African Journal of Disability
ISSN: (Online) 2226-7220, (Print) 2223-9170

Exploring challenges experienced by older persons in accessing health services in Malawi

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Dates:
Received: 27 Mar. 2025
Accepted: 21 July 2025
Published: 30 Nov. 2025

Background: Malawi, like other developing countries, is not prepared to adequately address the health needs of older persons.

Objectives: This article explores challenges older persons experience in accessing health care.

Method: This article is based on data from two large. Conducted in Blantyre, Phalombe, Dowa and Rumphi Districts, the EquitAble study examined self-reported barriers. The GeoHealthAccess study examined geographical barriers, conducted in Blantyre and Phalombe. A sub-sample of 338 (17%) older persons of the 1991 respondents in the EquitAble study is used in this article. Respondents were asked to identify factors that made it difficult for them to access health care. Sixty-six in-depth interviews and two focus group discussions with older persons were conducted to obtain in-depth information about barriers to accessing health care.

Results: Barriers experienced by older persons in accessing health care included being unable to pay to for services at fee paying health facilities; failure to pay for transportation; long distances to health centres; mountainous terrains; having severe rheumatism; living alone; poor attitudes of health workers; and shortage of staff, medicines and equipment.

Conclusion: To address these challenges, there is need to have adequate health workers with knowledge of diseases and conditions experienced by older persons and the introduction of outreach health services targeting them.

Contribution: Poverty at individual level and health system factors are major barriers to accessing health care by older persons. There is a need for the development and implementation of strategies to better improve access for older persons.

Keywords: Malawi; older persons; health care access; challenges; barriers; disability; poverty.

Introduction

Ageing is a global phenomenon that requires countries to address the health and care needs of older people, defined as persons 60+ years-old (UN 2022). This is a particular challenge for low- and middle-income countries (LMICs) struggling with lack of resources, insufficient and fragile health and care services (Fanelli et al. 2020). To build sustainable health and care systems in LMICs, data and knowledge are needed to ensure that the needs of older persons in LMICs are met in ways that are adapted to context and not mere copies of existing health and care systems in other parts of the world (Goodman-Palmer et al. 2023). Understanding older people's needs and utilisation of health care is one important factor within this knowledge need. The ambition of this article is to contribute to building knowledge on challenges older people face in seeking health care in Malawi, building on comprehensive cross-disciplinary research on access to health care in the country.

The rapid increase in the population of healthy older people contributes to communities in many ways; for example, they can be employed or they can be involved in volunteer work (Rowe & Fried 2019). Families with older people also benefit through financial support and being assisted with household chores, such as childcare (UNDESA 2017). While such contributions to society by older people are appreciated, the major challenge is that nearly all countries, regardless of their socio-economic status, are poorly prepared to effectively meet the increased health care needs of older people (HelpAge International 2017; Rowe & Fried 2019).

How to cite this article: Munthali, A., Eide, A., Braathen, S.H., Mvula, P.M., MacLachlan, M. & Mannan, H., 2025, 'Exploring challenges experienced by older persons in accessing health services in Malawi', *African Journal of Disability* 14(0), a1712. https://doi.org/10.4102/ajod.v14i0.1712

Note: The manuscript is a contribution to the themed collection titled 'Growing disability studies on the African continent: The career contribution of Prof. Leslie Swartz' under the expert guidance of guest editors Prof. Brian Watermeyer and Prof. Lieketseng Ned.

In developing countries, including Malawi, the general population already experiences various challenges in accessing health services, including the critical shortage of health workers, inadequate funding, shortage of medicines and equipment and long distances to health facilities (Chukwudi et al. 2015; Government of Malawi 2017). Long waiting times also characterise public health facilities with patients waiting for their turn to see the health provider. This is particularly challenging for older persons (Hillbrom 2016). In general, older people experience a wide range of health problems, often resulting from chronic illnesses, with symptoms such as back and neck pain. While older people have equal rights to access health services for the health problems they experience, it has been observed that they use health services less frequently compared to younger people (World Health Organization [WHO] 2016).

There is an urgent need to effectively plan how health needs of older people can best be addressed in Africa's health systems. The challenge, as argued by Chukwudi et al. (2015), is that in Sub-Saharan Africa the availability and utilisation of health services among older people is poorly reported, and existing health management information systems do not report access to health services by age. It is only in 2015 that Malawi started paying greater attention to older persons with the development of the National Policy for Older Persons (MoGCDSW 2015). The vision for the current Health Sector Strategic Plan (HSSP) for Malawi 2023–2030 is to achieve a state of health for all the people of Malawi [regardless of age] that would enable them to lead good and productive life (Ministry of Health 2023). Malawi's HSSP therefore takes on board the Sustainable Development Goals, especially Goal 3 – *Ensure healthy lives and promote wellbeing for all ages*. While the HSSP targets all persons regardless of age, there are no specific interventions in the HSSP targeting older persons.

