Elderly Women, Rural Liveability and Access to Health Care in Rural Zimbabwe: A Review from a Human Rights-Based Approach

Matilda Maoneke *, Tafadzwanashe J. Magavude *, Kuthbert K. Zvokuomba, Mukaira Yeukai, Kadyauta Richard

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Article

Elderly Women, Rural Liveability and Access to Health Care in Rural Zimbabwe: A Review from a Human Rights-Based Approach

Matilda Maonekie [1,*], Tafadzwanashe. J Magavude [2,*], Kuthbert. K Zvokuomba [3], Mukaira Yeukai [1] and Kadyauta Richard [1]

[1] Woman's University in Africa

[2] Elevation Research and Consultancy

[3] Zimbabwe Ezekiel Guti University

* Correspondence: mmaoneke@wua.ac.zw (M.M.); tafadzwamagavude@gmai.com (T.J.M.); Tel.: +263 772 939 368 (M.M.); +263 777 593 997 (T.J.M.)

Abstract

Elderly people have the right to essential welfare and support services that encompass access to healthcare services. This article explores the day-to-day psycho-social encounters of elderly women in accessing health services in rural Zimbabwe. The research utilised the qualitative research approach in which four key informants were purposively selected for interviews and the snowballing sampling technique used to reach out to eight elderly women who participated in the study. The study was guided by the Human Rights-Based Perspective which informs our thoughts on vulnerabilities of elderly women's in rural Zimbabwe. The study established that the difficulties of elderly women are tied to the deteriorating health status due to ageing connected to declining family support. As a consequence, the elderly women find themselves in some form of social isolation which generates a state of peril for the rural elderly women. The study established that such isolation results in acute vulnerability, intensified marginalisation and diminished access to essential healthcare services. The study recommends that the duty-bearers, that is, the state and stakeholders, should take up their responsibilities and design tailor-made health services that cater for the daily needs of elderly people in rural communities.

Keywords: healthcare; elderly-women; isolation; coping; human-rights

1. Introduction

The wellbeing of older persons has increasingly become an important concern within global development discourse, particularly in developing countries where social protection systems remain fragile. In rural Zimbabwe, elderly women face multiple structural barriers that limit their access to essential healthcare services, including poverty, social isolation, declining family support systems, and inadequate health infrastructure. These challenges are further compounded by gender inequalities and age-related vulnerabilities that marginalise elderly women within both social and institutional structures. This study, therefore, examines the psycho-social challenges faced by elderly women in accessing healthcare services in rural Zimbabwe, with particular focus on Mukarakate Village in Murehwa District. The paper is structured as follows: the first section presents the background and contextualisation of ageing and healthcare access within global, regional and Zimbabwean contexts; the second section outlines the conceptual and theoretical frameworks guiding the study; the third section discusses the research methodology; and the final sections present the findings, discussion and conclusions of the study.

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2. Background and Contextualisation

The world over, as revealed by literature, the plight of the elderly in rural communities is characterised by precarity (HelpAge 2012). Social protection mechanisms for older persons in rural areas remain limited, characterised by very poor service provisions and non-existent or very low pension, as well non-existent community-based care systems (Chikoko et al., 2022). As a result, elderly people, particularly women, are frequently forced to develop their own coping strategies to manage health challenges and daily survival in the absence of structured institutional support. The case of elderly women is highlighted because Kinsella (2000), Yana Van Der Muelen, Joseph and Zveglich (2021) note that the life expectancy for older women is higher than that of older men. This phenomenon of higher life expectancies of women entails that elderly women spend a greater proportion of their lives either living under the care of others or by themselves, which in itself creates difficulties for people battling health issues and resources for survival.

HelpAge (2012) notes that half of the global population lacks access to essential health services, especially in resource-constrained societies. In that regard, one of the groups in need of the highest level of health care is older women. Smeeding and Sandstrom (2005) postulate that elderly women become susceptible to vulnerabilities due to high poverty levels tied to non-existent or low pension support systems. Thus, this study foregrounds the argument that elderly women face a myriad of challenges rooted in customary and patriarchal ideologies that generate some forms of gender discrimination. Gorman (2000) argues that despite the fact that the ageing process is an inevitable aspect of human life, societal attitudes and approach to dealing with the social problem are also skewed. After all, ageing is partly shaped by social constructions, with each society holding its own perspectives and worldviews about what it means to grow old (Gorman ibid). Thus, in many developing countries, ageing is often perceived as beginning when individuals are no longer able to make active contributions to themselves and society at large.

