Elderly and rural health Care in Zimbabwe: exploration on available health care systems and challenges faced in accessing health services.

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Abstract
The main objective of the study was to explore the health serves availability and challenges that are faced by rural elderly people in accessing healthcare services. The study utilised qualitative methodology through which in-depth interviews and focus group discussions was used to gather data from sample 12 participants. Some of the challenges identified include health illiteracy, financial problems, poor patient-provider relationship, quality of healthcare and lack of health insurance. Based on the findings of the study, the paper proffers some recommendations which include fully enforcing the free health policy for the elderly, reviewing it for it to cater for the aged when they are referred to private practitioners. The study concluded that the support from the government in assisting the elderly to access health care must be reviewed and fully enforced, to take into consideration the challenges the elderly face when they are referred to private practitioners.

Key terms: Health systems, elderly, rural communities, health care

Introduction of the Study
According to the United Nations (2002) an elderly person is a person who is sixty years and above. The lifelong process has seen the elderly in rural areas regressing to a state of dependence. This culminates in decrease of roles and activities they partake in the society which calls for adequate social protection measures for them to meet their day to day needs. Ageing as a process comes with a lot of social problems which among others health is a great concern for those living in rural communities. Although substantial efforts that have been made in addressing the health needs of the aged by the government, the family and non-governmental organisations; the issue of them constantly facing challenges in accessing health care remains an area of great concern in Zimbabwe (Nyanguru, 2007). Unless such issues are revisited, the
health problems of the elderly will remain a big question among the elderly in rural areas. This forms the major crux of this study which seeks to explore on forms of health systems available and the challenges faced by the rural elderly in accessing health care.

Longevity is a phase in life which results in a number of loses which affect the individual’s physical, mental, and social well-being. Major loses which often comprise ageing are loss of social and support networks, spouses and significant others (Orr & Piquerasi, 1991). Despite these loses, the aged people are viewed as people who have attained social achievement. The elderly’s presence is regarded as of great value in different societies worldwide. The disastrous effects of modernisation, have massively contributed to changes in patterns of families such as the disintegration of the extended family network system. According to Sidhisena and Ratnayake (2009), the elderly have become a disability and an economic risk due to continuous changes which have resulted in new religions and new forms of economic control. Given this evidence, the aged people are the most affected without a strong available support system.

A dramatic shift however in the “last decade” has occurred which has seen African household disintegration due to the HIV and AIDS plague and migration. Most infected have been the economically active and this has caused decrease of cash remittances to the aged people based in rural areas. Thus the aged are facing a lot of livelihood challenges especially the need to meet the health needs with the extended family system no longer reliable. The situation of the elderly is made complicated as most of them survive under low-income households making it one of the hardest tasks in them needing to raise income to meet their health needs. This has since been exacerbated by the economic meltdown which has been characteristic of Zimbabwe. According to Zimbabwe Medium Term Plan (2011-2015), the economic challenges of the past ten years has led to poverty increase and vulnerability as it negatively impacted on social services delivery and lack of organised selection criteria has led to omission of the terminally sick, old and handicapped. The pensions, health benefits and personal savings have thus been rendered futile.

The era of prolonged existence requires not only individual efforts but also government commitments to build a social, economic and physical atmosphere favourable to health ageing. The aged comprise a minority group struggling for
survival especially in rural areas. With the coming of colonization, the welfare of the aged was jeopardized due to a lack of a reliable social security system. Without such a social security system, the elderly residing in rural Zimbabwe are exposed to a variety of risks in matters concerning their health. According to Hall and Mupedziswa (1995) there is lack of a broad social security system with the only present old-pension scheme after independence restricted to non-Africans. The economic stagnation, lack of vibrant support systems and migration has eroded the foundation for old people (Madzingira, 2006). In 2012 however, the Zimbabwean government signed into law the Older Persons Act [chapter 17:11] an initiative which is expected to benefit the old aged in social protection.

Locally, the public health system is the main provider of healthcare services, complimented by mission hospitals, faith based and non-governmental organisations (Muriviwa et al, 2013). Rural communities have been affected more due to political upheavals and economic crisis which Zimbabwe has gone through. This has affected provision of health services especially in rural areas where the operation is on a shoe string budget. There is massive shortage of skilled professionals and an eroded infrastructure with ill-equipped hospitals. Such a development has not done any good as the rural based elderly are facing challenges in accessing health services. Hospitals and clinics in rural areas rely heavily on user fees for their day to day operation, with most of these user fees out of reach for the elderly.