This article explores the challenges that older persons in Malawi experience in accessing health services. There are a few studies that have been conducted among older persons in Malawi, but these have not focused on access to health services. This article is based on data from two large studies, namely the Equitable Project and the GeoHealthAccess Project, where qualitative and quantitative data were collected over the period 2009–2017. The overall objective of both projects was to explore the challenges that vulnerable populations, including older persons, experience when accessing health care.

This article has been written in honour of Prof. Leslie Swartz, who played a very important role in both the Equitable and the GeoHealthAccess studies upon which the article is based. In the Equitable Study, Prof. Swartz was part of the team that conceptualised and developed the proposal, and after funding was obtained, he provided overall leadership of the qualitative component, including the training of research assistants and supporting country teams in Malawi, Namibia, South Africa and Sudan. He also supervised students, notably those who completed their PhDs using Equitable data. Thereafter, Prof. Swartz supported country teams on the EquitAble study to draft and finalise manuscripts, which were eventually published, ensuring that the data reach those who need it. Besides this, in the GeoHealthAccess study, he was part of the project's advisory board and contributed to the development of the qualitative methodology. We would like to thank Prof. Leslie Swartz for his overall contribution to the field of disability studies research and, most importantly, for our collaboration and friendship with him over the past several decades.

Research methods and design

Context

Malawi is divided into three regions: northern, central and southern. Across the regions, four districts were chosen for the EquitAble Project: Blantyre and Phalombe Districts in the southern region, Ntchisi in the central region and Rumphi in the northern region. Blantyre is an urban area and the commercial capital of Malawi with a projected population of 1 406 236 people in 2024 (National Statistical Office 2017). The poverty rate for Blantyre is estimated at 40%. Phalombe is a relatively poor district where 64.5% are poor. It has a projected population of 502 825 people in 2024 and is one of the districts with a very high population density at 225 persons per km^2. Phalombe is mostly inhabited by the Lomwe people. Ntchisi has a population of 376 921; 41.4% of the people are poor and it is mostly inhabited by the Chewa people. Rumphi's population is estimated at 259 391 and 37.3% of the people in this district are poor. The Tumbuka people are mostly found in Rumphi. Rumphi, Ntchisi and Phalombe are mostly rural areas, and their main source of livelihood is subsistence agriculture. These districts were chosen taking into consideration the cultural diversity prevailing in Malawi.

In each district, the District Health Office was the point of entry. Within each district, two health facilities were chosen: one belonged to the Ministry of Health, while the other belonged to the Christian Health Association in Malawi (CHAM), a network of health facilities owned by churches. The Ministry of Health provides free health services in its health facilities, while CHAM charges user fees. There is no overlap in the catchment areas of CHAM and Ministry of Health facilities. In order to ensure that the payment of user fees does not constitute a barrier to accessing health services, the Ministry of Health has established Service Level Agreements (SLAs), which have been signed between District Health Offices and CHAM facilities (Ministry of Health 2011). The SLAs aim at removing financial barriers in accessing health facilities, especially among the Malawian poor (MoH [MSPA] 2014).

Eight health facilities were selected with the help of the District Health Offices as follows: Nthenje and Lura Health Centres in Rumphi, Mkhuzi and Khuwi Health Centres in Ntchisi, Chitekesa and Mwanga Health Centre in Phalombe and Chileka Seventh Day Adventist (SDA) Hospital and Chimembe Health Centre in Blantyre (Swartz et al. 2011). During the GeoHealthAccess study, two facilities where the

EquitAble study was implemented, namely Chimembe in Blantyre and Chitekesa in Phalombe, were selected. Data were collected in the catchment areas of these health facilities.

Study design

The EquitAble Study had three components, namely policy analysis using the EquiFrame, a comprehensive qualitative study and a large household survey. This article uses data from the qualitative and quantitative components of the EquitAble Study.

A total of 244 IDIs were conducted in the EquitAble Study: 81 were carried out in Blantyre, 63 in Phalombe, 50 in Ntchisi and another 50 in Rumphi. More females (142) were interviewed than males (102). These IDIs were performed with a wide range of informants, namely users of health services, non-users of health services and providers of health services (Munthali et al. 2019). Of the 244 IDIs, 66 were conducted with older men and women whereof 45 were with females, and 21 with males. Table 1 summarises the IDIs that were conducted in the EquitAble study with older persons aged 60-years-old and above.

During these IDIs, older persons were asked whether they accessed health care in the same way as everyone else in their family or community, the factors that made it difficult for them to access health care and whether they experienced these factors.[1] In the GeoHealthAccess study, two districts and two health facilities from the EquitAble sample were selected for further in-depth explorations through focus group discussions (FGDs), of which two FGDs were carried out, one with older women and the other with older men.