According to the World Health Organisation (2024), the population of older persons is increasing at an unprecedented rate in both developed and developing countries. The report goes on to show that the number of people aged 60 years and above is projected to rise from 1 billion in 2020 to 2.1 billion by 2050. The projection signifies that this growth will go together with social protection challenges for the vulnerable, especially in developing countries where social safety net systems are often inadequate or diminished (Kaseke, 2015). The growth in this population has significantly impacted various aspects of society, which include health care systems, with a particular focus on the need for accessible and effective health services (Makhubele, Mabvurira, Matlakala & Mafa, 2020). The United Nations (2022) posits that by the mid-2030s the population of those aged 80 and older will increase to 265 million, outnumbering infants This demographic shift has heightened the demand for innovative care solutions to provide elderly individuals with better access to healthcare, especially in underserved areas (Iwuagwu et al., 2022). According to the World Health Organization (WHO, 2015), population ageing in Sub-Saharan Africa is projected to increase at a faster rate than anywhere else in the world, with the elderly population rising from 46 million in 2015 to 157 million by 2050. Although various efforts have been made across Africa to support ageing populations, these measures remain largely inadequate, particularly for elderly women in rural communities. Many of these interventions fail to account for the unique needs of those outside formal employment structures, leaving a significant portion of the elderly population without consistent access to healthcare, support services, or financial assistance (Kaseke, 2015). Studies from Tanzania, Zambia, Kenya, and Malawi have shown that the absence of formal care systems for informally-employed individuals forces elderly people to rely heavily on traditional safety nets, which are often unpredictable and no longer as reliable as they once were (Otoo & Osei-Boateng, 2010). This trend highlights a broader regional incapacity to establish long-term, sustainable. In Sub-Saharan Africa the situation of elderly women has been worsened by the weakening of the extended family system, particularly in urban areas, compounded by the devastating effects of the COVID-19 and HIV/AIDS epidemics (Bhattarai, 2013). As urbanisation accelerates, many families have moved away from rural areas, thereby breaking the ties that once held the extended family together. The breakdown of

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traditional extended family systems and the absence of informal care-givers increases feelings of stigma, isolation, emotional and distress among the elderly women.

Despite the growing population of older persons, there is another intriguing dimension to this discourse of limited research on the lived experiences of elderly women in rural communities, especially in developing countries. Thus, this study is an attempt at not only exploring the lived realities of elderly women in rural Zimbabwe, but also generating new knowledge in the subfield of gender and ageing.

In Zimbabwe, the population of older adults (65 and older, as categorised by the government, has steadily increased, from 4.7% in 1982 to 6% in 2017 (ZimStat, 2018). This statistic also clearly reflects a rampant rise in the number of elderly individuals, signalling significant demographic changes and the need to improve care facilities for the elderly, particularly elderly women in rural areas. Other projections for Zimbabwe show that the proportion of people over 60 years old is expected to increase by more than fivefold over a 100-year period, rising from 4.7% in 2000 to 25.2% in 2100 (Makore & Al-Maiyah, 2021). Estimates by the United Nations Department of Economic and Social Affairs (2021) show that in Zimbabwe there are 573 341 people above 64 years old, of which 241 280 are males and 332 061 are females in Zimbabwe. Studies have highlighted that elderly women in Zimbabwe are less likely to access health care than men, often due to a combination of factors, including negative perceptions of ageing and the belief that they are 'too old' to seek medical attention (Zhou, 2014). This shift has made it more difficult for older women to have easy access to health care facilities. At the community level, informal networks that include the church and local volunteers historically played a crucial role in supporting elderly women. However, these networks are no longer more visible due to migration and economic stress (Dhemba, 2013). Many elderly women who once relied on this kind of support now find themselves alone, facing the additional burden of navigating the health system without assistance. Therefore, the study explores the lived experiences of elderly women with regard to the quality of their lives in rural Zimbabwe. In doing so, the study answers the following questions: What is the state and quality of life experienced by elderly women in rural communities of Zimbabwe? How do they deal with issues of access to health and other social protection services in the rural enclave? These circumstances raise important human-rights concerns, particularly regarding equality, dignity, and access to essential health care services, as recognised in local, regional and global social-protection standards.