**Research Methodology and Material**

The study was conducted in a rural setting. The area under the study was Village 1 Sumerton in Ward 6 of Masvingo North district in Masvingo Province. It is located 40km away from Masvingo central business district. Thus Village 1 Sumerton was purposively selected based on the knowledge that the area had the characteristics of the questions under this inquiry. The research was qualitative in nature. Availability sampling was used to select 10 elderly respondents. Purposive sampling was used to select two key informants. According to Engel and Schutt (2013) purposive sampling enables the researcher to select the sample they feel will reflect the best information that satisfies research objectives. The 2 key informants included health worker at the local clinic and an officer from Masvingo Department of Social Services since they interact with the elderly in rural areas on their needs. Key informant interviews and focus group discussions were used collect
information for the two key informants and ten elderly participants respectively. Focus group discussions enabled the researchers to holistically understand some challenges being faced by the aged and the available healthcare systems in the area of study. All responses were audio recorded during data collection process.

Before commencement of data collection, participants were informed about the objectives of the study, what they were expected to do, that participation was voluntary, that they could refrain from answering any questions they felt uncomfortable with, that they could discontinue at any point during the process, that information they gave would be treated with confidentiality, that there were no direct benefits in participation and that anonymity of the participants would be ensured. Clearance for the entry into the study area was obtained from the District Administrator.

Results

The profile of respondents

Of the 10 elderly who participated in the study, 4 were aged 60 to 70 years, 2 were aged 70 to 80, 3 were aged 80 to 90 while 1 was aged above 90. In terms of education level, 2 had primary education, 2 had secondary education while 6 had not gone to school. Unsurprisingly, no elderly had history of formal employment, all of them were in informal employment. The majority of elderly (7) were not in marital relationship while 3 were still married. It was also established that all elderly (10) have more than 3 dependents with 6 as highest number of dependents. All key informants mentioned that they have tertiary education qualifications.

Available Health Care Systems for the Elderly

Modern Health services

The study also revealed that the majority of the participants (7) preferred the use of modern healthcare services. Some elderly revealed that they were in favour of modern health services. The reasons cited by the elderly for the preference of the health care priorities range from distance to the nearby healthcare facility, financial issues and health workers attitudes.

Traditional Health services

The traditional system also proved to be easily accessible as they did not need to pay and if they were compelled to do so they could do so in kind. Hence, this meant the elderly visiting the locally available traditional and faith healers. The elderly respondents revealed that they also chose the traditional model due to their cultural and religious beliefs

One respondent had this to say:

‘Kana ndiri ini zvangu kuenda kumhiri uko kwa Sekuru Chinyakata zvirinani nokuti..."
This can be loosely translated to mean that: The respondent prefers consulting traditional healers, since the traditional healer is competent enough. Hence this was the reason why the respondent had remained healthy.

**Home based medicine**

A minority of the elderly confided that they opted for informal care providers especially women back home as they provided better service than the one provided at the local clinic and hospital. They regarded them as people with vast knowledge in traditional medicine and were also caring and understood the elderly’s health needs. One of the participant noted that;

One participant noted that:

“Zvirinani kuti ndiwane rubatsiro panyaya dzeutano pamba nekuti hapana mari yandinobudisa uyezve ndinobatwa zvirinani pane zvandinoitwa kuChipatara.”

This translates to mean that; the respondent finds it better to receive health care at home since there are no financial expenses and there is better service offered than that from the hospital. The above findings are in sync with Hossen (2010) who argued that, women and other home based care providers have emerged as important health care providers due to their knowledge in traditional medicine and better understanding of the elderly’s needs. All elderly revealed that their beliefs on the effectiveness of these health care services played a role in their choice. Some noted that they blended the modern and the traditional system for better service.

**The challenges faced by the elderly in accessing health care**

The findings of the study revealed that the aged face a plethora of challenges in accessing health care. Some of the challenges that the researcher noted include financial challenges, health illiteracy, religious barriers, cultural beliefs and distance to health facilities.