The quantitative component of the EquitAble Project involved a survey in the catchment areas of the eight sampled health facilities. Ten research assistants, comprising six females and four males, were recruited and trained for 6 days. Four of the research assistants were persons with disabilities. In each catchment area of the eight health facilities, five enumeration areas (EAs) were randomly selected, and a listing of households was conducted. In each EA, the household listing involved screening for activity limitations using the Washington Group on Disability Statistics' six questions on activity limitations, followed by a random selection of households. In each EA, 40 case households and 10 non-case households were randomly sampled. Case households were those with members with disability, while controls were households without members with disability. Three questionnaires were administered: one was for the household, and then the second one was for the individual with a disability and a control in the household who did not have a disability. For this article, we looked at one question that was contained in both the individual or case and control questionnaires:

1.Prof. Leslie Swartz who played a very important role in both studies upon which this article is based. In the EquitAble Study, he provided overall leadership of the qualitative component, including the training of research assistants in Malawi. In GeoHealthAccess, he formed part of the project's advisory board and specifically contributed to the design of the qualitative study.

TABLE 1: Older persons interviewed in the EquitAble study.

District	Number of older men	Number of older women	Total interviewed
Blantyre	9	24	33
Nchisi	3	3	6
Phalombe	6	17	23
Rumphi	3	1	4
Total	**21**	**45**	**66**

> Considering your own experience, tell me whether the following make it difficult for you to get health care [*Refer to Table 2 for responses*]: [*Read out the alternatives, and show card. Circle only one code for each row*]. (Van Rooy 2018)

A total of 1991 respondents participated in the survey: 16.8% (338) of these respondents were aged 60 or more. Just more than half of the respondents (53.9%) were older persons with disabilities, while the rest (46.1%) were without disabilities. Scheppers et al. (2006) performed a study among ethnic minorities and classified the barriers they experience in accessing health care into three levels: (1) patient level, where factors related to patient characteristics such as sex, ethnicity and income play a role; (2) provider level, where factors such as sex, skills and attitudes of the provider play a role; and (3) system level, where characteristics such as policy, organisational and structural factors play a role (Scheppers et al. 2006). This framework will be used because when barriers experienced by older persons in Malawi are analysed, one finds that they are similar to those found by Scheppers et al. (2006).

Ethical considerations

Both studies were approved by the National Health Sciences Research Committee, a local institutional review board whose secretariat is in Malawi's Ministry of Health. The equitable study was approved on 06 January 2009 by the National Health Sciences Research Committee, an ethics committee whose secretariat is in Malawi's Ministry of Health, with ethical clearance number 09/01/1011. The GeoHealthAccess study was approved on 01 November 2017 by the National Committee for Research in the Social Sciences and Humanities of the National Commission for Science and Technology with Ethical clearance number P10/17/217. All the study participants provided consent before the interviews were conducted. Participation in this study was voluntary: participants were told about the purpose of the study, and while their participation was important, they were also informed that they were free to withdraw at any time.

Results

The results in this article will be presented using Scheppers et al.'s framework.

Barriers to accessing health care among older persons

This study found that most older persons suffered from general body and joint pains, which made it difficult for them to perform activities, including walking to health

TABLE 2: Barriers included in the EquitAble survey.

Options		The extent to which this is a problem				
		No problem	Small problem	Moderate problem	Serious problem	Insurmountable problem
a	Lack of transport from home to health facility	1	2	3	4	5
b	No services available	1	2	3	4	5
c	Physical access to facility	1	2	3	4	5
d	Because of faith/belief	1	2	3	4	5
e	Negative attitudes among health workers	1	2	3	4	5
f	There is no accommodation at the health facility	1	2	3	4	5
g	Communication with health workers	1	2	3	4	5
h	Standard of the health facility	1	2	3	4	5
i	The journey to the health care is dangerous	1	2	3	4	5
j	You did not know where to go	1	2	3	4	5
k	Could not afford the cost of the visit	1	2	3	4	5
l	Don't have the necessary document (health card passport)	1	2	3	4	5
m	You thought you were not sick enough	1	2	3	4	5
n	You tried but were denied health care	1	2	3	4	5
o	The health care provider's drugs or equipment were inadequate	1	2	3	4	5
p	Could not take time off work or had other commitments	1	2	3	4	5
q	You were previously badly treated	1	2	3	4	5
r	Could not afford the cost of transport	1	2	3	4	5
s	Other (specify)	1	2	3	4	5

Source: Adapted from Vergunst, R., 2016, 'Access to health care for persons with disabilities in rural Madwaleni, Eastern Cape, South Africa', PhD thesis, Faculty of Arts and Social Sciences, Stellenbosch University; Van Rooy, G., 2018, 'Equitable access to healthcare services for people with disability in the regions of Khomas and Kunene', PhD dissertation, University of Namibia

facilities for health care. Some older persons reported accessing health care in the same way as other people:

> 'I access health care the same way as everyone else in the family and as everyone in the community.' (62-years-old, female, with mental illness, Blantyre)

However, most older persons reported that they experienced some challenges in accessing health care. We discuss the barriers that older persons experience when accessing health care according to Scheppers et al.'s (2006) classification.

