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DEPARTMENT OF SUSTAINABLE DEVELOPMENT

A SOLUTION BASED ASSESSMENT OF THE BARRIERS TO HEALTHCARE ACCESS AMONG WOMEN IN BUHERA DISTRICT WARD 14

BY

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APPROVAL FORM

This research is suitable for presentation to Bindura University of Science Education. It has been checked for conformity with the department guidelines.

(Supervisor’s signature)

DECLARATION

I MUFARO MABIKA declares that this dissertation titled a solution based assessment of the barriers to healthcare access among women in ward 14 Buhera Rural, Zimbabwe is my original work and a result of my own investigation. All literature reviewed in the study was acknowledged and a reference list is provided.

Signed: …  Date: ……03/06/2025

DEDICATION

I dedicate this work to Buhera community and my family for the continuous support financially, spiritually and also through social guidance throughout the four year course at Bindura University. If it was not their support probably this could have not been achieved.

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First and foremost I would like to thank the Almighty God for giving me an opportunity and strength to pursue my education. I would also like to extend my appreciation to the Department of Sustainable Development together with my untiring supervisor, Mr. Gomo who was a generous source of knowledge and whose responses gave me direction and intellectual guidance. My warmest gratitude also goes to all the participants who took their time to share their views and realities hence informing the general picture of this study. To my family and friends, I say thank you for your unwavering support and encouragement that made me to complete this dissertation, may God bless you all.

ABSRACT

Ensuring equitable access to healthcare is a cornerstone of global development, yet women in rural parts of Zimbabwe, particularly in Buhera District Ward 14, continue to experience significant challenges in utilizing health services. This issue is critical, as limited access not only affects individual well-being but also undermines broader community health and development outcomes. Despite existing studies on healthcare access, there remains a lack of research that specifically focuses on context-based, solution-oriented analyses within rural districts like Buhera. Many existing assessments overlook localized dynamics and fail to offer actionable strategies grounded in the lived experiences of rural women. This study examined specific barriers women face in accessing healthcare and identifying feasible, community-driven interventions. A mixed-methods approach was adopted, combining quantitative data collected through questionnaires with qualitative insights from focus group discussions and interviews with key stakeholders, including healthcare workers, local leaders, and women from the community. Questionnaires, key informant interviews and focus group discussions were used to collect data from a sample of 66 people. Findings indicate that limited financial constraints, high travel costs, inadequate health infrastructure, long distances to health facilities, and cultural norms significantly restrict women's ability to seek timely healthcare. Secondly, the study also noted that delayed diagnosis, increased mortality rates and economic burdens among individual and family are among the impacts of poor access to health. The study offers evidence-based recommendations such as the introduction of mobile health clinics, women empowerment, investment in local health centers, and culturally tailored health education programs. These findings underscore the importance of designing health interventions that are both gender-responsive and context-specific, with implications for policymakers, NGOs, and community leaders seeking to improve rural health outcomes.

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CHAPTER 1: INTRODUCTION

1.1 Introduction

Healthcare is a very important aspect in human's life and much effort has been invested in searching for supportive systems and strategies to enhance the performance of health systems in low- and middle-income countries. Buhera District, located in Manicaland Province, Zimbabwe, faces significant challenges in ensuring equitable healthcare access for its population, particularly women. Disparities in healthcare access and utilization persist, compromising women's health outcomes and quality of life. This assessment seeks to identify and analyze the barriers hindering healthcare access for women in Buhera District ward 14, with a focus on developing practical solutions to address these challenges.

1.2 Background of the study

Internationally quality healthcare provision has been of great concern. Conferring to the WHO Framework for Health Systems (2022), quality health provision extends to a well-functioning health system that ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, adequacy and cost effectiveness or healthcare access to be regarded as successful all the building blocks must be available within communities. However, Globally, Women in rural areas across different regions face unique challenges in accessing healthcare, influenced by geographical, cultural, and socio-economic. This significant challenges are often due to a combination of factors, including the location of healthcare facilities, societal norms that prioritize men's health needs, and the lack of transportation options. The longer distances can lead to delays in receiving care, which is particularly critical for maternal and reproductive health services (WHO 2020).