**Distance**

The distance that the aged have to endure to access health care services is a major challenge for them. The respondents, when asked on some of the challenges they faced in accessing health care, all divulged that they had mobility challenges. This was made worse by the situation that the nearest clinic was over twenty kilometres away. This finding is supported by Nemet and Bailey (2000)’s view which augments that there is a crucial relationship between distance and utilisation of health care. One
respondent had this to say on the challenge of having to endure a long distance:

‘Kiriniki iripadyo nesu ndeye kuGokomere. Dai pari padyo taikwanisa kufamba netsoka nokuti pane makiromita ayo asi asingakodzeri kuti ndinge ndichinoonekwa nanaChiremba nguva dzose’.

Loosely translated to mean that; the nearest clinic for the respondent is located in Gokomere which is located several kilometres away. Thereby making it difficult for the respondent to travel there and seek medical attention.

Non-availability of Health Care Providers

The key informant noted that the local clinic had two qualified nurses and two nurse aids. Hence with such a shortage of staff they were overwhelmed by the great number of patients who flocked the clinic. She had this to say;

‘Basa rinotiwandira chaizvo ini neumwe wangu nguva zhinji nokuti ini navamwe nurse tinenge tichitarisirwa kubatsirwa varerwe vakawanda munharaunda ino apa tiri vashoma.’

This can be loosely translated to mean that: the participants has a lot work to do since she and her colleague are expected to attend to a great number of patients in the community of which they are short staffed.

Financial Challenges

Other participants revealed that they were constantly referred to private hospitals in town where they had to pay large sums of bills to receive medical treatment. Hence, they struggle to raise the required income to be able to be attended to by the nurses. One of the respondents in the researcher’s study had this to say on their failure to access health services;

‘Zvinondirwadza kuti handichakwanisi kunge ndichiongororwa nanaChiremba nemhaka yekushaya mari. Dai yanga isiri nyaya yekakura ndaimira mira pamwe ndaiwanawo dhora ndoonekwa nanaChiremba.’

This can be loosely translated to mean that: failure to access health care from doctors is a heart-rending experience. The respondent laments that had it not been for old age, the respondents would have tried to make some mechanisms to raise money and consult doctors. The study also revealed that women were the most affected by financial problems. Of the six elderly women who were interviewed, the majority (4) showed that lack of money was the lynchpin of the most problems that they faced in accessing health care. They revealed that during their earlier ages, rarely were they involved in any income generating initiatives. They owned none or no meaningful assets which they can rely
on to afford health care. This was due to the societal expectation that they were supposed to take care of children and be housewives. This actually supports Hossen (2010)’s argument that old women in Bangladesh are the most affected due to their economic marginalisation which limits their affordability to health care services. Their social and culturally defined roles are the reason why they do not own any means of production.

Health Illiteracy

From the focus group discussions that were conducted, the study established that the elderly suffer more from health ailments due to health illiteracy. This was identified in both situations where the elderly were not aware of current trends regarding health services initiatives and understanding basic health information, symptoms and safe health practices. Of the ten participants, the majority (7) concurred that they would only seek health services upon appearance of severe symptoms. This finding is in relation to Bourne et al (2010)’s cross sectional study in Jamaica which revealed that unlike the urban based elderly, the elderly in rural areas did not take any health preventive measures only seeking medical attention when they were ill. Hence, such a situation made the elderly more prone to shocks, hypertension and other pressing health ailments. Results from the interviews showed that the elderly also lacked health education which results in poor knowledge of health ailments. When asked about their health decisions and knowledge about health information, one of the respondents said;

‘Ndinongoenda kuchipatara kana ndaona kuti ndiri kuratidza kudzimbikana nemuviri zvakanyanya.’

This can be loosely translated to mean that; the respondent only visits and seek medical attention when symptoms become severe. These health decisions can be attributed to several factors among lack of health education which translates to poor self-management which jeopardises the health status of the aged.