Patient -level factors

Patient-level factors that presented barriers for older people to access health care included being poor, long distances to health facilities, not being able to sit on a bicycle, living alone, not being sick enough and incompatibility with modern medicines.

Being poor

Most older people reported that they were poor; hence, they could not access health services at a facility belonging to CHAM, as such facilities charge user fees, unlike public facilities where services are provided free of charge:

> 'When someone is sick and does not have money that means he cannot access health care services because the nearest [*health facility*] is a CHAM facility where patients can only access services after they have paid for them.' (64-year-old, male, Blantyre)

This made some older persons, for example, a 61-year-old informant to just purchase medicines from local shops, and this was cheaper than seeking care at a CHAM facility. It is not only older persons who have problems paying for health care at the CHAM facilities, there are many people who experience this problem:

> 'Most people in the area are poor and this affects their lives more especially the people with disabilities when they don't have money and are sick, it is hard for them to hire a car or oxcart to and from the facility.' (88-years-old, male, visual impairment, Blantyre)

Public health facilities in Malawi also refer patients to CHAM facilities for further treatment. For example, older people reported that patients at Lura Heath Centre in Rumphi are referred to Livingstonia Mission Hospital, which is a CHAM facility and situated very far. Lura Health Centre does not provide an ambulance to take people to Livingstonia Mission Hospital: Livingstonia Mission Hospital provides ambulance services at MK5000 to transport a patient from Lura Health Centre to Livingstonia Mission Hospital. Many people cannot afford to pay this for transport. Table 3 [Line 11] shows that 56% of older people without a disability mentioned that the cost of the visit to the health facility was not a problem for them to access health services. However, a much lower proportion of older persons with disabilities, at 49%, reported that the cost of the visit was not a problem. Table 3 [Line 18] also shows that 39% of older people with a disability and 30% of older people without a disability experienced problems affording transport costs. Among older people with disabilities, 32.8% and 21.7% had serious or surmountable problems with the cost for accessing health care and transport cost, respectively. Corresponding figures for people without disability were 16.5% and 8.8%.

Every patient is supposed to have a health passport where a doctor or medical assistant will record the diagnosis and treatment that has been given. This health passport is sold in public health facilities. Some older persons reported that because they were poor, they could not afford to purchase a health passport; hence, they were sent back to look for money and buy a health passport:

TABLE 3: Factors that make it a problem for older persons to get health care (N = 338).

Number	Question†	Older persons without disability (N = 158)						Older persons with disability (N = 180)					
		No problem	Small problem	Moderate problem	Serious problem	Insurmountable problem	Total	No problem	Small problem	Moderate problem	Serious problem	Insurmountable problem	Total
1	Lack of transport from home to facility	42.4	11.4	10.8	30.4	5.1	100.0	30.0	7.8	12.8	38.9	10.6	100.0
2	No services available	41.1	15.8	14.6	25.3	5.1	100.0	31.1	16.7	16.1	33.3	2.8	100.0
3	Physical access to facility	71.5	13.9	7.0	7.6	3.2	100.0	64.4	10.0	11.1	13.3	1.1	100.0
4	Because of faith	89.9	5.7	1.9	2.5	0.0	100.0	95.0	1.1	3.3	0.6	0.0	100.0
5	Negative attitudes of health workers	60.1	11.4	12.0	15.2	0.0	100.0	58.9	7.8	16.7	14.4	2.2	100.0
6	No accommodation at facility	82.9	6.3	3.2	7.6	1.3	100.0	84.4	4.4	4.4	5.6	1.1	100.0
7	Communication with health workers	84.2	8.2	2.5	4.4	0.0	100.0	83.3	6.1	4.4	4.4	1.7	100.0
8	Standard of the health facility	90.5	7.0	0.6	1.9	0.6	100.0	90.0	4.4	3.3	2.2	0.0	100.0
9	Journey dangerous	77.8	8.9	5.1	8.2	0.0	100.0	73.3	6.7	10.0	10.0	0.0	100.0
10	Not knowing where to go	91.1	4.4	1.9	2.5	0.0	100.0	94.4	1.7	1.7	2.2	0.0	100.0
11	Could not afford the cost	55.7	10.8	12.7	16.5	0.0	100.0	49.4	6.7	11.1	25.0	7.8	100.0
12	Don't have the necessary documents	68.4	15.2	9.5	7.0	4.4	100.0	72.2	10.0	5.6	10.6	1.7	100.0
13	Not sick enough	74.7	12.7	8.9	3.8	0.0	100.0	73.9	13.3	8.9	3.9	0.0	100.0
14	Tried but denied health care access	82.9	7.0	5.9	3.2	0.0	100.0	78.9	6.1	8.3	5.6	1.1	100.0
15	Inadequate drugs or equipment	40.5	10.8	17.1	29.1	1.3	100.0	41.1	9.4	23.9	23.3	2.2	100.0
16	Could not get time off work	71.7	8.9	3.2	8.2	2.5	100.0	83.3	8.9	3.3	3.3	1.1	100.0
17	Previously badly treated	75.9	15.2	4.4	3.8	0.0	100.0	70.0	10.0	11.7	6.7	1.7	100.0
18	Could not afford transport cost	70.3	8.9	11.4	8.2	0.6	100.0	60.6	9.4	8.3	17.8	3.9	100.0
19	Other	98.7	0.6	0.6	0.0	1.3	100.0	97.2	1.1	0.6	1.1	0.0	100.0