3. Conceptual and Theoretical Framings

Understanding the experiences of elderly women in accessing healthcare requires clarification of several key concepts that underpin the study, namely human rights, ageing, and the elderly. This study deploys the United Nations (2018) conceptualisation of human rights as the fundamental freedoms and entitlements that every individual possesses by virtue of being human. Within this framing, there are rights holders who in the context of this study are elderly women and the duty bearer is the state and stakeholders who work with it in making sure that the rights of elderly women are protected and observed. According to the United Nations (2018), these rights are universal, inalienable and indivisible. They include the right to dignity, equality, health, and social protection. Therefore, in the context of an ageing population, human rights frameworks emphasise the responsibility of states and governments as well as other institutions to ensure that older persons enjoy equal access to healthcare services, social security and protection from discrimination, as well as experiencing dignified life free from social isolation (Yamin, 2008).

The study also deploys the World Health Organisation's (2015) definition of ageing as a multidimensional process that involves biological, psychological and social changes that occur throughout the life course transcending from being active, energetic to losing natural vigour and agility (World Health Organisation, 2015). While ageing is often understood in biological terms as the gradual decline in physical capacity, it is also socially constructed, with societies defining the roles, expectations and status associated with older age. In many developing countries, ageing is frequently associated with declining productivity and increasing dependency associated with the

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traditional view of older persons as poor and instead of view this phenomenon as offering alternatives. Hence, Formosa (2015:2) argues that for the developed economies aging has become evidence of positive trajectory in national development because it depicts the notion that, "...we have succeeded in bringing death rate down". Associated to the term 'ageing' is 'elderly', which in this study refers to individuals who have reached old age, often defined chronologically as persons above the of 60 or 65 (United Nations, 2022). However, beyond chronological age, the concept of the elderly also reflects social and economic realities associated with ageing, such as retirement, declining health, reduced mobility, and increased reliance on social support systems and networks. In rural spaces of developing countries, the elderly often experience compounded vulnerability due issues to do with underdevelopment.

Building on the conceptual understanding of human rights, ageing and the elderly, this study is guided by the Human Rights–Based Approach (HRBA). The Human Rights–Based Approach is particularly appropriate for analysing healthcare access among elderly women because it recognises them as rights holders who possess legitimate claims to healthcare services, while governments and institutions function as duty bearers responsible for fulfilling those rights (Sida, 2021). This human rights ecosystem is good for accountability and responsible management of services for vulnerable groups.

The approach emphasises that unequal power relations, gender inequality, age-based discriminations and other structured exclusions often prevent vulnerable populations from fully enjoying their rights as humans (Humanists International, 2020). Within rural Zimbabwe, these inequalities manifest through inadequate healthcare infrastructure, limited social protection mechanisms and declining community support networks, which disproportionately affect elderly women. The central focus of the Human Rights-Based Approach is the recognition that unequal power relations, gender inequality, age-based discrimination and social exclusion deny elderly women their human rights and perpetuate vulnerability in old age (Avilés, 2015). This makes the perspective particularly credible for assessing both the capabilities of elderly women (rights holders) and the responsibilities of the government and institutions (duty bearers) in ensuring access to healthcare services. The Human Rights-Based Approach places strong emphasis on marginalised groups, hence, it becomes the most appropriate guiding approach in understanding the situation of elderly women in the ruralscape. The Human Rights–Based Approach is guided by the following key principles: participation, accountability, non-discrimination, empowerment, transparency, and linkage to legal standards (Balan, 2024; Harper, 2025). Participation requires that elderly women be meaningfully involved in decisions affecting healthcare planning and service delivery in their communities. Accountability demands that government institutions possess the mandate, resources, and willingness to fulfil their obligations toward elderly women, particularly in rural healthcare systems. Non-discrimination requires deliberate measures to eliminate age-based stigma, gender inequality, and rural marginalisation in healthcare provision. Empowerment calls for strengthening elderly women's capacity to claim their rights while also building institutional capacity to deliver age-sensitive services. Transparency requires that information about healthcare services, eligibility criteria, and social protection programs be accessible and understandable to elderly women. Linking services to human rights standards ensures that national policies align with constitutional provisions and international commitments recognising the right to health and dignity in old age.

This study adopts the ideological position that elderly women possess the same fundamental human rights as all citizens, alongside specific rights arising from age-related vulnerabilities and gendered life experiences. International human rights instruments and global ageing frameworks developed under the guidance of the United Nations and the World Health Organisation emphasise the importance of dignity, equality, and access to healthcare for older persons. These frameworks reinforce the obligation of states to ensure that ageing populations are not excluded from essential services.

