biggest challenge we face is the lack of clinics. For us, it is better to remain and die at home than to travel long distances to the nearest clinic. Sometimes, you do not get medication after walking long distances, but only a prescription"* (Participant N, May 2018).

The narratives of Participant N show that there are few clinics in the district and that older persons stay at home rather than walk long distances. Few healthcare services in the community can result from the neoliberal approaches, which focus on centralizing healthcare services and limiting service provision to remote and rural areas. According to the World Bank (2016), development indicators in Zimbabwe show that the population of rural residents was reported at 67.72%, with almost 12% being older persons. Previous studies have reported that unmet healthcare needs emanating from barriers to access have resulted in delays in receiving appropriate care, preventable hospitalizations, and the inability to get preventive services (Healthy People, 2020; Dhemba, 2015; Chiweshe & Makusha, 2012). A combination of factors can affect access to healthcare services by individuals and communities. Whether people have access to healthcare services depends on their circumstances and environment.

According to Savedoff (2009), availability considers the supply of healthcare services in terms of the amount and quality of the population's needs. Levesque et al. (2013) concur that availability measures the extent to which the available services meet the population's healthcare needs. This study found that older persons living in the CSD struggle due to the unavailability of healthcare services. Most of the participants reiterated that in their district and respective wards, there was unavailability of healthcare services that suited the complexities of their illnesses and diseases that affected them. To this end, their vulnerability is exacerbated by inadequate health care and poor health outcomes, which are attributable to their diminished financial resources and intrinsic capacities. Given that most rural older persons hail from socially and economically disadvantaged backgrounds, it is not surprising that they are more vulnerable to inadequate availability of healthcare services (Ncube-Makore & Nhapi, 2022). These findings were illustrated by one of the key informants, who said:

> *"Healthcare services in our rural clinics tend to be more focused on primary health care and do not cater to the conditions of the older person in rural areas. These people need more care and attention, which our government hospitals and clinics fail to provide. In some instances, healthcare workers often lack the training to deal with the specific needs of older persons"* (Key Informant 3, June 2018).

The narratives of Key Informant 3 show that the availability of healthcare services in CSD is highly compromised. Healthcare services currently available in the district need to adequately meet the needs of the rural older persons. Borrowing from Jacinto et al. (2014), this lack of availability is most likely to result in the healthcare needs of older persons being overlooked and misdiagnosed in a primary healthcare setting. The main argument herein is that older persons, due to their special physiologic conditions and vulnerability to various chronic diseases, need more attention than other age groups. Thus, providing care for older persons with multiple health issues is complex. This is also supported by a statement made by one of the respondents, who had this to say

> *"Our wish is that when people are lucky to have a government clinic, let there be no other burden put on them so that they can survive. As you can see, I live near*

the clinic, just walking distance. However, I do not use healthcare services very often, but as older adults, our health needs comprehensive treatment, such as diabetes. I was diagnosed with Type 2 diabetes, but the clinic does not have medication available every time I go there. So, what is the point of going there if I cannot get treatment for this ailment? *Our clinics do not even have Paracetamol tablets that stop the pain. All they are giving now are prescriptions, but we do not have the money to buy the drugs at pharmacies"* (Participant M, May 2018).

The sentiments expressed by Participant M reflect the importance of the five As of the Penchansky and Thomas (1981) model of access to health care, which reflects that the availability of structures will not significantly improve access to and utilization of a service if the other four dimensions have not also been addressed. For example, what has been reiterated above shows that the unavailability of medication for chronic illnesses, often found in older persons, may catalyze the non-utilization of healthcare services. It is sufficient to argue that the unavailability of proper medication influences rural older persons' non-utilization of health care. Rural clinics in Zimbabwe are in a dire situation, with the lack of necessary medicines causing preventable deaths (also see Mangundu et al.,2020). Therefore, the availability of infrastructure does not warrant the provision of comprehensive health care. Moreover, this also impacts the health of older persons in these communities. The government has failed to ensure people's rights to access affordable, quality, and primary healthcare in government health facilities.

Makoge (2016) concurs with the sentiments cited above, highlighting that if one dimension of access to health care is neglected, it may hinder health-seeking behaviors among individuals. Not only is the mere presence of facilities not an adequate measure of availability, but it also misses the more important issue of the goodness of fit, that is, the interaction between the characteristics of the providers and the expectations of the clients that determine the acceptability of the resources. The Zimbabwean government's bureaucratic supply system is plagued by poor procurement policies and practices that make drugs costly or unavailable. The collapse of the Zimbabwean pharmaceutical industry has rendered the unavailability of essential medication even worse, with the country's healthcare system being heavily reliant on donor support and imports. Furthermore, the

worsening economic system has made it difficult for healthcare to cater to vulnerable groups, such as older persons. In tandem with this, participant B narrated that:

> *"Our clinics are not designed like hospitals and cannot meet all our needs unless nurses are given higher training and health centers are properly equipped. They should provide services such as the ones that hospitals offered during British rule when the healthcare system had good doctors and adequate medicines"* (Participant B, May 2018).

The above-cited narrative provides an insight into the inability of the local health system to offer comprehensive care, which is inherent in the many challenges and barriers facing it, ranging from a shortage of doctors and drugs to poor funding and inadequate maintenance and equipment of the healthcare facilities. This confirms the views of Woelk (1994), who states that the authoritarian rule of the former President of Zimbabwe, Robert Mugabe, destroyed one of Africa's most robust healthcare systems. Poor funding and wrong policy selection or implementation have crippled the healthcare sector (Rusvingo, 2014a). The public healthcare system has deteriorated so much that it is not uncommon for people to die in the corridors of health facilities or at home for lack of money to go to private health facilities (Meldrum, 2008; Nyazema, 2010; Kidia, 2018).

From the above narrative and analysis, it is not in doubt that Zimbabwe requires a new model of healthcare, which ought to address the multi-faceted problems of underfunding, eliminate wastage and corruption so that the country can improve dwindling staff morale, bring transparency to opaque procurement procedures, an infusion of a human rights paradigm in the governance of the public health system, and a robust public oversight about the performance of the public health structures. Mangundu's study findings (2017) alluded that Zimbabwe requires a strategic action plan that includes improving health infrastructure, providing appropriate medical drugs, providing medical equipment at the rural health facilities, and improving the healthcare system's capacity.

Further, multiple barriers exist, making access to health care in rural places even more complex. In rural CSD, the obstacles include geographical isolation, socioeconomic inequalities, and unequal distribution of healthcare services. Older persons expect an ideal healthcare system to always be functional, practical, and capable of meeting their needs.

This condition reflects Penchansky and Thomas's (1981) concept of healthcare access; thus, if the healthcare system does not accommodate the needs of the ageing population, it affects their perceptions of those services, often resulting in a loss of confidence. The availability of healthcare access is a dimension that has not been met in the local clinic, which did not have a doctor, qualified support staff, or adequate drugs, let alone provide various services that meet the older person's needs. Commenting on the challenges faced by older persons, Key Informant 2 narrated that:

> *"The biggest challenge we face is that rural clinics are designed to manage single diseases, and they inadequately address the problem of multi-morbidity, which mostly affects older persons. Some older persons have been diagnosed with chronic ailments requiring special treatment as the third-level care or treatment offered at a referral level"* (Key Informant 2, June 2018).

The above extract shows that rural clinics in Zimbabwe cannot offer considerable healthcare needs to older persons. Notably, older persons living in rural places often face a "double-edged sword" as they encounter the physical, social, and economic changes accompanying ageing in healthcare services that offer fewer resources. Such fragmentation can result in healthcare failing to adequately meet the needs of older persons and leading to substantial, avoidable costs for older persons and the entire healthcare system (Nolte & Pitchforth, 2014). The findings show that another factor that discourages older persons from seeking healthcare services is the disengagement from health services characterized by insufficient medical practices that do not support the multi-morbidity of older persons. The ubiquity of these barriers means that, in addition to improving the coordination of care, integrated healthcare services must be tailored to meet the specific needs of older persons; this cannot be improved if services do not meet older persons' needs. In Zimbabwe, rural older persons are generally more disengaged from medical practices due to limited services and poor referral systems. This is illustrated in the extract below:

> *"Specialist doctors tend to be concentrated in big urban centers. They shun rural areas because they fear their surgeries might collapse since the general rural population cannot pay for medical services. Also, rural hospitals are mostly understaffed and are inaccessible to many"* (Key Informant 1, June 2018).

Technically, patients must present themselves at the entry-level facilities first and then be progressively referred upwards if their condition warrants such a referral. However, the Ministry of Health and Child Care has admitted that, in practice, the referral process functions poorly. The challenges resonate from a dysfunctional referral system, poor equipment, and a shortage of human resources. The conditions of rural healthcare facilities could be better so that people bypass them and self-refer to higher-level facilities, hoping to get the desired care. Also, the most basic medical and surgical care is available only in the central and better-equipped general hospitals. The risk of having multiple non-communicable health conditions also increases with age and, if not adequately addressed through robust care coordination, can lead to high death rates among older persons. As a result, people bypass their local healthcare facilities, thus putting pressure on larger institutions, especially central hospitals (Yao, 2018). Whether the problem lies with perceived or fundamental inefficiencies or inadequate resource allocation is anyone's guess, but there are structural problems that should be resolved. Although there is no standard or universal model for healthcare availability, the basic requirements are that a sound healthcare system needs to readily provide effective, safe, and good-quality care to those who need it. Therefore, the above referral structure results in a handicapped system, a lack of essential medicines, commodities, and transportation services, and a poor-quality service delivery system have compounded that. On this note, a participant stated that:

> *"I have lung problems; so whenever I go to Chivi Rural District Hospital, I am referred to a doctor resident at the hospital, and he always tells me that I need to see a specialist., So, what is the point of us going there? I understand that special treatment is only available in Harare and Bulawayo. How do I get there when I am old and poor? Older persons are left to die as we cannot afford specialist treatment. In this instance, we do not go to the clinics"* (Participant C, May 2018).

Participant C's narrative shows the fragmentation and disengagement evident in Zimbabwe's healthcare system. The situation has been compounded by socio-economic hardships and the unavailability of healthcare providers and facilities to obtain healthcare. What is equally devastating is that facilities are not accessible since they are not located near the population they are intended to serve. The location of specialist treatment is centralized only in the two major cities, Harare (420 km) and Bulawayo (300km),

significantly impacting those needing these services. It is a double-edged sword for older persons, as treatment for chronic illnesses is beyond the reach of older persons in Zimbabwe. The worsening economic conditions in Zimbabwe have significantly impacted the vulnerable groups in the rural areas, mainly affecting the older persons who have never had formal employment in their prime years. Each year, thousands die from preventable and curable diseases. Prices of life-saving drugs and consultation fees for specialist services have more than quadrupled, making healthcare services unaffordable and inaccessible to a poor majority. This has put the lives of millions of Zimbabweans at risk. One critical issue the government needs to address is the preference of pharmacies, private doctors, laboratories, medical diagnostic imaging centers, and hospitals to peg fees in United States dollars and use the parallel market rates for Real-Time Gross Settlement (RTGS) payments (at the time of the study 1USD was equivalent to 25000 rtgs**)**. Consultation fees at private facilities in Zimbabwe range from US$20.

Zimbabwe gained independence in 1981 and inherited institutions that reflected the values of the socio-economic order of the previous regime. The delivery of health services was heavily skewed to the urban areas and the predominant hospital sector. The rural regions were primarily underserved, and the Government's health policy was to ensure an equitable distribution of health care to all population levels. By so doing, it is expected to eliminate disparities between the urban and rural sectors. Decades of underinvestment in the healthcare sector in Zimbabwe have interrupted efforts to develop access to health in rural areas where most older persons reside. This situation has been worsened by political and geographical barriers and the unavailability of the human and financial resources needed to improve access to health in rural and remote communities. As discussed in Chapter 6, older persons in rural areas tend to have higher levels of certain diseases, predominantly because of socio-economic conditions exacerbated by a lack of healthcare resources or the means to access the healthcare resources available, resulting in significantly poor levels of health. The global shortfall of medical drugs contributed to the recommendation made by the Sustainable Development Goals for supporting research and development in medical drugs and vaccines for the prevention and control of infectious diseases (WHO & World Bank 2015). Countries should develop and implement policies that improve all populations' access to affordable medical drugs, in line with the Doha Declaration on the TRIPS

Agreement of 2001 (WHO & World Bank 2015). Accessibility and affordability of medical medicines reduce the global disease burden and high mortality rate since timely health-seeking behaviour contributes to good health outcomes. A study conducted in Zimbabwe by Mangundu (2017) concluded that the inadequate distribution of physical resources, shortage of material and human resources, and a lack of financial resources are inhibiting the quality of services in the healthcare system, mostly in rural areas.

Rural settings in low and middle-income countries are bedeviled with poverty and high disease burden (Menon et al.,2015) and lack adequate resources to deliver quality healthcare to the population. For instance, drug shortage is widespread in rural health facilities.