†, Question: Considering your own experience, tell me whether the following make it difficult for you to get health care: would you say it is a problem, small problem, moderate problem, serious problem or insurmountable problem?

> 'Some time back I had malaria and I went to the health facility for treatment. I was asked to buy a health passport since I did not have one. I had no money to buy a health passport and was sent back to look for the money for the health passport before being given treatment so that the doctor should record the details. I tried pleading with the health worker who was sending me back but she refused and told me to go away and come back if only I buy the healthy booklet …' (70-year-old, female, no schooling, farmer, Phalombe)

The survey shows that there were slightly more older persons with a disability (72%) who reported that they had no problems with necessary or requisite documents than older persons without a disability at 68%. The necessary documents in this case meant having health passports. These results demonstrate that there is hardly any difference between older persons with and without disability.

Long distances to health facilities

Some older persons reported that they stayed very far from health facilities. These older persons found it difficult to walk to such distant health facilities during illness episodes because of numerous factors, including being disabled, experiencing a lot of pain because of conditions such as rheumatism and being weak because of old age:

> '… I am very old and have so many problems especially in walking. I cannot walk a long distance, I feel pain the whole body so when I am sick and with the long distance I cannot manage to walk so I just stay at home and find that another day I am able to wake up and life goes on like that. Sometimes when my grandchildren have money they buy tablets for me from the groceries and I get well – when they have no money I just stay at home.' (61-year-old, female, Phalombe)

A 90-year-old man in Blantyre reported that together with his wife, they do not access health services although the health facility is nearby because they are very old. In some catchment areas, for example, around Chimembe Health Centre in Blantyre, older people, including those with disabilities, reported that the place is hilly, and this made it very difficult for them to go for health care services. One 83-year-old female informant in Blantyre reported that older persons fail to access health care because of a lack of strength in their bodies and they cannot walk the 18 km distance to the facility to access health care. There is also no public transportation system in the area, which forces many older people to use locally available treatment options.

Some older persons reported that the long distances are exacerbated by the fact that transport is not provided for patients from the communities when they are going to health facilities. Table 3 [Line 1] shows that most older persons experienced the problem of transport from home to the health facility. Furthermore, among this sample of

elderly, more people with a disability (70%) than without a disability (59%) reported this. Almost half of older respondents (49.5%) reported serious or surmountable problems in getting transport, while this figure was down to 35.6% for people without disability. In some cases, older people resort to using traditional medicines during illness episodes because these can easily be found within the community and are cheap, instead of walking long distances to health facilities:

> '[*L*]ong walking distances make it difficult for a person to access health care. Because of old age, many older persons find it difficult to go to the health facility. Instead, they prefer using traditional medicines because they are cheaper and easy to find' (69-year-old, female, Nthenje Health Centre, Rumphi)

Not being able to sit on a bicycle

Bicycle is one of the common means of transport in the study sites. Those who do not have bicycles often use bicycle taxis. However, numerous older people reported that they were non-users of modern health care because they could not sit on the bicycle:

> 'Transport is also one of the major problems the health facility has. There is no transport to fetch people who have difficulties in walking from their areas to the hospital. The only means of transport which is common in the area is bicycle taxis but with my condition I cannot use it.' (80-year-old, female, informant, Blantyre)

> 'I have been experiencing body pains, but nobody escorts me to the hospital for healthcare services. The people around just buy for me some tablets from groceries because they cannot carry me on their back and on the bicycle because I have dizziness when on the bicycle so this makes it difficult for me to access healthcare services and for others to escort me to the hospital.' (70-year-old, female, blind, Phalombe)

While people, including relatives, may want to take older people to health facilities, their failure to sit on a bicycle carrier makes it difficult for them to access health care.