Based on this perspective, the Human Rights-Based Approach demonstrates its relevance in unpacking the socio-economic and structural challenges affecting elderly women's access to

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healthcare in rural Zimbabwe (Tsara & Mwapfaa, 2025). Healthcare access is understood not only as a service delivery issue, but as part of a broader social protection system that should safeguard the dignity and well-being of elderly persons. Within this study, elderly women are viewed both as individuals with healthcare needs and as members of families and communities whose rights must be protected through responsive social and health systems. Therefore, by recognising elderly women's rights in this way, the Human Rights-Based Perspective is advantageous because it focuses on the whole person within their social environment, linking healthcare access to broader systems of social protection, community support, and policy responsibility. This directly connects with the study's concern with healthcare accessibility, institutional support structures, and community-based coping mechanisms. However, while legislation and policy frameworks recognising the rights of older persons exist in Zimbabwe, legal provisions alone cannot eliminate exclusion, stigma, or discrimination. There remains a need to transform social attitudes, strengthen service delivery systems, and ensure practical realisation of elderly women's rights to healthcare.

4. Research Methodology

The study utilised an in-depth engagement and interactions of the researchers and the researched within the qualitative research approach. This approach was selected to afford a close fit between the research methods and research questions asked (Creswell & Poth, 2016). The study's target population was elderly women in Mukarakate Village in Murehwa Zimbabwe. Mukarakate is a community that typifies a rural context where elderly people experience significant barriers to healthcare access due to factors such as inadequate health facilities, geographic remoteness social isolation and deeply rooted cultural norms. Selection of research participants was based on both purposive and snowball sampling techniques. Since this was a qualitative study targeting a small sample, only eight elderly women, four key informants who participated in key informant interviews, providing rich insights into the experiences of elderly women. The key informants comprised 1 representative from the Department of Social Development (DSD), 1 community leader, 1 health worker from a local clinic, and a 1 religious leader. This was complemented by the deployment of a convenience sampling technique in selecting 6 members of the community who participated in a focus group discussion and researcher observations which acted as mechanisms for data triangulation. All these research methods and data collection and generation mechanisms helped in producing a rich data corpus that went through the thematicised data analysis. We worked with themes that emerged from the data and this allowed us to focus on phenomenal issues that arose.

In every research, the researcher should consider ethical issues that surround the study as a way of protecting research participants. We were guided by Murphy and Dingwall (2007) in appreciating and observing research ethics as the right way to treat each other as humans within research relationships. This perspective put a lot responsibility on us as researchers, hence, we observed the key right to participate in the study, withdraw at any time and allowed participants to sign consent forms. We shared these issues with the research participants at the initial stage of our interactions and assured them of our strict observance of individual privacy and confidentiality, which we did by carrying out interviews within their private homes and deployment of pseudonyms in the research report, for the concealment of identities. Every elderly woman is identified as 'Mbuya', a Shona term for granny, grandmother or any elderly woman. Consequently, we followed Kelman's (1982) classical ideas of avoiding treating research participants as a means to an end, but as an end in themselves.

5. Study Findings

The study findings are presented under the following sub-themes: compromised support systems for the elderly in the wake of the demise of the family and kinship networks in rural Zimbabwe; discrimination in the context of dementia-witchcraft accusations; compromised

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communications for the elderly in the face of dwindling support from duty bearers; and lastly a discussion and recommendation section.

Warped-up Support and the Demise of Family-Kinship Networks

The study carried out in Murehwa rural communities established that there is weak support network for most elderlies, more so for women, who constituted the majority. The first tie of the support for the elderly come from the immediate relatives within the nucleus family. The African kinship network within the patriarchal arrangement is that as the parents retire and become elderlies, their roles of taking care of the family are taken over by the energetic young people within the family setting. Then according to the laws of nature, the elderlies become the first to be 'swallowed by the earth', meaning dying earlier than the young. In this natural setting, the elderlies are not exposed to lack of support during their last moments of life. Their families take care of them in every respect including health matters. However, what we observed in Murehwa were cases of elderly women whose children and grandchildren passed away earlier than them, leaving them exposed to the vagaries of life. The second tier of support for elderlies and other vulnerable people in the rural areas which we established during field work were the relatives and kinsman connected by genealogy and totem. This was highlighted by a key informant, a traditional leader who indicated that under normal circumstances, elderlies are eventually taken care of by relatives be it distance or close. But with the advent of modernity and westernised individualised lifestyles, elderlies in Murehwa were noted to be left to fend for themselves and struggle with their failing health status amidst poor health delivery services. A key informants said:

> *Our traditional kinship-based networks based on belonging to the same family, clan and totem have been weakened by western philosophies of life. Nowadays, becoming an elderly mean exposure not only to deteriorating health but being exposed to lack of support to access medical services. Even those of own blood may just live their lives in towns without looking back to us in contradiction of the Shona language proverb; chirere chigokurerawo mangwana (look after and take care of the young today so that they will in turn look after you tomorrow).*

The study also established that this absence of support networks does not only affect their ability to access health services but also compromises their adherence to necessary medical procedures, as older people sometimes begin the journey of being forgetful. A research participant, Mbuya Mapita, highlighted this point as she said:

> *Staying alone is difficult my son, there is no one to take you from home to the clinic. In some instance I would want someone who can carry me because my legs are no longer strong.*

One of the research participants, Mbuya Cheza, also said:

> *Being a loner is something else it affects your mental well-being people label you as mad for l will be speaking to my self somethings with the grasses, twigs and logs even the walls when l fail to endure the pains in my body.*

Mbuya Rimbi also had this to say:

> *Staying alone, out of site is the most painful no one hears your cries of pain, the cry of need one day it gets worse you just have to crawl all the way to the road sleep there until a passer-by comes through for you.*

The study also gathered that the unpredictable nature of the elderly with unknown health statuses has created the need for effective monitoring systems by neighbours to cater for immediate response in times of need. Participants reiterated that neighbours play a crucial role in taking care of the elderly women in Murehwa. The research further established that community neighbours keep checking on elderly women for psycho-social, health and emotional changes. We further noted that the community has an ingrained responsibility of offering care to the elderly within the framework of *Ubuntu* tradition and philosophy whose ethos bind society together. We established that the help that was offered to the elderly women was anchored on this African philosophy whose ethos emphasise collective, community, interconnectedness, solidarity, and responsibility (Mugumbate & Chereni, 2019). *Ubuntu* reinforces the moral obligation of community members to care for the

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vulnerable under the mantra, 'I am because we are'. Thus, few cases were reported of neighbours who monitor and provide care, collect medication from medical centres and sometimes use their scotch carts to transport the elderly to health centres. As such, despite all the observed fragmented kinship and family systems, the wide community was observed to be helpful in terms of the elderlies accessing medical care. One neighbour to Mbuya Hute said:

> *Without caring neighbours it would have been a case of dry bones and dust but the continuous checks, lookout and timely medical care/attention they necessitate has enabled longevity.*

Mbuya Marimo also added weght to the conversation by saying:

> *Our lives as old people are solely in the hands of the community, if they abandon us we are bait to the underdogs, we automatically become history.*

However, the support network encountered severe constraints arising from other facets of life and influenced by spiritual beliefs conflated in lack of knowledge about issues of ageing amongst the rural society, as discussed below:

Discrimination and the Witchcraft-Dementia Nexus

The study findings indicate that elderly women in Murehwa District experience stigma and discrimination tied to weak or no support networks at all. Cases of elderly women outliving their offspring and even grandchildren were not a new phenomenon in the study site. Such cases were more evident in the immediate post HIV/AIDS era when sexually-active persons in a household died earlier than the elders. Participants indicated the existence of this trend in Murehwa community too, in which elderly women become the only surviving members of some households. The study, thus, established that such elderly women experienced limited or no support networks for them to enjoy humane life experiences. Tied to this social phenomenon were cases of dementia. Dementia as a medical condition was not known by villagers and other members of the society. Those who interacted with the research team believed that the real issue with some elderly women who sometimes experienced loss of memory was in fact an expression of witchcraft tendencies. The study established that it is because of such mind-sets and beliefs that elderly women in Murehwa area experienced isolation, exclusion and lack of support from other members of the same community. In another study that corroborates our empirical evidence from Murehwa, Dhemba (2013) argue that stigma and discrimination on the basis of strong belief in witchcraft even discourage older women from seeking medical care resulting in more complex situations.