> *Sometimes, we (health centers) run short of drugs; we cannot get standard paracetamol for our clients. What is more touching is the unavailability of essential medicines for treating chronic illnesses such as BP and diabetes, and most of those in need are older (*Key informant P, June 2018).

Healthcare facilities in rural Zimbabwe are suffering chronic shortages of critical drugs; many patients die of easily curable diseases (Mangundu, 2020). According to a report done by WHO in 2016, the poor availability of essential medicines in health facilities, substandard-quality treatments, frequent stock-outs, and suboptimal prescription and use of drugs, faced with these difficulties in accessing modern medicines, many Africans resort to ritual and herbal remedies, known across diverse African societies as traditional medicine. Compounding these dire situations, the shortage of primary healthcare facilities has exacerbated the quality and adequacy of care.

Most patients are older and without access to modern drugs found in urban settlements. Consequently, some end up defaulting on treatment due to the unavailability of the medication. This is explained in the following extract:

> *"In some clinics, some nurses give us painkillers as a "treat-all-drug," but this is not their fault as they try their best to ease our pain. Most medicines are unavailable, leaving them with no choice, and they often advise us to go to big hospitals such as Masvingo General Hospital, of*

which I would need money for transport to get there" (Participant M, May 2018).

The above narratives posit that the shortage of essential drugs has dire consequences on the sick, and this also affects the rural population, which is poor and vulnerable in CSD. Such constraints reflect the poor quality of care due to the unavailability of essential medication. Hence exposing older persons to more health risks. The shortage of drugs is not unique to Zimbabwe, as it was observed that in many Sub-Saharan countries, there is a severe shortage of medical supplies in public health institutions (Taruvinga & Simbarashe,2015; Bawontou et al.,2021). This is compounded by the heavy reliance on importing raw materials to manufacture medicine (Beargie et al.,2019). Hence, this spells serious trouble for rural areas since they are typically the last to access any imported or manufactured medicine due to their inaccessibility. According to a 2017 newspaper report, 95% of drugs are donor-funded, with the government contributing only 5%. The shrinking tax base in Zimbabwe can no longer fund critical sectors such as health. The unavailability of drugs for non-communicable diseases and poor equipment can encourage older persons to seek healthcare services. Rural clinics in CSD are struggling to provide adequate health care to older persons, and confounding this situation is resource unavailability, which has been caused by the country's economic meltdown, which has left the healthcare sector in shambles. The healthcare fabric of vulnerable people has been eroded, and the deepening financial crisis severely affects the government's ability to fund the public health delivery system and restricts poor people's access to healthcare (Dhemba, 2013; Dhemba, 2015). Many governments or public health services have closed in recent years, and shortages of drugs and essential medical equipment have brought many hospitals and rural clinics close to ruin. The availability of equipment in a health facility was statistically significant to access. This concurs with Firoozeh's (2009) study, which found that an unsuitable physical environment and lack of necessary facilities affected older persons' healthcare access.

The sentiments expressed by Participant M reflect the importance of the five A's developed by Penchansky and Thomas (1981). For example, the availability of and access to a healthcare facility will not significantly improve access to and utilization of healthcare services if the other four dimensions have not been addressed. One can conclude that the availability of infrastructure does not always warrant the provision of comprehensive health

care. If certain healthcare services are unavailable, utilization will become limited as older persons have unmet healthcare needs. Rural clinics in Zimbabwe are in a dire situation, with the lack of essential medications causing preventable deaths. The cash crunch and a weakened economy have exacerbated access to health for rural older persons who are economically worse off than before. A report published by WHO in 2017 on Zimbabwe acknowledged that several factors inhibit access to health care but stressed that the shortage of resources and skilled personnel has crippled healthcare provision in Zimbabwe. The report also avers that low-income countries experience poor availability of essential medicines in healthcare facilities, substandard-quality treatments, frequent stock-outs, suboptimal prescriptions, and subsequent use of drugs. A participant reported that:

> *"We thank the government for providing us with clinics, but they are just empty buildings. We cannot get medical help as the clinics lack basic medicine, running water, or electricity. So, it is pointless telling you that we have a clinic in our ward; therefore, I feel that the government should listen to us and consider our healthcare needs"* (Participant Z, May 2018).

The above narrative emphasizes the need to adopt older persons-friendly mechanisms to address the concerns of the older persons who participated in this study. They perceived the need for a friendly mechanism as consistent with the continued shortage of skilled staff and instruments in healthcare service centers; otherwise, the acceptability issue can pose significant risks to the likeliness of receiving healthcare support from those healthcare service centers. The consideration of community-based professional assistance was highlighted in the respondents' responses from the higher-income group, where the necessity is rationalized by focusing on the vulnerability of older persons. Because of older persons' exposure, impediments often scuttle the healthcare-seeking process. At that point, the older persons' respondents perceive the need for community-based professional assistance.

Giddens' structuration theory suggests that the poor health practices of the community populace are as important as the absence of healthcare facilities in that community in terms of understanding why health outcomes are poor in each community. This suggests that poor

health practices may lead to poor health outcomes, while poor health outcomes may limit an individual's capacity to engage in good health practices. Similarly, the absence of healthcare facilities can influence community residents' engagement in poor health practices, which could be the driving force behind ensuring that healthcare facilities are constructed in the given community. It suffices to say that formulating policies to address access to healthcare problems will be highly handicapped if society cannot appreciate the duality of structure or the falsity of the dual nature of structure and agency. This then provides a more holistic approach to understanding culture and social organizations.

> *"Well, as you can see, this is Chivi District Hospital that caters to the population in this area. We strive to serve older persons subject to resources. No services are specifically designed for older persons, but we serve with great humility. Our hospital is utilized and overwhelmed as it tries to care for patients in this area properly. We also rely mostly on donor-funded medication; sometimes we do not receive the stock, meaning that patients will be affected, and the situation is very dire, especially to the older persons who are on medication for chronic conditions"* (Key Informant 3, May 2018).

The above narrative from one of the critical informants shows that it has not been feasible for them to provide all the services on an equal basis, as the Ouagadougou Declaration of 2008 stipulates, due to problems such as scarcity of resources and under-funding from the State government. Access to essential medication at rural clinics has been worsened by the government's underfunding of the healthcare sector. One of the critical priorities of the Ouagadougou Declaration is to improve the effectiveness of healthcare service delivery; thus, countries should provide comprehensive, integrated, appropriate, and effective essential healthcare services; design their models of delivery and estimate costs; and ensure service organization and stakeholder coordination to promote and improve efficiency and equity (WHO African Region, 2008). To enhance effectiveness and efficiency, Zimbabwean healthcare centers must be well-equipped and adequately resourced. The government must also prioritize health care and allocate money per the Abuja Declaration of 2001, not the 9% allocation the health sector received in the 2019 national budget. Even though Zimbabwe is a state party to numerous treaty bodies, covenants, conventions, and

statutes that guarantee the Right to Health, the situation indicates a lack of commitment to making this right a reality rather than a mere aspiration.

Rural clinics in Zimbabwe and Chivi District are not an exception, as they are struggling to provide adequate health care to older persons, and this has had implications on resource unavailability emanating from the economic meltdown experienced by the country. This has plunged the healthcare sector into shambles, thus eroding the health fabric of vulnerable people. The deepening financial crisis has severely affected the government's ability to fund the public health delivery system and restricted poor people's access to health care (Mhazo & Maponga, 2022). Many governments or public health services have closed in recent years, and shortages of drugs and essential medical equipment have brought many operational hospitals and rural clinics close to ruin. These adverse economic conditions have resulted in the healthcare delivery system experiencing reduced healthcare service provision and under-investment in the protection of older persons. The inaccessibility of health care has dramatically impacted the availability of services. Most of the older persons are heavily reliant on public healthcare institutions, which are currently underfunded and receiving just 8.3% of the budget, which is below the average of 15% stipulated by the Abuja Agreement (2001) and below the average allocation set for Sub-Saharan countries (Dhemba, 2015).

Also, the macroeconomic developments in Zimbabwe have had a considerable bearing on health. The decline in socio-economic status during the decade epitomizes a reversal of the gains realized during the early decade after independence. Beginning in February 2009 marked the economic revival phase, which has mainly been fragile. Economic growth needed to be more consistent, with the years 2009, 2011, and 2012 attesting to GDP growth rates above 9%, while the period after 2013 saw economic growth declining to below 5%. These developments hugely affected the health services sector, particularly reducing the availability of and access to healthcare services. Zimbabwe is committed to the 2030 Sustainable Development Goals, with a specific focus on Goal Number 3, which focuses on good health and access to health care as a fundamental human right, asserting that achieving universal care can only be done by ensuring timely access to quality healthcare without financial hardship (Lancet, 2010). Zimbabwe, therefore, constitutes a significant proportion of some of the world's most impoverished populations and individuals '*left behind*.' The

prevailing economic situation in Zimbabwe renders this goal unattainable, given the escalating healthcare costs and unavailability of basic and essential medicine for older persons. The country is currently experiencing tight budgetary constraints, vastly affecting healthcare availability.

Poor health practices may lead to poor health outcomes, while poor health outcomes may impede individuals' capacity to engage in good health practices. Similarly, the absence of healthcare facilities can lead to community residents engaging in poor health practices. In contrast, poor health practices could ensure that healthcare facilities are constructed in that community. It suffices to say that the formulation of policies that are meant to address access to health care problems will be highly handicapped if people are unable to appreciate the duality of structure or the falsity of the dual nature of structure and agency. This fosters a more holistic approach to understanding society and social organizations. Commenting on this issue, one participant narrated that:

> *"One of the biggest challenges is that even if the facility is there, nurses and doctors come here once a week to see the patients. We cannot cope with such a scenario. The government must provide us with proper resources, from medical equipment, health personnel, and stationery for administrative purposes. Patients are sometimes told to go and buy "an exercise book" to write the prognosis and the required medication. This burdens the older persons, as most rely on their family members for financial support"* (Participant L, May 2018).

The above narrative shows that structures in rural healthcare, such as the availability of medical equipment and personnel, impact the population's health by determining access to health and resources. This can have a significant impact on how healthcare services are provided. The structure that frames rural healthcare provision ultimately functions as a critical determinant of the nature of the healthcare services and their utilization by older persons. A complementary analysis was also provided by Key Informant B, who stated:

> *"We do not have a functioning ambulance; a non-governmental organization donated the one you saw outside, and it specifically caters to*

the health program they are partnering with this hospital. We cannot use it no matter if we have an emergency" (Key informant B, June 2018).

The above narrative shows that it is catastrophic for a big hospital to operate with few doctors available on minimal days and times. It also shows that the government's inability to provide hospitals and clinics with essential medical equipment and supplies may discourage many residents from seeking healthcare at health centers. The availability of functioning resources, such as ambulances at the district health facility, is statistically significant to access. In the face of rising needs, Zimbabwe's healthcare budget is chronically underfunded, and essential medicines, diagnostics, and supplies have been depleted due to foreign currency shortages. Barriers to the availability and effectiveness of health care in rural communities have been well-documented; however, little is known about the strategies the rural populace uses to overcome such barriers. The availability of healthcare refers to the comprehensiveness and physical presence of healthcare services that meet a minimum standard; these services are appropriate, acceptable, and available to the needs of those utilizing them. Campbell et al. (2000) alluded to the fact that availability also refers to the extent to which systems provide facilities (which are in the structural form) and services (the processes) that meet the needs of the people. The poor health delivery system in CSD promoted the thriving of private health providers as older persons were referred to private surgery and pharmacies that had become alternative health facilities, which is beyond the reach of this particular group.

Even where healthcare services are available and affordable, access to medical drugs is limited. There is often a shortage in the supply of medical drugs, especially in the rural parts of Zimbabwe. The economic crisis in Zimbabwe has also led to a lack of medical supplies and equipment in public health facilities, leaving professional nurses with limited options to provide treatment (Nyakatawa et al.,2016; Kevanal et al., 2013; Nyazema, 2010). Zimbabwe's Health Assessment in 2010, cited in Chirwa and a study on healthcare delivery in Zimbabwe (MOCHW, 2012), reported the same findings as the current study, indicating that only 20% of rural health facilities had essential medical drugs for the treatment of common chronic diseases. Providing medical drugs at rural facilities is crucial to improving the health outcomes of communities (Govule et al.,2015). Zimbabwe's current system fails in three respects critical to any healthcare system: policy, people, and funding. The result is

that it is unable to deliver the most basic care. There is a lack of medicines and functioning hospital equipment. It is also a system devoid of empathy. From the views shared by older persons in the understudied area, they believe that one goes to the hospital to die, not to have one's health restored.