Patient-Provider relationship

Findings from the focus group discussions revealed that the health workers’ attitudes were discriminatory in nature. Most of the respondents noted that the poor rapport they had with nurses was one of the reasons for not visiting the clinic for medical services. According to Davidson (2012), central to health uptake is a positive relationship that should exist between the health care provider and the patient. They posited that they were not treated with worthy and dignity as nurses tended to respond and treat the harshly by the nurses. Poor patient-provider
relationship is likely to see decrease in health uptake as the elderly are disrespected by the nurses. This view is augmented by Mahmud (2004) cited in Hossen (2010) who contended that older women in rural Bangladesh often complain of the treatment they get from nurses as they are treated as though they are people without their intelligence. One of the elderly had this say on the relationship they had with the nurses;

‘Chinonyanyotirwadza ndechekuti tikaenda kukiriniki kuti tinoongororwa tinozobvakatorwa sevanhu vasingafungi uyezve vanotitora sepwere’.

This can be loosely translated to mean that: The most painful situation is that the respondent is seen as people without any intelligence and treated as children.

Social Security
The fact that the majority of the respondents were not formally employed automatically ruled them out of pension schemes. The elderly respondents thereby revealed that they looked upon support from the government and the family which they however, revealed that it was not enough as they struggled to meet their health needs. The same view was echoed by the key informant who contended that the elderly among other vulnerable groups of people across the world with those in Zimbabwe receiving $20.00 a month. Hence, with the economic situation in Zimbabwe, it becomes a great challenge for the elderly to be able to take care of their needs at home and save some money for their health needs. He had this to say;

‘Mari inopihwa vanhu vakwegura kubva kuhurumende hainyatsokwani kuti vange vachinyatsochengeteda hutano hwavo sezvo mari iyi ichotarisirwa kuti ivachengetedze kudzimba kwavanogara’.

This can be loosely translated to mean that: the money the elderly receive from the government is not enough to ensure that the elderly take care of their health as the grant from is also expected to be helping them in their various households.

Quality of Health Services
The poor quality of health care services is one of the challenges faced by the elderly in accessing health care. The challenge of poor quality of health services revolves around the clinics which are poorly funded by the government, hence in the end such a scenario compromised the quality of health care provided. The majority of the respondents noted that the reason why they seldom seek health care was that they were not satisfied with the type of health care they were going to receive at their local clinic.
**Discussions**

Findings from the in-depth interviews revealed that modern health care services were available for the aged in Village 1 Sumerton. This included visiting health medical centres such as clinics and hospitals. The traditional health care services were also accessible which included consulting the traditional healers in the nearby villages, faith healers and other religious leaders of different churches. More so, women among other people with healthcare knowledge were also consulted in matters of health especially in the home based medicine system. These findings are in sync with Hossen (2010) who argued that there are basically three health care alternatives available for the elderly worldwide. The three components are namely the modern health system, the traditional and the home based medicine. These three systems interplay to make sure that the elderly have access to health care services.

The modern health care system has emerged as the most popular form of health care system across the world Khan (1986) cited in Hossen (2010). Community health workers, health assistants, nurses and doctors form part of the providers of these health care services. These operate at various medical centres. Hence, the elderly through payment of user fees get access to this form of health care system. The traditional medical system is mainly provided by traditional or faith healers and drug vendors. According to Hossen (2010) people in Bangladesh still seek the care of traditional healers to diagnose health problems. Faith healers also treat various illness with this possessors of religious knowledge greatly respected in the community. This has also emerged as a popular system due to the ability of the elderly to pay both in cash or kind.

Hossen (2010) opined that services in rural areas are also provided in the form of traditional home based medicine mainly in developed countries. Thus, there is no reliance on the modern and the traditional system. The neighbourhood simply manages it at household level. According to WHO (2013), historically women have been the major players in this system with rich knowledge. They would prepare various herbs to treat various illnesses together with the assistance of other villagers.

Chatts and Roberts (2010)’s study augment on the nexus between distance and utilisation of health care services. In Zambia the major challenge arises from the distance to the nearest healthcare service, hence the old people due to their decreased mobility are affected as they cannot walk to these health services. The
issue to health care services is also aggravated by the fact that the roads in rural areas are bad making navigation to health facilities a great challenge. The above finding is also validated by Adesiji et al (2012) whose study revealed that a great number of the aged were discouraged to search for health care services due to long distances they had to grapple with in their bid to access health care services. Nevertheless, distance affected the elderly to varying degrees. The study found that the magnitude of long distances was low in those who had money to travel to the clinic and the hospital in town. From the findings above, one can note that the distance one has to endure to get to the health services determines the health seeking ability of the elderly. The elderly revealed that they did not have any source of income which further compounded on the woes of the elderly as they cited that they had no money to travel to the health centres to get medication. Despite a minority of the participants noting that they were aware that user fees had been abolished, they noted that the government had to cater for their transport to the hospital as they could not walk to the health centres.