Mbuya Mamoyo had the following to say:

> *I think some people of old age like me experience low self-esteem due to societal marginalisation and discrimination because of the misconceptions and lack of knowledge about dementia. People think that when an older person shows disorientation during a verbal engagement, it would be a sign that they practice witchcraft.*

Therefore, these beliefs and lack of knowledge about dementia result in the societal view that ageing automatically becomes a stage in the life cycle of a person to practise witchcraft. In the context, elderly women experience limits in who they can interact with and it becomes difficult for them to enjoy life in its full range. During our field visit to Murehwa, we interviewed a key informant from the local medical centre, who narrated a case of an elderly woman who was met during the night while partially dressed and this incident was viewed as a case of witchcraft. However, the plight of the elderly woman was lessened when the nurses at the local clinic indicated that the elderly woman was a dementia patient. Our interview with the key informant then pointed to the fact that because many people in rural areas do not put on pyjamas at bed time, when time for peeing comes, one has to go outside naked. For a dementia patient staying alone, this may result inwandering around and failing to remember or go back into the house or hut. When one is seen by any other person in that state during the night, this becomes a pure case of witchcraft. Our study findings about this phenomenon concurred with Brooke and Ojo (2020) in Ghana, Aballa et al. (2025) in Nigeria, and Nukunya (2010) in Kenya. The study established that customary and cultural beliefs about ageing

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and lack of knowledge, as well as lack of support from duty bearers, among other factors, created ageing conundrums and convolutions in Murehwa District.

As a form of coping with the problems, elderly women in Murehwa District tended to lean towards the churches because they were forthcoming and supportive as a spiritual body. The church embraced all categories of disadvantaged people in society and became the 'immediate family' to some. The majority of the elderly women research participants supported this development, noting that this 'second family' played a vital role in the transfer of spiritual energy, which is crucial in the life of any person.

Tied to the issues discussed above is the overarching condition of absolute poverty amongst the elderlies. The study established that poverty compromised the wellbeing of the elderly women in Murehwa District. A key informants emphasised that rural livelihoods are largely sustained through physically demanding activities such as farming, firewood collection, water fetching, and other forms of manual labour. However, due to age-related physical limitations, many elderly women were no longer able to effectively engage in these strenuous household chores which affected their food security status. This was corroborated by a Social Development Officer (formerly Social Welfare Officer) in the district, who said:

> *The elderly in our communities do not have any steady income and largely survive from hand to mouth. The available social protection programmes are limited, and many of them face challenges in accessing this support.*

Unlike younger members of the community who can engage in labour-intensive agricultural activities which constitute the bulk of rural livelihoods, elderly women often depend on irregular support from neighbours, relatives or well-wishers. Our study established that this dependence arrangement is not always reliable, hence, the exposure to extreme vulnerabilities. Cases of elderly household-headed families were talked about during interviews where the young members of the households eventually leave the elderlies alone as they migrate to other areas in search opportunities. In the face of these vulnerabilities in rural areas, the government, through the Department of Social Development Office, had records of some social protection initiatives for vulnerable households. We noted that cash was remitted to elderlies through the cash transfer programme as well as food assistance by some non-governmental organisations. These were administered by the Department of Social Development. However, there was no consistency in the service delivery, including on the Assisted Medical Treatment Order (AMTO) which is strongly related to this study. We witnessed abrogation of duty by the duty bearers in the provision of medical assistance to the elderlies in rural Murehwa. Its non-existence practically and availability in theory represented a confused framework. As such, elderly people did not know about it, hence, this was not only a gap in service delivery but failure to uphold the human rights standards as prescribed in the Human Rights Council and locally in the Constitution of Zimbabwe.

Although the participants applauded the government of Zimbabwe for putting in place some measures towards assisting the elderly in accessing medical services, the provisions are not adequate. The majority of participants raised concerns over a weak social security system that is incapable of covering major medical costs of medical services which are needed by the elderly people. These findings concur with Kaseke (2015) who observes that even though the government of Zimbabwe made efforts to assist the elderly, its interventions fail to account for the unique needs of those outside formal employment structures. Dhemba (2013) is also of the view that the Pensions and Other Benefits Scheme also failed to address the problem faced by the elderly in Zimbabwe.

The study further revealed that rural healthcare facilities are characterised by insufficient geriatric care services. Findings indicate that the majority of healthcare facilities in rural areas of Zimbabwe lack adequate diagnostic equipment and trained healthcare professionals to address the complex health needs of elderly patients. From a Human Rights–Based Approach, these shortages reflect gaps in accountability among duty bearers, particularly government institutions responsible for ensuring equitable access to healthcare services. The Human Rights-Based Perspective emphasises that the state has an obligation to make healthcare services available, accessible,

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acceptable, and of good quality, especially for vulnerable populations such as elderly women. According to the study, these resource constraints often result in increased morbidity and mortality among older persons. Evidence from focus group discussions showed that limited medical resources in rural facilities increase the burden on elderly women, who are frequently forced to travel long distances to access specialised treatment and diagnostic services. This situation not only increases financial costs, but also deepens social and health inequalities.