Living alone

Some older people lived alone. Many of them were not able to go to the health facility alone. The absence or unavailability of people who could take them to a health facility made it very difficult for them to access health care:

> 'There was a certain time when I had malaria and I failed to go to the hospital because there was nobody to cycle me to the facility and I just bought some panadols at the nearest market just to kill the pain.' (60-year-old, female, informant, Phalombe)

> 'I experience many problems … I have a financial problem, the health centre is very far about 15 km away and there is no one who can escort me to go to the health facility.' (90-year-old, female, Blantyre)

Some older persons could not travel to the health facility alone because of the disability they had. For example, a 70+ year old blind woman could not travel to the health facility alone without being escorted. Another 85-year-old woman in Phalombe reported that the health facility was very close, but she could not walk there because she suffered from severe rheumatism:

> 'The main problem is old age and lacking somebody to carry me to the health facility for the services. Rheumatism is the only problem that makes me to fail access the services because my legs pain me so much that I cannot manage walking to the facility besides being near. My eyes also have some problems and I am not able to see properly due to same old age.' (85-year-old, female, Phalombe)

One 64-year-old man with epilepsy in Phalombe reported that when he had seizures, people found him and took him to the health facility for help. He added that at one time, he fell on fire and his aunt found him still unconscious and shouted for help. His neighbours then took him to the hospital. He explained that although he stayed alone, he needed someone to escort him to the hospital because of his condition. While this 64-year-old man was helped by neighbours, there were others with disabilities who were not helped during illness episodes. A 73-year-old woman with mental illness in Blantyre reported that when she was sick, her relatives left her in the house and they failed to send her to the hospital claiming that they were tired of her.

Provider-level factors

Poor treatment of elderly persons by health workers

Poor attitudes of health workers towards older people were the major barrier at the level of service providers. In most cases health workers treat their patients in a friendly manner. However, some older persons in this study reported that some health workers did not treat them all that well. For example, an 80+-year-old woman in Phalombe reported that when elderly persons go to the hospital, they are treated in an unfavourable manner by health workers. As a result, some resort to traditional medicines during illness episodes instead of seeking care from the health workers. A woman older than 65 years (exact age not known) in Ntchisi reported that whenever she was sick, she did not go to Mkhuzi Health Centre, which is closer to her home village. She used the traditional medicines because of the attitude of the medical assistant, who she says is very rude in treating patients:

> 'Last year I suffered from malaria and went to Mkhuzi Health Centre to seek treatment. When I got into the medical assistant's office, I was disappointed to hear from the medical assistant that the medicines are for the youth not the elderly persons. Despite this, I received the treatment but I decided to stop going to the hospital since that time up to now, I do not go.' (65+ year-old, female, informant)

> 'There are so many obstacles that I face when seeking health care. I went to the facility another time when I had abdominal pains. When I explained the problem, the doctor said that *ndiukalamba umenewo* [*this is old age*]. I felt sorry for being discriminated.' (83-year-old, female, informant, Ntchisi)

> 'The minor obstacle [*I face*] is the behaviour of some health workers: they are rude and harsh, so the community is always not comfortable with such personnel. A few health workers at Chitekesa Health Centre are rude and harsh and this is the obstacle I face at Chitekesa.' (60-year-old, male, Phalombe)

There were also some older people who reported that some health workers are rude and harsh, and this is an obstacle not only for older people but for other population groups as well. Table 3 shows that 40% of the older people without a disability and 41% of the older people with a disability mentioned that they experienced negative attitudes from health workers, with 15% and 14%, respectively, reporting this as a serious problem. Table 3 further shows that 24.1% and 17.1% of elderly without disability and 30% and 21.1% of elderly with disability had experienced being previously badly treated or having tried but been denied health care access.

System-level factors

Shortage of staff

The problem of shortage of staff does not affect older persons only, it is a problem that affects all the patients. In this study, older persons reported that there was in general a shortage of staff in health facilities, and this was reported in all the four districts where the EquitAble study was conducted:

> 'There is shortage of staff. There are only two members of staff at Lura Health Centre who serve a large population of patients. This results into congestion at the facility.' (71-year-old, male informant, Lura Health Centre, Rumphi)

> 'There are not enough members of staff and this makes patients wait on the benches for long hours because a lot of patients seek health services from the facility but health workers are just few of them …' (64-year-old, male, with epilepsy, Phalombe)

A 70-year-old woman in Rumphi in the catchment area of Mzokoto Health Centre also reported that there is only one nurse and a medical assistant. She explained that sometimes the medical assistant goes to Rumphi District Hospital for a workshop: the nurse becomes very busy as she has to provide all the services. This makes the patients to take a long time to get the treatment. In some cases, the facility is closed; hence, the facility does not provide services. The non-availability of staff is one of the major problems experienced by older people, as can be seen in Table 3: 58.9% of the older people without a disability and 68.9% of the older people with a disability reported this as something that made it difficult for them to access health care.