Structural constraints influence health-seeking behavior in rural health care and can force older persons to use medication readily available. 'Unacceptable' health care can negatively impact geriatric health by determining access to and provision of healthcare services. Dessa et al. (2018) aver that the acceptability of healthcare providers to the clients is an indicator of the utilization of services along with the capability of accommodating clients in a service structure and affordability, availability, and accessibility issues that are necessary for measuring the strength of the connection between healthcare providers and healthcare seekers. Matching patients' preferences (acceptability) and needs for health care with the ability of services to meet them must be considered together to avoid unintended consequences (Kreute et al.,2021). The dimensions of access are not an independent construct. For example, in rural Zimbabwe, the government mainly focuses on the issue of geographical access and the proximity of clinics within rural settings as a way of alleviating some of the accessibility factors, but this could inadvertently impact service delivery if these provided services do not meet the needs of the older persons population. Reducing geographical barriers to healthcare service alone can fail to guarantee acceptability to the users (older persons). Most of the studies on access have focused on one aspect of access (mainly geographical access to and availability of services).

7.3 Professionalism Ethics and Access to Health for Older Persons in CSD.

Health professionals' values, beliefs, and attitudes toward older persons affect how they view and approach those in their care, which affects the quality of care that older persons experience (Abdi, 2019; Liu et al., 2013). In the utilization and accessibility of proper health care, providers' attitude plays a significant role globally. Nurses provided front-line health care for older persons in various settings, including preventive care in primary care offices and the community, acute care in hospitals, and long-term care in nursing homes and assisted living facilities. To provide high-quality older people care, nurses' attitudes toward older people and their knowledge of the aging process are of paramount importance

for practice and quality of care (Baumbusch et al.,2016; Huang, 2013). Good knowledge and favorable nurses' attitudes are essential and regarded as a requirement for good quality health services for older people in various settings. This attitude stems from providers' professionalism, confidentiality, treatment, and interpersonal relationships. Many older persons complained of being misunderstood by the healthcare personnel at the clinics and the central district hospital (Chivi District Hospital) as one of the barriers stopping them from seeking health care. They expressed displeasure with the unfriendly and unapproachable nature of most nurses at the clinics in Chivi. Thus, one respondent said,

> *There is no examination; you are just given something without any review. That is a problem for me. I always think about other people who might have the same tablets* (Participant C, May 2018).

> *My experience is when I say to the doctor that my feet pain and burn, then they say it is arthritis, and they give tablets, And the next day, it is the same again (and I do not know what it is) when I ask to be examined, they examine with clothes on. That is all they do. I am fed up* (Participant D, May 2018).

> *You go to the clinic with your illness like this arthritis; they ignore what you tell them. Like now winter is coming, we have aches; I have something under my foot. It is like an ear of corn, and it makes it difficult to walk. I have reported this at the clinic several times, but no help has been given* (Participant L, May 2018).

The service provider's attitude is one of the pertinent arguments raised in Penchansky and Thomas' theory of access. Acceptability benefits older persons by suggesting that healthcare facilities, goods, and services must be appropriate and sensitive to their healthcare needs. Healthcare services that are age-friendly or responsive to older persons must consider their diversity as they are not a homogenous group but facing varying health risks and circumstances (Baer et al.,2016). Considering Penchansky and Thomas' conceptualization of access, acceptability is a critical element of access and drives many of the disparities in healthcare and health outcomes older people experience today. The lack of good healthcare services indicates that the users who do not "fit" are either left out or must alter their circumstances to "fit" into the system. Older persons are sensitive and would require an enabling environment. The theory underpinning this analysis is agency.

Despite the persistently inauspicious nature of the healthcare environment that characterizes the study, some nurses exhibited positive attitudes towards older persons. According to Giddens (1984), the agency suggests intention or consciousness of action, sometimes implying possible choices between different activities. It follows that some nurses in this study consciously chose to interact well and politely communicate with clients, contrasting with some nurses who decided to show harmful practices towards clients. This can be augmented by the statement made by one of the respondents,

> *"I always go to the clinic when Nurse Gumbo is on duty because she is accommodating. She sometimes checks on me to see if I am taking my medication. She is one of the few nurses at our local clinic who goes beyond her call of duty to help us. Even my neighbor loves her as well. One day, I was alone at home when I fell ill. She passed by that day and advised me to take moringa leaves to help lower my hypertension. She understands that traditional herbs benefit older persons, though she is a trained nurse"* (Participant X, May 2018).

The above narratives concur with a study conducted by Lamsal (2012), which suggested that human actions are determined by the societal forces over which they have no control. However, in this case, older persons in Chivi South District have poor health, which appears to be influenced by their relations with nurses, who act as the structure in healthcare utilization. In this regard, the structure is viewed as the rules (norms of society) and resources (material and nonmaterial possessions of a given community) that constrain or facilitate human actions (Giddens, 2003). This shows that the actions of human beings do not exist independently of structure. In the context of the older persons living in rural Chivi South District, nurses' perceived non-respectful attitude and unapproachable interactive style at clinics can be considered a structural barrier to healthcare utilization and access. This concurs with a study by Mashura in 2020, who alluded that the ageist stereotypical behaviors of nurses affect the healthcare utilization of older persons. He also cited UNECA's 2007 p.73, that negative health personnel attitudes lead older people to prefer death over clinics. Zimbabwe lacks literature on older person abuse at healthcare institutions. Older person abuse in Zimbabwe is not explicitly mentioned in statutory instruments representing older persons, unlike other vulnerable groups like orphans and children. For instance, it was clearly stated that children needed to be protected from abuse,

neglect, and maltreatment in the Child Rights Convention (CRC) of 1990, the African Charter on the Rights and Welfare of the Child (ACRWC) of 1995, and the National Action Plan for Orphans and Vulnerable Children (NAPOVC) of 2004–2010. This lack of attention has exposed older persons to institutional abuse.

Considering their age and physical conditions, older persons expect care and respect from nurses; however, they need to be more satisfied because their expectations are generally unmet. They shun formal healthcare utilization without being accorded the needed respect and care. Older persons experience stereotypical labelling, such as referring to them as frail, unproductive, and sickly, which demonstrates that age is a factor driving the social exclusion of this population. Commenting on how they are treated at public clinics in rural Chivi South District, some participants had this to say:

> *"Nurses do not want to treat us because we are old, so maybe they feel that the drugs are wasted and prefer treating the young as they have more to give to the economy and society than us. We are regarded as having reached our end of life, and treating us when we sick, they feel that they are wasting medical resources"* (Participant C, May 2018).

Nurses' attitudes towards older persons often view their illnesses/diseases as unimportant issues and are frequently seen as annoying obstacles to the enjoyable practice of medicine. Additionally, they take up beds that could be used by "more" people. Younger patients who deserve it. These perceptions lead to the frequently seen and preventable consequences of medical disinterest in seeking healthcare. Some have claimed that limited hospital resources should be saved for the younger population rather than allocated to older persons. This is supported by Dhemba & Dhemba (2015), who assert that ageism is pervasive in most of Africa.

Health professionals have prejudicial views of older persons as nagging and needing attention rather than genuinely needing medical attention. This trivializes older persons' health problems, leaving them feeling ignored and discriminated against. The patience required to deal with older persons is essential in ensuring they find safe healthcare centers for seeking treatment. According to Butler (1975), who coined the term, ageism results in older persons being "categorized as senile, rigid, and old-fashioned in morality and skills.

Ageism allows those of us who are younger to see old people as 'different.' We subtly cease to identify with them as human beings, making us feel more comfortable about our neglect and dislike of them" (Butler, 1975, p. 894). Ageist attitudes towards older adult care have been linked to poor quality care, such as reducing older adult independence and decision-making (Courtney et al., 2000). The narratives below postulate that the lack of patience among nurses mitigates the challenges faced by older persons.

> *"Disrespect on the part of some nurses is another thing that prevents me from using formal healthcare services, especially public ones. Some nurses are very unfriendly and disrespectful. They do not have time for poor older persons. Some of the nurses should be talked to because a smile from a nurse is a form of medicine"* (Participant X, May 2018).

> *"The disrespectfulness exhibited by nurses, especially female ones, is common in government hospitals, which mostly prevents me from seeking healthcare. This is uncommon in private hospitals because a nurse could be sacked instantly when a patient has reported. Such reports are uncommon at government hospitals, allowing some nurses to behave that way. I went to the hospital complaining about chest pains. The best the nurse could do was to embarrass me. 'We do not have medicine to give the older persons; give the young ones a chance, go home'"* (Participant Z, May 2018).

The above narratives show that it is not only about physical or structural factors that hinder older persons from accessing health care. Poor healthcare access therein can also be attributed to the behaviour of those in the healthcare system's structures, especially nurses. Drawing insights from Giddens' (2003) Structuration Theory, this affirms that there is a recursive relationship between the agency (health-seeking person) and the structures (clinics/hospitals). To put it into perspective, this implies that the poor health profiles of rural Chivi South District can be attributed to poor health practices, which could be the unprofessionalism demonstrated by the nurses. This recursive relationship can then influence the agency's behavior, that is, the rural older persons in Chivi South District. This is due to the environment, which is either enabling or constraining. The constraining aspects have far-reaching effects on the study participants' lived experiences.

"In our African culture, old people were the source of wisdom and respect, but it is not there anymore" (Participant X, May 2018).

The ability of nurses to provide responsive healthcare and maximize the health outcomes of older persons depends critically on developing positive attitudes. Additionally, nurses' supportive behaviour towards older persons when they seek healthcare lessens erroneous notions of older persons as a burden on society (Kavlak et al.,2015). Respect for older people is still a prominent tradition in African civilizations; however, because of social and cultural changes brought on by modernization and urbanization, it appears likely that older people are either alienated from or isolated inside African society (Pillay & Maharaj, 2013). Research on nurses' attitudes regarding caring for older persons in Zimbabwe is scarce. The scant research suggests that views regarding caring for senior citizens are complicated and inconsistent. Further research on individual and group influences on nurses' attitudes is required to develop a solid evidence base. Interventional studies are needed, as well as the creation of trustworthy and valid measures to gauge nurses' attitudes about caring for older persons.

Giddens' Structuration Theory supports the critical submission of the current study, which is the notion that the poor health practices of the community residents are as important as the absence of health facilities in the community in understanding why health outcomes are deficient in the given society. Nurses need to have a positive attitude toward patients and patient care. These critical submissions find complementarity in studies done in comparable disciplines. As an illustration, Ajzen (2005:23) asserts that attitudes are "latent hypothetical characteristics inferred from external observable cues." Seemingly, anecdotal evidence provided by Tkatch et al. (2017) and Dias et al. (2012) confirms that health workers' negative attitudes affect patients' health-seeking behaviours and quality of care and health outcomes and have far-reaching effects on the well-being of older person patients. The disrespect shown to older persons by the nurses can lead to a situation whereby the older persons refrain from seeking health care in times of illness.

In most developing countries like Zimbabwe, the healthcare system in rural areas where most of the older persons reside needs to be well-designed and structured to cater to the

needs of geriatrics, whose healthcare needs are more complex than those in urban settings. This presents significant challenges to older persons and healthcare workers. Aboderin and Beard (2015) averred that older patients did not use commercial providers because of the unavailability, perceived poor quality, or the age-insensitivity of services offered in government facilities. These findings suggest that providers' attitudes may improve proper healthcare utilization among older persons in Zimbabwe. As alluded to by the participant:

> *"Some say we are useless, and the only thing left for us is death. And I do not like how people talk about old age. Give us a chance; we are still important in this society"* (Participant B, May 2018).

Older persons are considered disagreeable, pretentious, attention-seeking, obstinate, and dependent. A caregiver stated:

> *Although my elderly mother was in tremendous agony, the staff believed she was lying. Even though she was crying out in pain, they did not believe her and thought she was only trying to get attention. Why they do not believe older adult patients when they say they are in agony is beyond comprehension* (Caregiver 2, June 2018).

The participants' views reflect the impact of the social misconception of ageing that has led to health discrimination and social seclusion of older persons. Due to this perception, ageing is viewed as unfavorable. This shows that it is essential to consider how upstream or structural factors trickle down to influence the health-seeking behavior of older persons. It has also been suggested that ageism can cause health disparities among older people at both the structural level (i.e., when societal institutions support bias against older persons) and the individual level (i.e., when older people assimilate unfavorable cultural views of ageing) (Levy, 2017; Westerhof et al.,2014). Future research should look into the connection between structural and personal ageism. Further research is necessary to understand how individual and structural ageism can amplify the adverse effects on one's health. To sum up, the current findings emphasize ageism as a social factor in health. There is a significant negative relationship between ageism and health, which is evident from the narratives given by older persons in CSD. Studies by Gvili & Bodner, 2021; Wurm et al.,2017 have found

that ageist attitudes and stereotypes hurt older persons as this will affect their health and will to live.