The Human Rights–Based Perspective views such challenges as being in need of strengthened institutional capacity, improved resource allocation, and deliberate policy implementation to address age-related healthcare needs. The approach highlights that healthcare access for elderly women should not be viewed as charitable support but as a legal and social entitlement grounded in human dignity, equality, and non-discrimination. Therefore, improving geriatric healthcare services in rural areas becomes essential for fulfilling state obligations and ensuring the practical realisation of elderly women's right to health. One key informant shared the following sentiments:

> *To tell you the truth my brother, Zimbabwe's health care facilities have limited resources. The situation is more complex to rural communities, facilities there do not even have what you may think is basic.*

Mbuya Mahoso shared:

> I would have negotiated with my fragile body to walk the long stretch to the clinic, only to be told that there were no medicines even paracetamol. Unless someone purchases for you from the city.

Mbuya Bangwe said:

> Going to the clinic it's just being hard headed and ignorant of the existing realities for its only being checked ones Temperature and BP, service rendered, they can't help us for we are now old and useless.

Ill-equipped health care centres alongside geographical and physical barriers hindered elderly women from accessing health care services in rural Zimbabwe. Participants highlighted that some of the building do not have ramps making it difficult for elderly women with mobility impairments to access healthcare services. Key informants added that lack of accompaniment further compounds the barriers to accessing healthcare for elderly women. This challenge was viewed as resulting in elderly women not receiving timely healthcare, thereby compromising their health outcomes and overall well-being.

Viewing these issues from a Human Rights–Based Approach, these physical barriers represent more than logistical challenges; they reflect shortcomings in fulfilling the principles of accountability. The right to health requires that healthcare services be physically accessible to all citizens, including elderly women with disabilities or mobility challenges. When healthcare facilities are not designed to accommodate ageing populations, elderly women are indirectly excluded from essential services. This situation undermines their status as rights holders and reflects gaps in the responsibility of duty bearers to provide inclusive healthcare systems.

Communication Convolutions in the Wake of Dwindling Support from Duty Bearers

The study also revealed that poor communication is a significant barrier limiting elderly women's access to healthcare services. Key contributing factors were identified as including limited access to social media where much health-related awareness is circulated and social isolation which hinders their ability to share healthcare needs and concerns. From the study, this combination of factors exacerbates their vulnerability to poor health outcomes and decreased quality of life. The findings resonate with Chikoko (2012), who indicates that gaps in social protection systems often leave vulnerable populations with limited access to information, services especially during times of crisis or economic hardship.

Mbuya Maruza narrated:

> *Not owning a small phone or radio means that you miss out important information especially those radio talk shows on health (Doctors on air).*

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Another research participant had this to say:

> I do own a phone gifted to me by my neighbour son but l can't afford data, charging is a problem so the phone it's buried deep in my bag. I'm dependent on passer-byes for information.

Though side-lined and not benefiting much from the power of technological prowess the study findings, exposes that volunteer care workers play crucial role in helping elderly women to access health care services. It was found that volunteer workers in Mukarakate Village help in providing elderly women with health care related information. Key informants also noted that these volunteer care workers provide them with the needs of the elderly.

However, while volunteer care workers play a significant role in supporting elderly women, the study revealed that they require proper motivation and training in order to perform their duties effectively. Participants indicated that many volunteers operate with limited knowledge of geriatric care, health monitoring techniques, and referral procedures. Without adequate training, their ability to identify early warning signs of illness or provide accurate health information may be compromised. In addition, the absence of incentives or structured support reduces morale and sustainability. Volunteers often lack transport allowances, communication resources, or basic material support, which makes consistent service delivery difficult. Over time, this may lead to burnout, reduced commitment, and weakened community-based care systems.

The study established that financial constraints are a major barrier to elderly women's access to health care facilities. The majority of participants indicated that the harsh economic environment in Zimbabwe makes it difficult for elderly women to raise money for their medication. It has been gathered that elderly women struggle to raise money for basics such as food and as such making it difficult to afford medical related costs. Bindura-Mutangadura, (2001) is corroborates these findings, noting that elderly women lack financial independence, resulting in poor health outcomes. Mbuya Matiza had this to say:

> *The problem is that we do not have money needed for medication. Even going to the clinic, we do not have money to buy drugs so there is no need for going to the clinic.*

Mbuya Murumbeni opined:

> *Money is the engine of life it drives everything, l do not even remember the last time l held a bigger note in my hands, these hands are accustomed to 50 cents, $1 notes which are not enough to cater for medication.*