Shortage of medicines

In all four districts, older persons reported that there was a shortage of medicines in the health facilities and this was especially in the public health facilities:

> 'Shortage of drugs at the facility make it difficult for a person to access health care because when one is suffering, he or she needs drugs to get cured and if there are no drugs, it means that a person may either die or continue suffering.' (70-year-old, hearing impaired, Ntchisi)

The shortage of medicines in public health facilities made some older people to think of accessing private health facilities where medicines are available:

> 'If only I had money, I could go to private clinics like Malamulo [*in Blantyre*] for treatment. This health centre [*here*] has inadequate drugs for several diseases. Most of the people whose financial status is good do access health care there but I am failing to access.' (90-year-old, male, Blantyre)

Many informants reported that there is a shortage of medicines in the facility. One 60-year-old man in Ntchisi reported that for him he does not experience a shortage of drugs because his medicine is always available. He reported that he was HIV+ and was on Antiretrovirals (ARVs), which are always available in the health facilities. At the community level, the Ministry of Health has deployed health surveillance assistants (HSAs) whose work is mainly preventive and promotive in nature. They also provide treatment for minor illnesses. An older person in Ntchisi reported that the HSA in her area used to provide medicines to her, but he was transferred, and hence she has problems accessing health care.

> 'I do not have any means of transport to get to the facility to access health care. I used to get formal medication from a nearby HSA when I got sick but since the HSA moved, it is very difficult for me to access health care again. I used to access medication for malaria. My access to healthcare is now very poor because I do not access medication anymore. I would like to go to the health facility whenever I get sick but I fail to do so due to transport constraints.' (77-year-old, female, informant, Ntchisi)

A 63-year-old female informant with a physical and mobility disability in Ntchisi further explained that as the facilities run out of medicines quite often, some patients do not even go to the facility when they learn from others that there are no drugs:

> 'Sometimes due to inadequate drugs, medical assistants give the same drug for may be three different kinds of diseases. For example, one may have a headache or a dry cough and someone may have a backache but due to shortage of essential drugs all these patients might receive Panadol. Hence, shortage of essential drugs at the facility makes it difficult for a person to access health care.' (63-year-old, female, mobility disability, Ntchisi)

Table 3 shows that inadequate drugs and/or equipment is one of the factors that made it difficult for older people to get health care: only 40.5% among older people without disability and 41.9% among older people with disability reported not experiencing the problem of inadequate drugs or equipment.

Discussion

This article demonstrates that poverty is at the core of the challenges experienced by older persons in accessing health care in Malawi. This manifests itself among the older persons and their households as well as at the country level, where the health system has challenges in addressing the health care needs. Older people experience challenges in accessing health care because of the cost associated with visits to the health facility during illness episodes. Most older people described themselves as poor; hence, they could not pay user

fees at CHAM facilities and could not afford the cost of transportation. World Health Organization (2016), HelpAge International (2017) and De Carvalho (2017) also found that older people have problems paying for costs of health care and for transport to health facilities. The cost of transportation is also exacerbated by long distances to health facilities; hence, many older people have problems walking long distances because of old age, disability and limited availability of public transport, especially in rural areas (HelpAge International 2017). It can also be argued that the cost of health care for older persons is exacerbated by the fact that they require someone to accompany them to visit the health facility, which implies that they need to pay for an extra person on transport, as well as negatively affecting the productivity of that extra person. Many older people also require health care more frequently than younger people and cost and distance make access to health care a huge challenge (HelpAge International 2017).

In terms of transport, while bicycles are a common form of transport, some older people found it difficult to sit on bicycle carriers. HelpAge International (2017) also reports that bicycles may not be appropriate for transporting people who are unwell, frail or have mobility problems. The implementation of outreach clinics has led to improved coverage or utilisation of immunisation services, among other health services. For example, in order to ensure that distance is not the reason for non-vaccination of children under five, Ministries of Health in the developing world conduct outreach clinics in order to reach children living in remote and hard-to-reach communities, and this has led to many children being vaccinated (Ashish et al. 2016; Munthali 2018). There is, however, limited availability of outreach services targeting older people (HelpAge International 2017) or people with disabilities, which constitutes one of the factors that make it difficult for older persons to access health services.

In Malawi, the catchment areas for CHAM facilities and public health facilities do not overlap as mentioned earlier; hence, as this study found, older people find it difficult to access services at CHAM facilities. The implementation of cash transfers in some countries has helped older people to access health services, as they use the cash they have received to pay for transport to get to health facilities, consultation fees and treatment costs, health insurance and prescriptions (HelpAge International 2017). The lack of health insurance for older people has also been identified as a challenge that makes it difficult for this population group to access health care (FAO & BSF 2007). The 2015/2016 Malawi Demographic and Health Survey found that there is low coverage of health insurance in the general population in Malawi, with 99% and 98% of the women and men aged 15–49-years-old, respectively, reporting not having health insurance (National Statistical Office 2017).

Numerous other studies in Malawi (Jafry et al. 2016; Mtonga et al. 2022; Ritter et al. 2022) have also found that there are long queues in public health facilities; hence, long waiting times. This was also reported in this study. Knight, Schatz and Mukumbang (2018) further reported that older people generally complain of tiredness, pain and hunger because of walking for a very long time or because of long waiting times at the health facility. While this problem is not unique to older people, it has been argued that this can be especially challenging for older people with physical or mobility challenges (Kelly, Mrengqwa & Geffen 2019; WHO 2004, 2016) and is exacerbated by non-prioritisation of older people in the delivery of health services (Kelly et al. 2019).