The study's findings indicated that older patients perceive age discrimination by healthcare teams and inequalities in hospital-provided care. It is, therefore, essential to address ageism and subsequent inequalities through short- and long-term policies and plans, as well as standardization and transformation of the present condition of hospitals to become an age-friendly environment (Zou et al.,2020). In this context, stigma can be described as a perception or fear of being treated poorly in the health care set by the care healthcare recipient (Ricketts & Goldsmith, 2005). Hence, healthcare providers must remain mindful, respectful, and empathetic of a patient's cultural or religious needs. People's expectations reinforce and reproduce a set of other expectations, and understanding the problems of older persons involves probing and tracing concepts and discourses around culture and religion before addressing healthcare policies and services. Incorporating the two aspects might help improve a successful geriatric paradigm due to its person-centered explanations. Ageist prejudice and hostility towards older persons affect their health and well-being and may hinder health equity.

7.4 Conclusion

The ageing population is growing significantly across all continents. A nursing workforce that can handle the ageing population is essential to ensure high-quality care for older persons. Negative attitudes about ageing and older persons also significantly impact healthcare utilization. There is a need to train healthcare workers on issues related to geriatrics and gerontology to recognize the needs of older persons and provide appropriate care to them. Ageist attitudes negatively affect healthcare providers; hence, they must be addressed. Policymakers and health care professionals should approach society holistically to understand how older persons in rural areas cope with their ageing problems. It is, therefore, essential to educate front-line health workers to change their misconceptions of ageing and illness and to improve their interactions with older persons to keep them from seeking healthcare in times of need. Planning and implementing solid and high-quality services that provide social solutions to the challenges posed by the ageing population's functional limitations, chronic noncommunicable diseases (NCD), higher risk of fragility,

and unfavourable health outcomes become imperative in gerontological care. Awareness, education, and practice will ultimately improve the effectiveness, quality, and appropriateness of healthcare services for older persons, especially in poor resource settings such as those residing in CSD and rural Zimbabwe.

CHAPTER 8

SOCIAL INEQUALITIES AND HEALTH CARE ACCESS AMONG OLDER PERSONS

8. Introduction

The previous chapter presented a nuanced discussion of the availability and acceptability of healthcare services for older persons living in rural areas. It contextualised the availability and acceptability of healthcare services for older persons and reiterated the significant mismatch between professional expectations, patients' needs, and patterns of uptake of healthcare services. This chapter builds on Penchansky and Thomas' concept of acceptability. It borrows from the Bourdieusian approach to class-related inequalities as an essential complement to the current understanding of the determinants underlying health inequalities in the understudy's healthcare services of older persons in a rural setting. Interestingly, his approach is broad enough to consider the monetary dimension of capital and other forms of capital (social and cultural) represented in lifestyle indicators and the symbolic dimensions of class relations, such as social relationships. This approach enables us to derive specific predictions based on the possession of different forms of capital by looking into the relative contribution of each of the capitals and the effects of different compositions of capitals, aiming to contribute to a broader understanding of the class-related mechanisms of healthcare access for older persons.

Social positions remain an essential determinant of health 'differential health status is probably the most enduring and incontrovertible indication of class (Bennet et al.,2009).

Bourdieu's (1984) concept of cultural and social capital, derived from his broader structure agency theory, shall complement and corroborate Giddens's structuration theory within the same theoretical paradigm indicated in chapter 3 of this thesis. The rationale is to show how the various forms of capital are deployed to circumvent the structural challenges within the same constraining structures. It is essential to realize how the same constraining structures present some opportunities for accessing healthcare through the various capitals at the actors' disposal. The overarching philosophy is that in as much as the same structures constrain, they are simultaneously and dialectically enabling based on agency and the mobilization of the various forms of capital. While Bourdieu (1984) reflected on the dialectical relationship between the habitus and the field, the field concept becomes critical for understanding the dynamics, vulnerability, and differential access to health services among the rural populace and the older persons under study. Consequently, the Chivi rural district, when it comes to accessing health care services, becomes a political arena where senior citizens with various forms of capital survive. Thus, economic capital, political capital, social capital, and symbolic capital become central in understanding the social standing of the citizens and their propensity to deploy these forms of capital in the quest to survive marginalization in this political field (See Bourdieu ibid).

It should also be underscored that several factors, such as environmental and physical influences, medical care, and social factors, influence healthcare access. The preceding chapters have examined structural, physical, and cultural barriers to accessing health care. It has primarily been noted that most older persons are disadvantaged due to the several factors that converge to create a systematic discourse of exclusion and vulnerability for older persons. This affects the prospects for achieving healthy ageing in CSD, giving sufficient insights into the plight of older persons in Zimbabwe. However, it will be an academic fallacy to homogenize the experiences of these social actors. The experiences in the area under study show that significant inequalities shape the healthcare experiences of older persons and put others at a more significant disadvantage in accessing healthcare access.

As noted in previous chapters, the significant structural barriers can sometimes be negotiated differently about the capital that one possesses. Thus, building on the forms mentioned above of capital in the field, this chapter navigates the differential experiences of

older persons as they attempt to access healthcare services in a volatile macroeconomic environment. The more capital one has, the better one's chances of getting the best out of the problematic situation that characterizes healthcare access for older persons. Lifelong inequalities, including those created by state policies, influence differential access to healthcare among older persons. Against this backdrop, the chapter explores income disparities and social capital differences and how these shape healthcare access among older persons in a rural context. The dynamics in this area shall be situated within the provisions of the Millennium Development Goals (MDGs) and the more recent Sustainable Development Goals (SDGs) in the global context and other policy provisions in Zimbabwe. These include but are not limited to the Constitution of Zimbabwe, National Development Strategy 1(NDS 1), and Vision 2030.

8.0 Inequality in Healthcare Access among Rural Older Persons

The current study established different forms of inequality in the health sector among older persons in rural areas. Despite many initiatives undertaken by the government and private players to improve the well-being and health of the ageing population in rural Zimbabwe, the findings drawn from the study revealed that older persons in rural areas of CSD endure severe health and socio-economic predicaments. In this respect, the polarisation characteristic of the Chivi community is exacerbated by health and socioeconomic disparities experienced by older persons at both the micro and macro levels. It is evident in this study that the sustainability of access to healthcare has been severely compromised for the senior citizens in Chivi. Findings also reveal that the underlying social inequalities stem from Zimbabwe's unfavourable micro and macroeconomic environment. To this end, many of the respondents in this study recounted how poverty and or lack of economic capital impinges on healthcare services unaffordable. In many cases, they hardly get the much-needed medical attention, which is critical given the vulnerability of old age. This unwarranted position is buttressed by one of the older persons who had been staying in Chivi South for her entire life who had this to say,

> *"I have been unwell for the past two years but hardly get medical assistance from responsible authorities. My biggest challenge is money. I cannot afford to get US $4 (approximately ZAR60) to visit the nearest clinic. Every time we ask for medical assistance, we are given empty promises. Maybe, if I were not a poor*

person, I could afford the medical treatment I need. On a sober note, my husband died five years ago at age 78, largely because of failure to get timely medical attention. He had been sick for a long time and only relied on traditional herbs. So, poverty makes me worried about my health issues. Gone are the days when we used to get maximum support from the government" (Participant L, May 2018).

On the same note, another older person in the same ward said,

"One of my biggest challenges is the shortage of money. I cannot afford to go to Masvingo General Hospital every month for a medical check-up. Since my son, who was the breadwinner, died, no one has taken me to the hospital. However, you must also know that our conditions as older persons are not the same. Some people like Mr.… (name withheld for ethical reasons) even afford to go to South Africa for medical check-ups. Their family is financially stable, and all his children are working abroad. So, you cannot compare his situation with mine" (Participant M, May 2018).

Much as the preceding experiences show the implications of a lack of economic capital on older persons' access to healthcare services, the following experiences clearly show the significance and interplay between economic capital and social capital in navigating the associated challenges. Thus, this resource among older persons in CSD works to the advantage of privileged groups over others, leaving significant health status gaps. In this regard, some of the citizens who were vulnerable to illness but endowed with both economic and social capital had this to say,

"I am fortunate because my children work and have good jobs. I am both hypertensive and diabetic, so when my appointment is due, my son sends a driver to come and ferry me to Harare for my medical check-ups. I have never missed an appointment. All my medication is always stocked up" (Participant O, May 2018).

"I was employed as a teacher but retired, so my NSSA premiums are paid monthly. Even if it is not much money if l gets sick, I can travel to Masvingo General Hospital as our local clinics have limited resources" (Participant P, May 2018).

The above chronicles show that financial constraints pose a considerable challenge for most older persons living in Chivi District. Only a handful of these people are covered by health insurance, especially public employees and those with employed children. Participants O and P narrate the different classes in the place of study. In Zimbabwe, getting health insurance is difficult for members of extended families. Health insurance companies only provide their services to nucleated families, such as fathers, mothers, and children, and it is a challenge for older persons. Under these circumstances, access to healthcare for older persons in rural areas largely depends on family members, which can result in difficulties getting timely and appropriate treatment. In addition to these predicaments, most of the older persons in the rural community of Chivi District do not have access to pension benefits, ultimately affecting their economic position. Thus, their economic class contributes to the lack of access to health care for older persons as the cost and quality of treatment are based on their overall low socio-economic position in rural communities. Such existing barriers limit equitable access to health care by disadvantaged social classes.

The disparities above between the various categories of older persons, based on economic capital and social capital and its mediation on access to healthcare, are contrary to the dictates of the social contract between the state and the citizens as stipulated by Hobbes in McCartney and Parent (2015). This is because the state is responsible for protecting and ensuring human and health security for all citizens. In addition, the state should also ensure equal access to income, which can be translated into economic capital and access to healthcare, particularly for the older persons under study. From the global context, this violates the provisions of the Millennium Development Goals (MDGs) and the Sustainable Development Goals (SDGs), which the government of Zimbabwe ratified. Chief among these goals for the community under study are Sustainable Development Goals 1, 3, and 10. These, among other issues, seek to end poverty, reduce the social inequalities in health noted in this study, and ensure good health for these vulnerable citizens.

Nationally, such social inequalities in accessing health care services are detrimental to policy prescriptions such as the National Development Strategy 1 and Vision 2030. These are the key policy documents guiding development in Zimbabwe. In principle, the rationale for ending social inequalities and ensuring social inclusion and justice for the marginalized group is anchored in the philosophy that *we are leaving no one behind as we march*

towards the prosperous and empowered upper middle-class economy' {National Development strategy 1}.

In addition, the narratives reveal that the perceptions and experiences of older persons in CSD regarding access to healthcare services differ based on socio-economic status. To put this into perspective, the current study maintains that the older persons in the study area have social hierarchies promoting unequal economic and social resource distribution. Differences in health status and access to healthcare facilities reflect the vulnerability of older persons with low economic status. Socioeconomic inequalities in access to healthcare services and their utilization are related to individual characteristics, which affect individuals' needs and search for such services. They are also associated with contextual variables, especially economic access through pensions and financially stable family ties with financial resources. Such variables can reinforce or hinder socio-economic inequalities in access to healthcare services. Despite the reduction in social inequalities with the increase in age, these inequalities persist, even to a lesser degree, and can influence access to healthcare services among older persons. The above observation is in tandem with the observation made by Shaw et al. (2014); they note that in high-income countries, socioeconomic differences in health, morbidity, and healthcare services exist in older age groups. Drawing insights from Penchansky and Thomas (1981), barriers to access to healthcare services are heightened by economic predicaments. In addition, most rural older persons, as in the context of Chivi South, struggle to access medical facilities owing to their low socio-economic status.

Older persons living in rural areas have access to fewer healthcare services and service alternatives than their urban counterparts. The development of specialized geriatric services is usually centralized within large urban centres. In contrast, rural areas host at least two-thirds of the older person population despite having limited or no access to geriatric healthcare services (ZIMSTAT,2012). Providing these services to a large, primarily rural, geographic area is a challenge when resources are both centralized and limited. Another reason for not seeking care was poor geographical access to healthcare facilities. Although distance has been cited as a reason for not seeking health care, not all rural residents are poor. Distance as a barrier may not be perceived to the same degree by people with low incomes and those more economically empowered. Further analysis reveals that most

respondents who did not report distance as a barrier to access to healthcare in rural areas may belong to less poor households since they can pay for transportation to far-off facilities while people with low incomes in rural areas cannot afford transport.

This study section posited that health inequalities may be deep-rooted in political and social decisions, resulting in unequal income, power, and wealth distribution. Poor access to healthcare and health inequalities exist in rural areas and are more evident in older persons with CSD. The factors that give rise to and worsen the situation are multifactorial. Access to universal healthcare can only be achieved through effective health systems, economic policies, and interventions, especially in rural areas focusing on older persons—a rigor of healthcare financing through budgetary allocation that addresses poor access to healthcare and health inequalities.