Though financially constrained, the elderly women have adopted a mechanism that covers up for their economical need through governmental aid. The agricultural inputs (seed and fertiliser) and food aid (wheat and sorghum) being distributed by the government in rural areas has played a crucial role not just in the sustenance of an important basic need but also a financial base. The study established that nearly half of the aid is reserved and kept as financial security solely for the purchase of essential medicines only when alternative health care systems have failed. Participants highlighted that the governmental gesture has become a means to an end temporarily empowering elderly women in their quest for financial independence. One participant said,

> *Buying medicines and food stuffs is of great difficulty due to shortage of money however the inputs and food aid in turn is partially used in the place for any cash transactions.*

6. Discussion

The study discusses the plight of elderly women in rural Zimbabwe under the following sub-themes: the fractured family and kinship networks and the adoption of western modelled lifestyle; stigmatisation and discrimination of elderly women in the wake of lack of knowledge of dementia leading to witchcraft accusations; the drying of support services; and lack of capacity of duty bearers to provide needed services by the elderlies. The challenges experienced by elderly women in rural Zimbabwe were a reflection of the constricted capacity of the duty bearers in protecting and

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promoting the humane and liveable lives by the elderly. This is also an affirmation to decision made and held by the United Nations General Assembly on the 3rd of April 2025, noting a gap in the protection of older persons. As a result, the UN Human Rights Council thus adopted a legal aspect within the human rights instruments for the establishment of the UN Convention on the rights of older persons with comphensive legal strategies to protect elderly's (UN General Assembly Human Rights Council A/HRC/48/53). Thus, the comphensive approach brings into the fold not only aspects of age, gender, and socio-economic status, but also the witchcraft-dementia nexus. This study concurs with many scholars, including Abubakari et al. (2025) and Aballa et al (2025), who point out the that while many African communities do not have knowledge about dementia, the rural health centres too do not have capacity to manage dementia related illness that affect the elderly women. Most suspected witches in Murehwa District were elderly women with dementia. The consequence of lack of knowledge about dementia leads to isolation of elderly women. This corroborates Quarmyne (2011), who observed the banishing of elderly women from refugee camps in war-torn areas, in breach of human rights of the elderly women. While other aspects that negatively affect elderly women in rural communities seemed to be understood by society, the study revealed no knowledge on dementia, hence the association with witchcraft (Brooke & Ojo, 2020). Thus, the study exposed the limits of the Human Rights-Based Approach in interrogating issues of the supernatural world since witches are believed to "...poses supernatural powers which they use to harm others or benefit themselves" (Abubakari et al. 2025:167). When duty-bearers do not have clear policies pertaining managing and protecting the rights of holders in the form of elderly women being isolated and discriminated on the basis of less known dementia medical conditions, elderly women get exposed to more harm. We share Ncube and Murray (2024) and MoPSLW et al.'s (2019) assertion that sound social assistance frameworks for the vulnerable is government responsibility, although it can be assisted by other stakeholders like NGOs and private corporates. These medical and related social services are provided by government because it is a constitution requirement as well as the fulfilment of the legal precepts of the Social Welfare Assistance Act [Chapter 17:06] and the National Social Protection Policy Framework adopted in 2016.

7. Conclusion

The study investigated wide issues surrounding the experiences of elderly women in accessing health services in Zimbabwe from a human rights perspective. A number of issues came out through the field work which was carried out in Murehwa District, a rural community. The rural spaces were most convenient for the study as we got guided by Quarmyne (2011), who posts that elderly women's issues are more understandable in rural settings. Thus, the study revealed issues of poor social security and health delivery services, support networks for the elderly that are dependent on the good will of individual. The study exposed the limits of duty bearers in protecting rights holders. The void created within family networks and the limits of the state, private corporates and NGOs in implementing strategies that protect elderly women were further exposed in the witchcraft-dementia nexus. The study showed that elderly women's plight is worsened not only by the health delivery system which is not capable of managing dementia but lack of knowledge of the medical condition by society, leading to witchcraft accusations. There is nothing in place to protect elderly women from being accused and abused as human rights bearers. Thus, the study recommends that duty bearers put in place not only the legal framework that speaks to the contemporary circumstances of elderly women, but also practical mechanisms and strategies that protect the rights holders. These should be in line with the modifications of the rights instruments of the UN Convention on the rights of elderly persons made in 2025. These were meant to address the gaps that were noted at that global level, hence the local level also ought to be informed by contemporary researches, inclusive of this one.

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