This study has shown that some health workers have poor attitudes towards older people, including telling them that medicines are for younger people. Such attitudes discourage older people from accessing health services. This finding is similar to studies conducted elsewhere (HelpAge International 2017; Kelly et al. 2019; WHO 2004) where poor attitudes of health workers characterised by disinterest, rudeness and aggression negatively impacted access to health care services by older people. The humiliating experience of older people when they are seeking health care might be because of a lack of appropriately trained health workers (HelpAge International 2017; WHO 2004).

Older people may also require that they are accompanied when going to health facilities. The lack or absence of someone to accompany them tends to compromise seeking health care. Older people, especially those who were blind, have arthritis or have other mobility challenges, said that they could not travel on their own without an assistant. HelpAge International (2017) further argues that the costs of transportation can be quite high, especially for older persons who require that someone accompany them to the health facility. These results generally demonstrate that more older persons with disabilities face barriers to accessing health care compared to those without disabilities, which is a great concern as they in general need more healthcare than persons without disability.

Currently, there are no special services available for older persons in Malawi's health sector. The Health Sector Strategic Plan 2022–2030 does not provide for special services or sections in the hospital for older persons. However, the National Policy on Older Persons in Malawi is committed to establishing older-person-friendly health services and lobbying for the inclusion of health services targeting older persons (MoGCDSW 2015; Nyasa, Mwakikunga & Chisati 2019). The 2024–2025 Strategic Plan for the Malawi Network of Older Persons Organization (MANEPO) also aims at promoting age friendly health services in Malawi and identifies two strategies aimed at improving access to health care by older persons. These are the sensitisation of health workers on the health rights of older persons and the provision of mobile health services targeting older people (MANEPO 2024). While the National Health Sector Strategic Plan 2022–2030 does not specifically provide for specific services for older persons, the availability of HSA (Community Health Worker), the lowest

cadre in Malawi's health sector based at community level, provides the potential for this cadre to provide services to older persons residing in communities, especially those who cannot walk to health facilities. However, this cadre has not been tapped to strategically provide services to older persons (Nyasa et al. 2019).

Conclusion

This study has shown that older people experience a wide range of challenges in accessing health care services, and this is particularly the case with older persons with disabilities. These various barriers explain why many older persons do not seek treatment or they delay in seeking care. There is an urgent need to address the problems faced by older persons while seeking health care. Older people will resort to using herbal medicines because of barriers they experience in accessing health care at health facilities (Hillbrom 2016). In order to address these challenges, as argued by Rowe and Fried (2019), there is a need for not only having adequate numbers of health workers but also ensuring that they have competencies in dealing with diseases and conditions experienced by older people. Because most older people have mobility challenges because of old age and they are poor, there is an urgent need to develop *community-based health and social services targeting older people* (Rowe & Fried 2019). These services should not be discriminatory of age and should be close to where older people live (De Carvalho 2017). There is therefore a need to have a health system which should target the most vulnerable populations, including older people, not at the expense of other population groups, but to ensure health care is available for all, in the spirit of the SDG's vow to 'leave no one behind'.

Acknowledgements

Competing interests

The authors reported that they received funding from the Norwegian Research Council and the EU, which may be affected by the research reported in the enclosed publication. The author has disclosed those interests fully and has implemented an approved plan for managing any potential conflicts arising from their involvement. The terms of these funding arrangements have been reviewed and approved by the affiliated university in accordance with its policy on objectivity in research.

Authors' contributions

A.M. conceptualised and drafted the manuscript and contributed to formal analysis, conducted fieldwork, contributed to project administration for both Equitable and GeoHealthAccess and reviewed and edited the manuscript. A.E. contributed to the training of research assistants, data analysis, was the work package leader for the quantitative component of the Equitable Project, led the administration of the GeoHealthAccess project, reviewed and edited the manuscript and led the process of getting funding from the Norwegian Research Council. S.H.B. contributed to the training of research assistants, conducted fieldwork for the GeoHealthAccess study, contributed to the administration of the GeoHealthAccess study, reviewed and edited the manuscript and contributed to seeking funding for the GeoHealthAccess study. P.M.M. conducted fieldwork, contributed to formal analysis and reviewed and edited the manuscript. M.M. led the administration of the Equitable Project, contributed to formal analysis, reviewed and edited the manuscript, and led the process of applying for funding for the Equitable Project from the EU. H.M. was project manager for the Equitable Project, contributed to formal analysis, reviewed and edited the manuscript and trained research assistants for the Equitable Project.

Funding information

The GeoHealthAccess was funded by the Norwegian Research Council while the EquitAble study was funded by the EU.

Data availability

The datasets from the EquitAble study and GeoHealthAccess studies are not publicly available, but requests for the data can be made to the Principal Investigators, namely Prof. Malcolm MacLachlan and Prof. Arne Eide of Maynooth University and SINTEF, respectively.

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