8.1 Class and the Politics of Inclusion and Exclusion in Healthcare Service among Older Persons in CSD

There has been a vast transformation of class in globalized rural spaces. Inequality in health is mainly a consequence of enormous socio-economic inequalities in society. The inequalities include differences between geographical areas within and between countries, ethnic groups in the population, occupations that can be classified into social classes, the employed and the unemployed, those with different levels of educational achievement, income groups, and the sexes. Social stratification divides society into layers (strata) whose occupants have unequal access to social opportunities and rewards. People occupying the top strata enjoy privileges that are not available to other members of society; people in the bottom strata endure penalties that other members escape. Older persons are also vulnerable in many other countries, particularly the global South. These underprivileged elements of society are sometimes presented in conventional literature as politically weak. They are often too sick, illiterate, or geographically dispersed to become politically active (see the macro theories of development). Nevertheless, and justifiably, some of the participants of this study provided narratives that contradict the precepts mentioned above. Participant B recounts that:

> *"I am fortunate because my children work and have good jobs. I am hypertensive and diabetic, so when my appointment is due, my son sends a driver to come and*

ferry me to Harare for my medical check-up. I have never missed an appointment. All my medication is always stocked up" (Participant B, May 2018).

The above narrative, therefore, refutes the assumption that people in rural areas do not have access to health insurance and health care due to their low economic status. The findings in this study established that some of the older persons in CSD also had employed family members or children who can aid when health care need arises. Participant B is among the few fortunate ones with a functional social support network. In this study, it emerged that there are challenges associated with familial support as an adaptation mechanism in this area. Nevertheless, the highlighted experiences of bonding social capital in the absence or limited support from formal institutions, which in a significant way comes in a horizontal and highly informal way for people with closely knit relationships in Chivi (see Putnam 2003). Evidence in Chivi shows that this form of social capital extends beyond the Zimbabwean borders, necessitating serious labor migration in Zimbabwe. To this end, many older persons rely on their relatives to supply the much-needed medication or facilitate their treatment, mostly in nearby South Africa, whose health security and services are relatively better than the Zimbabwean situation. Remitting medicines is, therefore, a novel way of filling the void in providing medical health care, particularly for older persons with chronic illnesses like heart disease, hypertension, and diabetes, among other related diseases.

A case in point to support the abovementioned position is that of Mrs. Matanga (not her real name), who has children and relatives in countries like Botswana, South Africa, the United Kingdom, and America. These relatives have been instrumental in her access to medication. She said these relatives take turns buying medication through her daughter, who resides in South Africa. She gets a prescription from the doctor that covers three to six months, which she then sends to her daughter to buy the medication. The daughter, in turn, uses her traditional remittance networks to send the medication home. She also indicated that a WhatsApp group had been created to discuss her health conditions and possible solutions. It should be underscored that many studies have been done on the significant contributions of remittances to household survival as a livelihood strategy (Maphosa, 2007). Nevertheless, remitting medicines is proving a novel and resourceful way of filling the void in access to health care. Some older persons pointed out that when their health conditions become

complicated, they rely on this form of social capital to get treatment in countries like South Africa and the UK.

Given the volatility of the Zimbabwean political economy, crossing borders to seek medical attention for the citizens endowed with social and economic capital is a rational and strategic approach to accessing health care. Nonetheless, evidence shows that this is one of the primary drivers of xenophobic sentiments, particularly in South Africa. In South Africa, it is believed that foreigners (predominantly Zimbabweans) are significantly straining the health delivery system (Chekero & Rossi, 2017; Makandwa & Vearely, 2017; Landau & Misago, 2023). Under these circumstances, access to health care for rural older persons mainly depends on family members. However, that can result in difficulties getting timely and appropriate treatment, especially for those without employed extended or immediate family members. Thus, an older person's economic class contributes to less access to health care, as the cost and quality of treatment are based on their overall low socio-economic position in rural communities. The existing barriers limit equitable access to health care by disadvantaged social classes. All societies have social hierarchies in which economic and social resources, including power and prestige, are distributed unequally. Differences in health status between social groups because of their position on the stratification, agency, and social capital scale are considered health inequalities.

The discourse on the significance of agency and various forms of social capital in fostering social inequalities and how it is instrumental for older persons' access to health care, with minimal support from the state, should be unpacked. While it is acceptable in the broader understanding and significance of social protection from below or community social policy, the fallacy is that emphasis on agency and mobilization of capital may dialectically give the state and quasi-state institutions some form of solace and justification for abdicating this moral imperative in social protection, social policy and the inalienable right to fulfil its obligations underlined in the social contract, discussed elsewhere in this chapter. The position is that if these citizens can provide for themselves under the constraining structure of health care, they should continue to do the needful on their own.

Evidence in Zimbabwe shows that it is not about the state's incapacitation but a question of political will. Thus, it is not an issue of unaffordability and unavailability of resources but

the maldistribution of resources based on misplaced priorities. This position can be supported by the observation that the state, just like many other African states, invests a lot in defense and state security at the expense of the critical elements of social policy and human security. This element has turned many African states into vampire states (Frimpong-Ansah, 1992). A vampire state in such a situation heavily taxes its citizens and invests that tax in its protection and the quest to establish a hegemonic power. Thus, in many budgetary situations, many resources have been directed in the wrong direction instead of the critical ingredients of social policy, such as economic capital, access to health, housing, and education, which are the linchpin of transformative social policy and an Afrocentric approach to social protection (Adesina, 2009; Mkandawire, 2016; Chibwana, 2016).

8.1.1 Social Security and Welfare among Older Persons

Social security and welfare for older persons in Zimbabwe is a shared responsibility of the family, local and international NGOs, and the state (Dhemba, 2013). As indicated in the preceding section, most older persons in Zimbabwe are not covered by existing social security schemes, leaving family members to provide for older persons. Despite this realization, in Zimbabwe, older persons have continued to be treated as a homogenous group with similar needs; hence, interventions targeted at assisting them have always taken a blanket approach that overlooks individual differences, especially with models of geriatric care and protection borrowed from Western societies. Hyperinflation has eroded the older persons' capacity to take care of themselves, but also the capacity of the extended family to play a crucial role in caring for older persons. This situation is captured succinctly by the statement made by one of the respondents in this study, who had this to say.

> *"I was employed as a teacher, but I retired. So, my NSSA premiums are paid every month. Even if it is not much money, I can travel to Masvingo General Hospital when I get sick, as local clinics have limited resources. I joined CIMAS medical aid when I was still working. Though they do not cover me comprehensively for medical attention, I know that if I am not well, I can consult at the clinic or go to the doctor"* (Participant C, May 2018).

An analysis of the account above shows that for an older person to benefit from the funds, they should have contributed during their working years. Chikova (2013) noted that most viable schemes cover only those who are or have been formally employed at some point in their lives and have been contributing to the schemes for a specified period. Hence, the government faces enormous challenges in enhancing universal access to social security. Another weakness is that the scheme pays for services received from public facilities but not from private institutions. This wakes many disadvantaged pensioners, conserving the general decline in service for many government hospitals in Zimbabwe. It was also noted that most schemes worked well at their inception, but service delivery deteriorated due to the economic meltdown from the late 1990s onwards (Masuka et al., 2012). However, the individual participants accessing NSSA premiums had social protection under some occupational schemes. Nonetheless, such social safety nets did not adequately cover the Zimbabwean workforce, and most were not compulsory. Thus, the social safety nets are either unsafe or porous in Zimbabwean. Studies by Kaseke, 2006; and Hampson, 1985 refute the Western social security model as it is mainly based on formal employment when a small fraction of the labor force is in formal employment, with less than 10% covered by social insurance. It should be underscored that in Zimbabwe, no social safety net programmes directly benefit older persons (Dhemba, 2013). Occupational schemes are primarily fragmented and only cater to the loss of income due to retirement. Giddens' distinctive approach to understanding the relationship between human agency and the structural constraints or opportunities that provide the context within which action occurs underpins much of his analysis. Participants' narratives suggest that how society is structured determines whether one has access to health care. According to Giddens's structuration theory, access to health care is one of the factors that "exist independently of individuals" but "constrain and enable" their behaviour. Access to healthcare is perhaps the most important thing to remember about these socio-structural factors. Thus, they are "social (not natural)," "made up" by human beings," and "dynamic (change over time)." So, these structural factors can be changed, fostering differences in individuals' health outcomes. This unhealthy situation is supported by one of the respondents, who said,

> *"I was blessed with three children, but all of them died of HIV and AIDS, and I was left with six grandchildren I am struggling to look after. I am old and do not*

get any assistance from anyone, even the government. As I speak, my heart is giving me problems, but l cannot afford treatment because medicine is expensive. I await God to take me" (Participant C, May 2018).

The views of Participant C resonate with the sentiments of Mitchell & Bruns 2011, that pensions, having economically stable family members, and those without can perpetuate inequalities in old age.

"I know of some community members who rely on their employed children and grandchildren who make sure that when they are sick, they are taken to the city for treatment. They always have money in case they need to visit the clinic. Amai Thomas always goes to South Africa for treatment for high blood pressure and diabetes. As for me, I do not have anyone to even ask for money as my children are married and are not working. So, I am suffering. One of my children is a teacher struggling to look after her kids. So I cannot put the burden on her. I am old and waiting for death" (Participant G, May 2018).

From the above narratives, one can note that the government should consider re-addressing the issue of helping older persons with grants. That can also assist them in accessing healthcare services. The older persons revealed that they did not have any source of income, which further compounded their woes as they cited that they had no money to travel to health centers to get medication. Zimbabwe's socio-cultural and political landscape has relied mainly on romanticized notions that all older people access welfare, care, and support from their extended family. However, the situation is more precarious for older persons without solid support networks, leading them to suffer and have poor health outcomes. Despite reducing social inequalities as age increases, these inequalities persist, even to a lesser degree, and can influence access to healthcare services among older persons. Socio-economic inequalities in access to health and use are related to individual characteristics, which affect an individual's need and search for health services. Social inequalities are also associated with contextual variables, especially economic access through pensions and family ties with access to economic resources. Such variables can reinforce or hinder social inequalities in access to healthcare services. Very few older persons are covered by health insurance, specifically former public employees and those with children who are employed.

Health insurance does not cover extended families; it only provides for nucleated families comprising the father, mother, and biological children, creating challenges for older persons (Dhemba & Dhemba, 2015). This outcome of the capitalist system renders it challenging for individuals to maintain a contemporary, urban, and industrialized lifestyle and forces them to survive on salaries (Mapoma & Masaiti, 2012). The economic situation in Zimbabwe has exacerbated the issue of access for older persons, making them unable to care for their needs. The safety net has been eroded as most older persons rely on the extended family for support.

> *"The government ought to understand that not all of us have medical insurance and have access to money; if I can offer my goat as surety, they need to understand it. We live in rural areas, and we are old and poor. Some have never been employed"* (Participant X, May 2018).

The sentiments narrated by Participant X show that the lack of financial resources and not having medical insurance were seen as the underlying causes of the inaccessibility of healthcare facilities and the poor health-seeking behaviour among the older persons living in rural areas of Chivi District. The capacity of the Zimbabwe government to fund healthcare has been eroded, resulting in costs of healthcare services surpassing healthcare capacity, especially at rural healthcare facilities that charge user fees. Chapter 2 of the Constitution Zimbabwe: Clause 21 (d) stipulates that the government should foster social organizations to improve the quality of life of elderly persons. However, this study clearly shows the Zimbabwean government's non-commitment to conform to laws that address the plight of older persons, such as the 'Older Persons' Act.' Unfortunately, the policy definition of older individuals receiving these entitlements to welfare is inconsistent. Section 82 of the Constitution describes an older person as someone above the age of seventy years, while the Older Persons Act defines an older person as a person over the age of sixty-five years (Makore & Al-Maiyah, 2021). This inconsistency of definition can adversely impact the access to welfare for older people and their right to welfare. This discussion shows that the government must fulfill its contractual obligation stipulated in the social contract between the citizens and the state. As a result, older people in Zimbabwe find it challenging to live a dignified life because of the social milieu, which is both restrictive and unsupportive (Chikoko et al.,2022). The social environment makes older

persons in Zimbabwe more vulnerable to problems, including poor health, desertion, and neglect, among other things.

Policies supporting people in later life, such as pensions, free health care, and treatment of chronic conditions, have slowly evolved in developing countries due to the massive rise in older persons. In 2012, however, the Zimbabwean government signed the Older Persons Act [Chapter 17:11], an initiative expected to benefit older persons in social protection. While this initiative is commendable, very little, if any, has been done by the government to meet this legal imperative. Thus, one respondent said, "*If there were laws and policies, I do not think we would be suffering like this."* This position is in tandem with Dhemba's (2013: 9), who established that the Act does not guarantee social and economic security in old age but political will on the part of the government.