The study established that all the participants complained about the service they received from their local clinic which they described as erratic. The participants complained that the health services were non-existent as it was not located within their radius. The elderly’s plight was greatly aggravated by the fact that the clinic which they got medical services was plagued by lack of providers of health care services. All the participants expressed their displeasure with the local clinic as it was at most short staffed, hence the medical practitioners would not adequately attend to the patients. The findings of the study confirmed the findings by Aged and Community Services Australia (2005) which revealed that the health of the elderly in rural and remote is poor as there are no providers for people in need of specialist care and also limited staff members. This view is also confirmed by Allain et al (1997) whose study posit that there is high staff turnover in rural based health centres with only a few number of nurses ready to settle in rural areas. The elderly revealed that the nurses were ill-equipped to provide health care for those in need of specialist care. The staff would always refer them to hospitals and other medical centres in town much to their chagrin. This also contributed to decreased uptake of health care services as some participants noted that they were referred to another medical centre where they were charged exorbitant fees. The above
findings were a barrier in the bid for the aged to seek health care. Perceived barrier is a phenomenon in the Health Belief Model in which barriers may prevent engagement in the health promoting behaviour (Glanz et al, 2002). In this case, the shortage of staff and the number of patients seeking medical attention was incompatible which resulted in difficulties for the elderly in seeking health care. The respondents also noted that the failure of the local clinic to provide specialist care such as heart problems and back aches worked against them. There was a correlation between non-availability of health care providers and failure to access health services by the aged. However, despite the general consensus that lack of health care providers in rural areas resulted in massive health challenges for the aged, it did so with varying magnitudes. A minority of the study participants revealed that they experienced very little problems compared with their fellow participants. They credited this to their high income support they got from their children and family members that enabled them to access private practitioners. This view was supported by Nyanguru (2001) who noted that the care of the aged has not emerged as a policy issue due to the support for the elderly coming from the children and the extended family. Nevertheless, non-availability of health care providers affects the elderly respondents’ drive to seek health care services. It was noted that the elderly were hard done as most of them cited that they had no money to access health care services. The majority of the respondents revealed that they had challenges with lack of money to seek medical attention. The above challenge was founded by Siddhisena and Ratnayake (2009)’s study on the challenges that comes with longevity in Sri Lanka. The study exposed that the elderly suffer most as they cannot afford hospital bills due lack of adequate health care insurance. A small number of the respondents (3) confirmed that they were aware that the elderly were entitled to free medication. However, they were turned away by the health care practitioners at their local clinic who demanded user fees to meet the clinic’s day to day expenses living the elderly with no option but to pay for health services. Other respondents revealed that they were constantly referred to private hospitals in town where they had to pay large sums of bills to receive medical treatment. Hence, they struggle to raise the required income to be able to be attended to by the nurses. The study also observed that, the elderly are also affected as they are not aware of
any current health information. Findings of the study revealed that they are not aware that user fees for those aged sixty years and above had been abolished. This culminated in low use of health services as the elderly complained of user fees as the major barrier stopping them from accessing health care. Hence, the reason why there is low utilisation of health care services. This actually supports Chatts and Roberts (2010) whose study in Zambia confirmed that seventeen percent of the elderly respondents were not aware that user fees had been abolished whilst a further two percent not aware that the clinic had been moved. Such a situation has proved to be a major barrier in the elderly’s bid to access health care services. Few respondents noted that the patient-provider relationship is exacerbated by lack of culturally competent health workers. The elderly respondents felt that the nurses did not consider their unique cultural practices. Hence, in such a scenario they had developed a sense of mistrust with these health care professionals. For example, some respondents revealed that it was part of their habit to supplement western medicine by also consulting locally available traditional and faith healers. This practice was however discouraged by the nurses as the respondents revealed that the practice was viewed as absurd. This gives credence to Davidson (2012)’s study which demonstrated that the most serious challenge affecting the elderly in rural areas in Mississippi America lies in lack of culturally competent health workers. Therefore, one can note that lack of culturally competent health workers is a major challenge for the elderly in meeting their health needs.