Healthcare services, especially in rural areas where the operation is on a shoestring budget. It might also hamper appropriate healthcare-seeking behaviour among older persons, thus obliging them to resort to traditional medicine or consult traditional healers than seeking modern healthcare. While alternative medicines have their challenges, it is evident that as much as the environment constrains the citizens under study, it also presents options they explore to ensure health security. Thus, they are proving to be rational and strategic actors rather than passive victims of their situation. Despite the above challenges affecting healthcare service provision and caring for older persons, the need to pay attention to this group is overlooked. Therefore, this study reviews that healthcare-seeking behavior was not well-known among older understudies. In other words, disparities among older persons in health and other areas often reflect accumulated disadvantage due to factors such as one's location, gender, socio-economic status, and ageist attitudes and practices. This has been compounded by inadequate laws and policies or their enforcement, making it difficult to ensure equal health and social security rights. Complicating the access to social services was the unavailability of medicines in health facilities and low access to income for basic daily living, such as the inability to pay for transport costs to health facilities (also see Nyandoro et al., 2016; UNICEF, 2016).

In addition to disparities in health care between older persons and the rest of the population, disparities are also evident among older persons themselves, such as levels of income and

safety net from their immediate or extended families. Although disadvantaged older persons tend to be more exposed to health-related risks and experience more health problems, they are often confronted with more challenges in accessing health-related services. Participant C narrated that her situation hinders her access to health care because the government shows no commitment to ameliorating the plight of older persons. They have little or no resources needed to access healthcare services. Despite the government abolishing user fees for persons over sixty-five years and above, older persons get referrals to private hospitals or are given prescriptions requiring them to buy medicines from private pharmacies, thus exposing them to more challenges. However, this excludes a small group of older persons who are looked after by their children who are employed.

Incontinences among rural older persons are found because of the high levels of unemployment and the economic meltdown in which even those in formal employment lack the financial capacity to look after their extended families in the rural areas. The family set up is also part of older persons' social security system. Some older persons concurred that they rarely received support from their families. With this support system no longer reliable, the health situation of older persons is jeopardized as they can no longer meet their unique health needs. Older persons are also disadvantaged as they are deprived of adequate medical cover, such as medical insurance, due to exclusive regulations governing healthcare insurance. It was further noted that older persons were turned away by most medical aid societies, revealing that applicants over sixty years were not eligible for cover. This view confirms findings by Muchetu (2014), who submits that applicants over sixty years old are considered an enormous risk as they are susceptible to illness. A discussion on the political economy in Zimbabwe and its implications on health service delivery can never be complete without alluding to other mitigating factors. It should be noted that many rural economies in Zimbabwe are agro-based. Climate change and the associated drought are ripple effects on older persons' economic capital. Of note is that economic capital through agriculture could be transformed into a reliable resource for getting medication under regular seasons.

8.2 Health Care and Social (in) Justice Paradox In Rural Zimbabwe

'Social justice' refers to distributing goods or services within a societal context (Braveman et al., 2011). It focuses on persons or groups of persons that influence the distribution of

social and economic services. This includes accessibility, availability, affordability, acceptability, appropriateness, and approachability of healthcare treatment (see Penchansky & Thomas, 1981). In the context of older persons, social injustice can be expressed in a variety of ways, including stereotypes about getting treatment, value judgments about the quality or worth of older persons' lives, or misconceptions about the desires of older persons for certain forms of treatments (Williams, 2009). In Zimbabwe, where the healthcare system is almost on the verge of collapse, and the moral fibre has been eroded, older persons are now more vulnerable to socio-economic exclusion and healthcare injustice. Ageism can occur in any socio-cultural context, including health care, which can be hostile to the needs and interests of older persons vulnerable to cruelty, harm, and injustice, including being subject to 'care services' that are unacceptable and denying them their fundamental human rights.

In the context of an ageing population, analysis of inequalities in healthcare provision among older persons has become a priority in the public health sector. However, research on this topic is still scarce. Prospective research should address current limitations, such as the often-theoretical analysis of social determinants of health status. A greater focus on and respect for the dignified ways in which older persons are not disadvantaged since they no longer contribute to the country's economic development can foster respect for them, thus dispelling the myths around the costs of caring for older persons. In this respect, this study argues that the social injustices the older persons face in rural Chivi South constrain access to health care. Facing discrimination at the hands of service personnel and providers can be detrimental to older persons' access to healthcare services. During the research process, participants gave accounts of social injustices and inequalities, saying:

> *"I once went to Parirenyatwa Group of Hospitals, and they told me that all old persons must be served before young people. Zvino isu tongoswera tichingowesha navanana (We spent the whole day in the same queue with young people). So, it is difficult for us. At Parirenyatwa, even when you want to see a doctor, you do not stand in a queue with everyone else; instead, they tell older adults to go in front, but you stand in the queue with everyone else. The healthcare workers do not respect older persons like me"* (Participant D, May 2018).

Participant D reiterated how older persons are systematically excluded from accessing treatment:

> *"The other challenge we face in clinics is that when we go there, nurses shout at us asking us what we are looking for here, accusing us of finishing the young people's medicine. So, those are some of our challenges; we are told to go and sit at home"* (Participant D, May 2018).

The above accounts exemplify discrimination that older persons go through at the hands of healthcare workers at different levels of care. Participant B recounts being told to wait in a queue until her turn came at a local clinic. Participant L recounted that older persons were not given preferential treatment based on old age at one of the leading hospitals in Zimbabwe. The participants' narratives below also show how older persons are treated. Participant A narrated that:

> *"They do not attend to us on time. They do not even consider that we are old people who must be treated first. You may die in the hospital queue because they do not care whether you are old. These are big challenges; they do not respect old people. They even select the people they know and attend to them first, even if you had come before them. They skip the line, and you sit there, fearing you might die. Then, you think of complaining but fearing that they might deliberately give you the wrong injection or tablets"* (Participant A, May 2018).

The narrative cited above shows that most nurses in rural clinics and hospitals give preferential treatment to patients from the reproductive age group. This makes older Chivi South people feel socially excluded from healthcare services. Such lines of thought epitomize the Giddensian idea of the constraining properties that have far-reaching effects on the health and well-being of the older persons in Chivi South. From the evidence cited above, this study established that healthcare workers' discrimination and lack of respect towards indigent older persons is an indisputable aspect that denies them access to healthcare services. The lack of such consideration reflects widely held assumptions about old age as a period of 'unproductivity' and economic dependence. These study findings confirm the literature provided by Nankwanga (2012). The author opines that in most communities, older persons have not been the primary focus of attention mainly because of

the widely held belief that they no longer have much to offer since they have already played their part; thus, they have outlived their usefulness in life. Although these findings are generally in harmony with the scholars mentioned above, the current study provides a neoclassical exploration of phenomena in healthcare services. Intervention strategies must be sensitive to age for healthcare services to be fruitful. Health care is essential and, therefore, unique, as it plays a vital role in influencing health; hence, it must be socially guaranteed. It must be socially guaranteed in a manner consistent with the overall health improvement and reduction of health inequalities attributable to healthcare consequences.

If social conditions create inequalities in the health and well-being of specific individuals in their old age, then the ethical problem extends far beyond priority setting in health care. Doing justice to older persons requires identifying the proper social response to prevent and correct the direct harm that broader social conditions have done to those people during old age and their entire lives. Intergenerational equity is imperative in access to health care for older persons. Intergenerational equity in economic, psychological, and sociological contexts is a concept or idea that encompasses fairness or justice in relationships between children, youth, adults, and older persons, particularly in terms of treatment and interactions (Summers & Smith, 2014). Similarly, the justice problem between generations arises when societies consider limiting healthcare resources allotted to older persons to increase healthcare resources available to the young. Contemporary debates on intergenerational justice focus on the problem of whether society should limit the allocation of scarce resources to older persons. The Giddensian theory of the sustainability of human well-being relates to the potential for changes through time and across space regarding a population group's geographic and demographic characteristics.

Penchansky and Thomas's (1981) concept of acceptability relates to cultural and social factors determining the possibility for people to accept the aspects of service; hence, all patients should be treated with dignity. Without acceptability, healthcare services might not be used, and when the quality of the health workforce is inadequate, improvements in health outcomes will not be satisfactory. The lack of such consideration, thus far, reflects widely held assumptions about old age as a period of 'unproductivity' and economic dependence. In most communities worldwide, older persons have not been the primary focus of attention, mainly because of the widely held belief that they do not have much to

offer since they already played their part and outlived their usefulness in life (Nankwanga, 2012).

Much as this study showed exclusion and related injustices for the respondents, as argued elsewhere in this chapter, their experiences cannot be generalized. It emerged that those with economic capital also had the propensity to transform it into symbolic capital based on their novel status and social standing within the community. Thus, they used this strategic position to access limited healthcare facilities. Those with relatives, particularly in the diaspora, could easily access the much-needed attention at local clinics. This can be buttressed by a statement made by one of the respondents who said, *In Zimbabwe, if you have money, you are revered. You can quickly get anything, including medical attention; remember, these nurses are also struggling, so sometimes we give them presents, so it becomes a win-win situation.*

In addition to the above, some citizens used their marginalized status to claim or to attract medical attention at various hospitals and clinics. This is also in tandem with Spivak's (2000) analysis of the role of strategic essentialism in accessing scarce resources for the marginalized sections of society like the older persons in Chivi. Thus, many respondents would demand preferential treatment at various centers based on age. Therefore, the *Majembere (aged)* status was a political resource and symbolic capital in the citizens' quest for health in such a political economy.

8.3 Conclusion

The preceding chapter dwells on the structural and social challenges older persons face in accessing Health services in Chivi South district. It acknowledges the impact of the macroeconomic environment and the citizens' access to health care. While the state and the economic environment constrain, older persons should not be viewed as passive victims of the said environment. Thus, it looked at how older persons mobilize various forms of assets and capital to deal with the detrimental impact of the volatile economic environment in Zimbabwe. It posits that while the ability to deploy agency is assisting the actors to survive, it has the unintended consequences of widening the already existing social inequalities, and this becomes counterproductive when it comes to the national and international legal and policy imperatives for the government of Zimbabwe. Zimbabwe's policies on older persons

rely on informal social networks and capital, with adult children and community members caring for them. These informal support networks face urbanization, migration, and socio-economic hardships and challenges. Therefore, it shows that health is affected by various personal, social, economic, and environmental factors.

Chapter 9

Summary, Recommendations, and Conclusion.

9. Introduction

This last chapter highlights conclusions of this thesis founded on replicating the research objectives and questions vis-à-vis the qualitative research findings. With the ageing population growing, healthcare systems will be stretched to their limit; however, the critical question is: Are countries in the African continent well-equipped to deal with healthcare focusing on older persons? According to the Global Health and Aging Report presented by the World Health Organization (WHO), the global ageing population stood at over 962 million in 2017, more than twice as large as in 1980 when there were 382 million older persons worldwide. The number of older persons is expected to double again and is projected to reach nearly 2.1 billion by 2050 (WHO, 2017). Access to health care and inequality is prevalent among older persons over 65 and above, who are poor and sometimes struggle with chronic illness. This study has established that older persons in Zimbabwe are affected socially and economically and are experiencing the worst healthcare

outcomes after the erosion of welfare and pensions due to the collapsed economy. Inequality in terms of access to health care among older persons has been a stumbling block and a growing public health concern because of the increasing number of older persons, and this is happening against the backdrop of the worst economic period in Zimbabwe (characterized by hyperinflation, a collapsed healthcare system and high unemployment rates).

The current political, social, and economic conditions affecting the Zimbabwean government have adversely affected the population's health. The government's inability to provide even the most basic public health services to its citizens means that those in need, especially older persons, are increasingly limited to more expensive private-sector healthcare providers, which they can ill-afford. The ageing phenomenon has been a global concern, given the rapid growth of the aged population experienced across all regions. Older persons and all spheres of society feel the burden of ageing, especially the healthcare structure. This burden is, thus, posing a significant barrier to older persons in developing countries, specifically African countries, because of the large portion of the aged population living in the African region and marred by poor and ineffective healthcare systems. Perpetuation of the inequalities is partly the basis of the malfunction of the health systems in Africa today. Despite the increasing number of ageing populations and an economic meltdown in the 1980s (Hampson, 1985), literature has not explored how older persons in rural areas such as the Chivi South District experience access to health care. In this respect, the main thrust of this study examined the paradox of healthcare access and its determinants, focusing on older persons with CSD in rural Zimbabwe. It was informed by Penchansky and Thomas' access to healthcare framework, Gidden's structuration theory, and Bourdieu's social capital theory were used to complement the proposed framework and approach.

The thesis has been organized into eight chapters. The first chapter sets the stage for the thesis by contextualizing the study and outlining the main objectives of the study. It highlights the critical questions raised by the study. The chapter notes that access to healthcare for older persons is an important issue that needs exploration since there is a significant rise in the older population. Old age presents significant health challenges, resulting in older persons being categorized as part of vulnerable populations. The chapter

also contextualizes the study of older persons in the socioeconomic conditions of Zimbabwe and argues that the prevailing milieu is significant in determining access to healthcare. The second and third chapters provide a comprehensive literature review and commence by problematizing the concepts of access to healthcare for older persons. Access is a complex component requiring an understanding of complex factors mediating the ability of older persons to reach health care services. Chapter three provides the framework for understanding access by showing structural and hidden factors determining access. Of particular note are Giddens' structuration thesis, Penchansky and Thomas' model of accessibility, and Bourdieu's concepts of habitus, field, and capital. These theoretical strands are essential in understanding access's overt and covert dynamics. It is the central argument of the thesis that structural factors- present in physical constraints of availability and ability to access resources are responsible for shaping the discourse on healthcare access. Moreover, the hidden cultural and mental practices are essential in determining access to healthcare and how older persons respond to health and healing issues. Moreover, the navigation dynamics are best captured by a close analysis of the sociopolitical practices of older persons as they try to access resources. The concepts of structure, agency, field, and capital from Giddens and Bourdieu provide an essential framework for understanding how older persons navigate the terrain of health and healing. Penchansky and Thomas' model is also essential in determining the quantitative, qualitative, and practical aspects of access to health care by older persons. It provides an essential lens for viewing issues of availability, accessibility, and suitability of healthcare resources for older persons.

In the fourth chapter, addresses the methodological grounding of the thesis. The phenomenological approach has been critical in determining the methodological orientation of the study. A qualitative standpoint relying on in-depth interviews was critical in the cocreation of experiences of older persons as they seek health care services. It allowed me to share the meaning-making experiences of older persons in their pursuit of health. The fifth chapter examines cultural constructions of health and situates older persons' health issues within the broader framework of culture, tradition, and daily practices. It looks to the strength of meaning-making in predicting the likelihood and patterns of health seeking by older persons. In the sixth chapter, I look at the impediments to health care and physical barriers that affect access to health. There is an evident marginalization of rural older

persons whose multiple forms of exclusion affect their abilities to access health resources. The seventh chapter assesses the availability and quality of health services and their appropriateness to the needs of older persons. The eighth chapter analyzes differential access and dissects the differences that influence the varied experiences of older persons. Different life worlds, opportunities, and capital are important in understanding differences in access to resources among older persons.

9.0. Thesis Arguments in Perspective

This thesis has been informed by four significant standpoints used to interrogate the issue of access to healthcare among rural older persons in CSD, Zimbabwe. Firstly, the study argues that culture is essential in structuring access to healthcare dynamics among older persons. Culture, broadly conceptualized as incorporating people's belief systems and health-seeking behaviours, is crucial to how older persons interact with healthcare facilities. It influences how they seek medical assistance and the scenarios guiding their healthcare choices. Culture is also seen in the patterns that evolve through years of praxis, creating an elaborate discourse of healthcare and illnesses for older persons. This discourse includes perceptions towards conditions, healthcare systems, and cultures of aging and disease. In these cultures, we see multiple stakeholders, including caregivers, healthcare practitioners, and even the patients themselves, creating patterns of behavior that influence healthcare dynamics.

Secondly, the thesis argues that older persons experience several structural barriers that impede their access to healthcare in CSD. Looking at the physical characteristics of access, the study contends that limited provisioning affects healthcare access for older persons. Rurality is one of the significant factors that summarise the disadvantaged position of older persons and accounts for the non-utilization of biomedical facilities by the group. Ultimately, physical features are an essential aspect shaping the healthcare access landscape. Coupled with the physical issues, the study notes several structural problems, including cost, that should be analyzed and addressed if the healthcare services of older persons are to improve. However, the issue of physical and structural barriers only addresses availability without uncovering the suitability of health services. Hence, the third argument of the thesis is that there is a need to understand the quality and appropriateness

of healthcare services available to older persons. The study argues that the services available may be inappropriate for older persons.

Thirdly, the thesis argues that an understanding of healthcare access is incomplete without an evident appreciation of the quality and suitability of available resources. Access to health should go beyond a mere face value observation and unravel the intricacies of suitability and utility of available care services. The growing ageing population requires a nursing workforce to provide high-quality care for older individuals. Negative attitudes about ageing and older persons impact healthcare utilization. Training healthcare workers in geriatrics and gerontology is crucial to recognizing and addressing these issues. Policymakers and healthcare professionals should approach society holistically, educating front-line health workers to change misconceptions and improve interactions with older persons. Quality and appropriateness of care are typically viewed as a component of healthcare that correlates with the potential for health improvements among older persons—the specific demands on older persons' medical issues are indicated in Chapter 7; experience and specialized training are required to meet their needs. Therefore, the education and training of geriatric nurses in the area must receive increased emphasis.

The thesis's fourth standpoint calls for examining diversity among older persons. Their health experience is contextual and varied due to the uniqueness of life worlds. Different factors influence their access to health as people command different forms of capital, which shape their health outcomes. The findings expand our knowledge of the significance of social and economic capital in influencing health and provide significant new evidence of the variations between older persons' social realities and areas in the social determinants of health. These could provide guidance and result in more efficient actions to enhance the health of older persons and lessen health inequities. Economic/social capital hardships significantly impact the utilization of healthcare services among older persons.

9.1 Critical Analysis of the Study

9.1.1 Understanding Healthcare Access for Older Persons

From the thesis standpoint, it is essential to understand access to healthcare for older persons from the social construct of illness. Successful aging requires a multidimensional

model, but biomedical models may be ineffective for assessing and implementing policies excluding older persons, perpetuating the myth of illness/physical health as the cause. Biomedical science studies on disease etiology and management have relied on the Germ Theory (GT). GTY explains disease etiology from the point of view of bacteria, germs, or viruses. Exposure to these harms humans and management must align with modern medical services. While the GT provides a robust disease causation theory, the theory only provides a monolithic assumption of disease causation. It neglects the socio-cultural construction of disease causation (Kleinman et al., 2006). Evidence has shown that a better understanding of disease causation and management can only be achieved by looking beyond the biomedical science domain to include a multi-causal explanation, including the role of culture in disease causation and management (Abdullahi, 2015). Culture gives people a general design for living and patterns for understanding and interpreting reality, including disease and illness causation and management. Therefore, for a holistic understanding of disease and its management, there is a need to understand people's worldviews.

While there is an underlying difference among African indigenous people and cultures, a point of convergence "is evident in the realm of spirituality, as well as in behaviours manifested in everyday life" (Sow, 1980, p. 125). Thus, socio-cultural issues, including health and illness in indigenous African communities, are explained from the realities of macrocosms, mesocosms, and microcosmos. The macrocosms are the domain of God, ancestors, and spirits and are understood within the context of religious beliefs. The mesocosms explain all conflicts and events, such as illness, disease, and death. This is the domain of traditional practitioners, priests, and rainmakers, believed to possess the metaphysical powers to influence human behavior, including inflicting pain. The microcosmos is the person's domain in his/her every day, collective existence. Thus, understanding health and illness in African indigenous communities and managing them effectively requires understanding the interplay between micro-, meso-- and macrocosms, which are the underlying assumptions of the constructionist paradigm. In the current study, the decision on how, where, and when to manage an illness usually starts with the caregiver's perceptions, interpretation, and understanding of the perceived cause(s) and symptoms and barriers to health service utilization. Acknowledging this by health care

practitioners and policy-makers is a sin qua non to effective management of disease and illness of the elderly in Zimbabwe.

The importance of social over biomedical access issues is embedded in traditional and cultural beliefs that need to be integrated into the healthcare system. This often interferes with health-seeking behaviours due to beliefs and perceptions. This jeopardizes their healthcare-seeking behaviours. Biomedical care in Africa and culture's influence on Africans' health-seeking behaviour cannot be underestimated. In many African cultures, older persons in rural areas have a different understanding of the causes of diseases, which often affect public health systems, policy, planning, and implementation. Health-related beliefs, values, and practices will considerably impact the definition of health problems; hence, their identification and the nature of action to prevent or address such problems are essential. Thus, culturally derived factors will, to a considerable extent, influence the preventive measures a cultural group will adopt and the patterns of healthcare service use. Unless health care is made more accessible to the public, it will remain the prerogative of the rich, predominantly urban dwellers, and the fortunate few living in rural areas. An upstream healthcare approach is needed to address the needs of older persons, as it pays attention to sociocultural factors influencing care access. Studies have explored this phenomenon from a biomedical model, which ignores the view that health and illness are relative and socially constructed. According to Coward (1989), the model suggests that health problems are individual, ignoring the social factors that can cause illness. Whereas the social model of health focuses on influences that can lead to poor health, it aims to improve health and well-being by addressing the social determinants of health. Findings from this study shed light on how participants across the spectrum of the healthcare system describe their perceptions of health and how their definitions may influence programmes designed to support healthcare maintenance. This approach attempts to move beyond the clinical model of health and thus provide a holistic insight into what rural older persons consider to be the determinants of health and their health needs over time.

9.1.2 Mainstreaming Older Persons' Health

Little investment in older persons' care shows limited attention at the policy and practical levels. Reaching older persons in isolated locations because of a lack of social support

should also receive increased attention. The rights of older persons continue to be ignored in discussions on non-discrimination and sustainable development mechanisms. There need to be more particular national measures to protect older persons; the existing ones are not administered well and need more coordination and accountability systems. Re-thinking the discourses of ageing in Zimbabwe, especially for older persons in rural areas, and ideas from this analysis may provide a starting point for changing the current discursive order and developing new representations of older people and policy possibilities. Policies for older persons, like the Older Persons Act and the national healthy ageing strategy, must reflect a deeper understanding of aging. This will improve the standard of living of older persons and healthy ageing. The inequalities in the lived experiences of older persons in rural areas and those who do not have access to welfare benefits should be adequately addressed in revised versions of the Constitution. Additionally, older persons must be acknowledged as significant participants in healthcare policies.

Access to health care services is a fundamental determinant of health outcomes. It varies across countries, groups, and individuals and is primarily influenced by social and economic conditions and health policies. Moreover, older persons remain almost as marginal to the global health policy debate. With increasing longevity and debilitating chronic diseases, older persons will need better access to physical infrastructure in the coming years. The lack of physical infrastructure is a significant deterrent to providing comfort to older people. Older persons need better access to physical infrastructure, both in their own homes and in public spaces. Improving rural health access has become more significant. As demographic and economic changes reshape settlement patterns worldwide, policymakers have used discrete measures (e.g., healthcare service utilization or access to a regular source of care) to assess access and identify areas for special policy consideration.

9.1.3 Re-examining: The role of Community-based care and Family and caregivers) In rural Zimbabwe

Zimbabwe used to have a successful village health worker programme in the 1980s, focusing on disease prevention and provision of community care at the primary level in rural communities where they connected the community and the formal health system. Revising this noble programme can help increase access to health in rural areas. The

MoHCC in Zimbabwe needs to reintegrate the use of village health workers into mainstream primary health care in rural and remote areas. Support from this group will help enhance appropriate health care offered to older persons. With the country facing a massive health workforce shortage, village healthcare workers are integral in alleviating poor access to healthcare services and unacceptable healthcare practices that older persons in rural areas may face. WHO (2016) supported the involvement of village health workers in helping to reduce inequities in accessing essential healthcare services, particularly in under-serviced or excluded vulnerable population groups. Though there is support from WHO, it cannot be used as a panacea for weak healthcare systems nor a cheap option for providing access to healthcare for underserved populations. The healthcare system in Zimbabwe is in shambles, with healthcare programmes failing because of poor planning and implementation, thus jeopardizing the credibility of the village healthcare concept.

9.1.4 Rethinking PHC and its Adequacy Older Persons' Health

PHC systems were designed to be used primarily with older persons with single or acute diseases. However, many older persons are now diagnosed with multiple long-term conditions. For older persons with various health conditions, navigating the complex health and social care systems and getting the proper care offers significant hurdles that can severely impact their quality of life and well-being. This study ascertained that the healthcare needs of rural older persons are not only determined by having access to healthcare systems in general and modern healthcare systems but also by social determinants that deter them from having comprehensive care and noting the multidimensionality of older persons' healthcare needs. Existing healthcare systems need to address the needs of older persons beyond the biomedical aspect. The study's findings indicate that rural older person's healthcare needs or determinants extend significantly beyond access to doctors or healthcare practitioners and the formal healthcare system. While having access to healthcare services was identified by many participants, there were aspects of older persons' support systems that underscore the influence of other healthcare determinants such as class, free healthcare, culture, geographical space (distanciation), and the economy. The research sheds light on the need for more information on and awareness of existing services available to rural dwellers, for instance, homecare and respite care

services. With limited access to pensions and welfare, no formal transportation services, growing financial concerns, and inadequate support, many older persons without economically stable families often suffer more than others. The results suggest that strategies outside the formal healthcare system are necessary for addressing rural older persons' healthcare needs.

9.1.5 Reconceptualizing access (What does healthcare access mean for older people?)

The study notes the complexity of understanding access. Access is not a straightforward concept that simple actions can achieve. It is complex and requires scratching below the surface to uncover multiple hindrances affecting older persons' healthcare outcomes. Strategies and policies towards improving healthcare access must consider the multidimensional aspects of healthcare for older persons. This includes infrastructure provisioning, the multi-discriminatory environment, and the more complex constructions of disease and illness among older persons. Access is a policy issue. It requires a revamp and implementation of policy provisions that can create a suitable environment for access to services by older persons.