The study found that the lack of a comprehensive social security system had jeopardized the health situation of the elderly. Most of the participants noted that, their situation in accessing health care had been endangered as they felt that the government had made no commitment towards their health situation as they had little or no resources to access health care services. The participants confided that despite the recent government initiative to abolish user fees for those aged sixty and above, they were always referred to private hospitals where they had to pay for the health services. The majority of rural elderly revealed that they look upon cash transfers in form of remittances from their children and grand children to be able to help them in meeting their health needs. However, there are lot of inconsistencies as rural elderly did not regularly benefit from their children due to factors such as high unemployment rates. The extended
family setup is also part of the social security system of the aged. The elderly concurred that they rarely received support from the family. With this support system no longer reliable it leaves the health situation of the elderly at jeopardy as they can no longer meet their unique health needs. The elderly are also disadvantaged as they did not have adequate medical cover such as medical aids due to regulations governing health insurance. It was further noted that they were turned away by most medical aid societies which revealed that they do not cater for applicants over sixty years. This view confirms findings by Muchetu (2014) who augments that applicants above the age sixty are considered a huge risk susceptible to illness by most medical aid societies thereby they do not accept them. The majority of the elderly in rural area noted that seeking health care from their local clinic was a major challenge for the elderly as they were at most referred to private hospitals and other medical centres in town. It was confirmed that the clinic continuously ran out of medicine. Therefore they had to either stay at home or visit far away medical centres. The clinic also dealt with minor illnesses, hence the elderly who required services for cataract, physiotherapy, heart conditions among other diseases were constantly referred to specialist services in the central business district. This was confirmed by the key informant (a nurse at the local clinic) who argued that the clinic ran out medical supply most times due to the unreliable supply from the government and the Ministry of health. The local clinic only had two nurses which also slowed down service delivery as they were overwhelmed by the high number of patients. It is therefore was difficult for the aged to visit other clinics and hospitals as they were far from their reach. The above finding is supported by WHO (2013) in which their study in South Africa revealed that unlike the urban elderly, the aged in rural areas are affected by poor quality of health services. They are faced with lack of medicine, lack of health care providers and health workers skilled in specialist care. Poor quality of health care was seen as a major challenge in the elderly’s attempt to access health care.

Conclusion and recommendations
The study found a myriad of challenges that affect the elderly in their drive to access health care services. It exposed the ineffectiveness of the free health policy for those aged sixty years and above as the elderly are still required to pay for their health care services. The study also revealed that the plight of the aged is greatly compounded by the long distances
they have to endure to access healthcare services. Further to this are financial challenges that are prevalent amongst the aged. This is due to the fact that most of the elderly respondents are covered by various social security schemes, which were however found not to be strong enough in solving the elderly’s financial issues. In a nutshell, the study revealed the enormous task faced by the aged in as far as accessing health care services is concerned.

The study concludes that the support from the government in assisting the elderly to access health care must be reviewed and fully enforced, to take into consideration the challenges the elderly face when they are referred to private practitioners. The distance to healthcare services must be limited through government decentralizing health centres. On the other hand there is need to improve health service delivery in rural areas as it affects the aged in accessing healthcare.

From the study, distance to the health centres was found to be very far. Thus there is need for the government and other health provider stakeholders to intensify the decentralisation of health care centres such as clinics and hospitals. This will shorten the distance the elderly have to endure to access healthcare services. Based on the results from the study, there is need for awareness campaigns that will target the elderly on current health trends and health policies. Such a scenario will allow the elderly to increase their health uptake as lack of health information is one of their major problems. There is a need for policy makers to revisit the current free health policy for those aged sixty and above. The policy does not cover the aged when they are referred to private hospitals. Due to the sophisticated nature of their health problems, the elderly are at most required to attend private hospitals as most government institutions do not cover them. There is need for improved financial support, machinery supply and medicine supply on rural based health centres. These health centres are poorly funded which makes the quality of health care provided poor. The health centres also constantly run out medicine supply and the clinic is also unable to provide specialist care treatment. The government should come up with initiatives to attract health professionals to rural areas as the rural based centres are at most affected by high staff turnover. The few staff members are overwhelmed, hence poor service delivery on the high number of patients.

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