9.2 Conclusion

The study sought to understand the dynamics characterizing access to healthcare by older persons in CSD. Given the increasing illness burden in old age, the study analyzed how several factors have shaped older persons' health. Older persons require access to health so that they reach the end of life with dignity and enable them to lead pain-free lives. However, it has been noted that this ideal is sometimes not achievable due to several factors that create hindrances to health access. Challenges in accessing health care in rural areas include geographic isolation, economic instability, provider shortages, discontinuity or fragmentation of care, disadvantages related to funding, stigma, lack of education about prevention, resource limitations, and ethical challenges. Research in rural ageing highlights medicalized dimensions of ageing, often overlooking the influence of social and environmental factors.

The current malignant situation affecting the health delivery system in Zimbabwe is a direct or indirect result of failure motivated by weak systems, leadership crisis, and poor

healthcare policies and, on the part of the government, the understaffing of key health positions and the failure to have policies and procedures that have those running health institutions accountable. The current healthcare status in Zimbabwe is an endemic failure that cannot provide essential health to its ordinary citizens. Currently, many lives are lost mainly due to system failure compared to the disease itself, which sometimes could have been prevented if there had been minimal intervention. Vulnerable groups are most affected, and rural older persons are not spared in this conundrum.

Using the term 'vulnerable populations, the researcher sought to move away from the risk-factor epidemiological thought, which tends to focus mainly on behaviour alone and suggests that some groups are vulnerable to their agency, position about the social structure, and social practices. Only by focusing on all three would one be able to reduce the social inequalities in the healthcare delivery system, as all three are at the base of these inequalities. Modern research on healthcare use and access have shifted from an individual-level focus to a combination of the individual, the healthcare system, the external environment, and the effects each has on the others. It has been argued that a good tackling of inequalities in health should address all three aspects of the structuration theory (agency, social structure, and social practices) rather than structure or agency alone. The Giddensian structuration theory and Bourdieu's social capital theory are crucial in healthcare arguments for vulnerable populations, predominantly rural older persons.

Additionally, the study's theoretical framework offers a broad range of perspectives from which the ageing phenomena should be studied, including those based on culture, socioeconomic status (social capital), location, and economic and political landscape of the particular country. Older persons' livelihoods need to be enhanced. The necessity of evaluating the nature of healthcare support received by the older persons population is thus essential not only from the perspective of the healthcare provider authorities but also from the point of view of the older persons themselves. The extremely harsh economic conditions have made economic considerations more important than the health of older persons. Older persons are thus increasingly marginalized within communities as they are viewed as a waste of already scarce resources. The unequal distribution of these resources has thus reproduced inequalities in the healthcare delivery system. This notion of exclusionary processes points to the importance of working upstream to address some of the

original causes of the unequal distribution of these resources. The fundamental factors impacting access can be regarded as upstream determinants of health.

This study identified several rudimentary determinants grouped in five pertinent themes extracted from Penchansky and Thomas' (1981) access to health care, that is, accessibility, acceptability, affordability, and availability and appropriateness. Potential improvements to healthcare access are apparent, and these can be achieved by considering rural older persons' overall status, including healthcare needs, socio-economic determinants, and cultural issues, rather than simply establishing healthcare centers. Access to healthcare facilities and services is prudent to ensure high living standards among the population; hence, regardless of age and geographical and socio-economic circumstances, access to health must be essential. However, the situation has been poor in the Zimbabwean rural context, particularly for older rural people. The public health sector in Zimbabwe is plagued by inadequate infrastructure, improperly distributed facilities, and a shortage of competent labour. Older persons in Zimbabwe experience exclusion about beneficial accessibility to basic social infrastructure and food security challenges. It is undeniably true that socioeconomic conditions influence the use and quality of life regarding health. The data findings in this thesis show strong justification for additional investigation into the interaction between socioeconomic characteristics and the ageing population's use of healthcare services. The government must commit to providing essential resources, including staff, to health centers serving the general public. Changing the national health insurance program's policies is crucial to make it accessible to older persons.

Access to health is characterized by complexities requiring multilevel analysis and interventions. Older persons require access to health, though the existing conditions create difficulties in realizing this ideal. There is still a long way to go in conceptualizing and understanding aging as well as its impact on the lives of older persons. In line with healthy aging goals, there is a need to ensure that older persons' welfare is enhanced through a critical upgrade of their access to health. Moreover, an integrated approach is imperative to deal with issues affecting older persons.

Recommendations

This section makes some overall recommendations for improving the conditions of older persons. In the context of the challenges raised, there is need to revamp healthcare provision and access for older persons in rural areas. It is imperative for the state and other actors to urgently advance social security for older persons, particularly those who have been marginalised from the formal employment and social protection. Much as the legal instruments necessary to provide protection for vulnerable citizens like the elderly there is need for implementations of these instruments especially the Older Person's Act and this will assist to solve a myriad of challenges in access to healthcare raised in the foregoing thesis. In line with the dictates of such international and national statutes including but not limited to the Sustainable Development Goals, Zimbabwe's National Development Strategy 1 and Vision 2030, it is the obligation of the state to reduce urban and rural inequalities in access to healthcare and protection. In addition to this, decentralization of health services to rural healthcare centers is also imperative. The strengthening of policies and allocation of resources towards older persons' health will also go a long way in improving availability and accessibility of rural healthcare centers.

Areas of further research

- Gender dynamics of access to health among older persons
- Policymaking and healthcare of older persons
- Consumption of alternative medicine among older persons
- Resuscitate primary healthcare
- Community based social protection

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Appendix A: Informed Consent Document: 216076132

Dear Participant,

My name is Evelyne Muzvidziwa (*student no: 216076132*). I am a Ph.D. candidate at the University of KwaZulu-Natal, Howard College. The title of my research is **Access of Health Care Services among Older Persons in Chivi South Rural District, Zimbabwe.**

This study will examine access to healthcare services among older persons in Chivi South rural Zimbabwe, exploring accessibility and utilization of modern medical healthcare services in modern rural spaces.

Please note that:

- The information that you provide will be used for scholarly research only.
- Your participation is entirely voluntary. You can choose to participate, not to participate, or stop participating in the study. You will not be penalized for taking such an action.
- Your views in this interview will be presented anonymously. Neither your name nor identity will be disclosed in the study.
- The discussion will take about one hour. The meeting will be recorded should the participant consent to it.
- The record and other interview items will be in a password-protected file accessible only to myself and my supervisors. After five years, in line with the university's rules, it will be disposed of by shredding and burning.

If you agree to participate, please sign the declaration attached to this statement (a separate sheet will be provided for signatures)

I can be contacted at the School of Social Sciences, University of KwaZulu-Natal, Howard College Campus, Durban.

Email: muzvidziwaeve3@gmail.com

Cell number: 0843899816/0745317910

My supervisor is Dr Jayanathan Govender, located at the School of Social Sciences, Howard College Campus, Durban, of the University of KwaZulu-Natal.

Contact details: Govenderj1@ukzn.ac.za

Mobile number: +27 83 491 7896

The Humanities and Social Sciences Research Ethics Committee contact details are as follows: Ms Phumelele Ximba, University of KwaZulu-Natal, Research Office,

Email: ximbap@ukzn.ac.za,

Phone number: +27312603587.

Thank you for your contribution to this research.

Appendix B: Declaration 216076132

I…… *(full name of participant*) at this moment confirm that I understand the contents of this document and the nature of the research project, and I consent to participate in the research project.

I understand that I can withdraw from the project at any time. I know the intention of the research. I, at this moment, agree to participate.

I consent/do not consent to have this interview recorded (if applicable)

SIGNATURE OF PARTICIPANT DATE

……………………………………………………………………………………………

Appendix C: Interview guide for older persons

My name is Evelyne Muzvidziwa (*student no: 216076132*). I am a Ph.D. candidate at the University of KwaZulu-Natal, Howard College. The title of my research is **Access of Health Care Services among Older Persons in Chivi South Rural District, Zimbabwe.**

This study will examine access to healthcare services among older persons in Chivi South, rural Zimbabwe, by exploring accessibility and utilization of modern medical healthcare services in modern rural spaces.

Name of ward ……..….

Name of the participant: ……..…….

Sex of the participant….....…….

Age of respondent ……..……

Personal details

1. Tell me your details
2. How long have you been living in Chivi south district?

Healthcare determinants

3. Can you tell me more about the nature and quality of healthcare services in the Chivi South district?
4. What challenges do you face in accessing health care services? If any.

5. Based on your personal experience, what are the main factors or conditions determining your access to health care services?

Subjective meaning of illness

6. Tell me about your health. What is your most important health concern?
7. What are the main problems in people getting the health care they need, and what solutions can you suggest?
8. What does being aged and aging mean to you? Tell me more
9. How does it feel to turn 65 and above? Tell me all your experiences with the process up to this point.

Welfare system

10. Do you know of any social protection or welfare systems available to older persons?
11. Do you qualify for them? If not, how do you navigate your day-to-day needs?
12. Are you aware of how older persons act? What do you know about it?

Acceptability of healthcare services

13. What are the challenges that come with being aged?
14. What are your experiences regarding access to health care services? Probe on waiting times at the facility, information regarding health for the older persons?
15. Please describe an experience when you could not get the care you needed from the health care system.

Access to healthcare

16. How do you perceive access to healthcare services in Chivi district?
17. Would you say you have good, poor, or limited access to health facilities, and why?
18. What are your recommendations to improve the services that are available to you?
19. What changes would you like to see?

20. Do you want to add anything else?

The interview guide Shona.

Makadii mbuya/Sekuru zita ndinoitwa Evelyne Muzvidziwa (*student no: 216076132*). Ndinodzidza pa univhesiti inonzi Kwa-Zulu Natal iri ku South Africa (Joni). Nhasi ndiri pakutsvaga kuda kunzwa kwamuri maererano nezvekuwana pekurapiwa kana muchinge marwara. Nenyaya yekuchinja kwe zvinhu munyika ndoda kunzwa muono wenyu nezve nzvimbo dzerapirwa kunyanya makiriniki. Munofamba sei kuenda, zvamunoda zvese kana marwara munobatsirika here pa kiriniki.

Dunhu……

Zita……

Murume/mukadzi……..

Zera remunhu anopindura (makore mashanu emakore yezera)..... .....

1. Mava nenguva yakadii muchigara muno maChivi?
2. Maringe ne zvehutano, munoona sei?
3. Mukugara kwenyu muno mudunhu pane zvigozhero zvamakambosangana nazvo here pakushandisa zvipatara? Kana zviripo ndezvipi?
4. Mukugara kwenyu muno zvii zvinhu zvinokutadzisai kuenda kuchipatara kana marwara?
5. Chipatara chamunoenda munofamba zvakadii kuenda ikoko? Uye munoshandisa chii maererano nezvifambiso/
6. Chii chamungati idambudziko rinosangana nevakwegura mukutsva kubatsirwa muurwere?

7. Chii chamakambosanga nacho pamakaenda kuchipatara? Ingava nguva yekuti mubatsirwe, dzidziso ine maringa nehutano hwevakwegura?
8. Mungati pane chakashata here kana chakaipa maringe nezvipatara kana makiriniki munharaunda ino?
9. Pane zvamunoshuvira kuti dai zvawedzerwa here pazvirongwa zve hutano zve vanhu vakwegura?
10. Chii chamunga shuvira kuti chiitwe chigabatsira vakwegura munharaunda ino?
11. Pane zvamungade kuti zvigadziriswe?
12. Pane zvamugade here kuwedzera pane zvatataura?

Appendix D: Interview Guide for Caregivers

My name is Evelyne Muzvidziwa (*student no: 216076132*). I am a Ph.D. candidate at the University of KwaZulu-Natal, Howard College. The title of my research is **Access of Health Care Services among Older Persons in Chivi South Rural District, Zimbabwe.**

This study will examine access to healthcare services among older persons in Chivi South rural Zimbabwe, exploring accessibility and utilization of modern medical healthcare services in modern rural spaces.

Name of participant……

Sex of the participant…….

1. What is the nature of your relationship with Gogo/Sekuru?
2. Do you have any source? If no/yes, Probe.
3. Nature of sickness of relative.....
4. What is your understanding of illness and disease affecting older persons?
5. What do you do when your relative falls sick?
6. Where do you go with them for treatment? Moreover, how often do you go there?
7. What motivates you to assist your sick relative?
8. How do fellow members of your religion assist your ill relative?
9. What is the community ‘s perception of your relative’s illness?

10. What do you think about older adults' lifestyles in our community? How do you think aging well can be achieved?

11. Meaning how aging well can be facilitated?

12. What obstacles stand in the way of aging well?

Resources/support

13. I am interested in your resources and support: If your loved one is progressively ill and you need health information, social service information, or family help, who would you talk to?