A study by Bloch (2020) shows that, In South Asia, 57% of rural women lack access to healthcare due to gender-based restrictions. These restrictions can emerge from cultural and religious norms that hinders women's mobility and their power in decision making regarding their health. Many women may acquires permission from their husbands and male family members to seek medical care, which can delay or prevent access to necessary services (UN WOMEN, 2020). In Latin America, 40% of indigenous women face significant challenges and cultural barriers when

accessing healthcare (PAHO 2019). These challenges includes lack of culturally competent care, where healthcare givers may not understand or respect indigenous practices and beliefs.

In the African context, Healthcare access for women in Sub-Saharan Africa is significantly affected by geographical constraints, with 57% of women lacking access to healthcare services due to these barriers (WHO 2020). This statistic shows the critical impact of location on women's health outcomes in the region. These barriers include distance to healthcare facilities and inadequate transportation. Many women lives in rural areas where there is limited health provisions and health facilities are located a distant away from people. This distance can hinder women from seeking important medical care, especially in emergencies hence inadequate transportation exacerbates the problem. Lack of reliable means of transport to reach healthcare facilities is also another challenge faced by women, leading to delays in receiving care. The lack of access to healthcare due to geographical constraints has serious implications for women's health in Sub-Saharan Africa which leads to higher rates of maternal and infant mortality, increased prevalence of untreated diseases, and overall poorer health outcomes, hence addressing these geographical barriers is crucial for improving healthcare access and ensuring that women receive the care they need.

Turning to Zimbabwe, women are facing many barriers which are hindering them from accessing healthcare. Women travel long distances to reach healthcare facilities, For instance, a woman living in a remote village like Buhera may need to walk over 10 kilometers to access the nearest clinic. This distance can be very challenging especially during pregnancy or emergencies, leading to delays in receiving critical care. A significant study by WHO found out that approximately 60% of rural women reported that the distance to healthcare facilities was a major challenge in accessing care, particularly for maternal health services (WHO, 2020). According to a national health survey, over 40% of women cited financial constraints as a primary barrier for not seeking healthcare (World Bank, 2020). Additionally, 30% of women reported that they could not afford transportation to healthcare facilities hence showing that even if medical bills became free, there are also indirect costs which can also hinder women from accessing health.

More so, in some communities in Zimbabwe, traditional and religious beliefs are discouraging women from seeking formal medical care. Research noted that about 25% of women in certain regions avoid seeking healthcare due to cultural stigma and circumstances surrounding

reproductive health issues (UNICEF 2020). Poor healthcare System in Zimbabwe also hinders women in accessing healthcare. WFP (2020) further argued that the healthcare system in Zimbabwe often suffers from shortages of medical supplies and trained health personnel, for instance, a woman may arrive at a clinic only to find that essential medications or equipment are unavailable, forcing her to seek care elsewhere or delay treatment. A qualitative study found that, in Zimbabwe over 50% of healthcare providers identified the lack of essential medical supplies and inadequate infrastructure as significant barriers to providing quality care. This highlights the urgent need for systemic improvements in healthcare delivery to ensure that women receive the care they need.

However, there are some research gaps among this topic, most researchers are focusing primarily on economic and infrastructure barriers neglecting the role of socio-cultural factors which hinders women in accessing healthcare. Researchers are also mainly focusing on adult women, leaving a gap for research on the specific healthcare access challenges faced by adolescent girls in Buhera. The research will therefore aim to investigate more on the challenges being faced by rural women in accessing healthcare.

1.3 Problem Statement

Women in Buhera are facing challenges in accessing healthcare services, **t**hese barriers contributes to poor health outcomes which includes high maternal mortality rates and limited access to essential reproductive health services. While Zimbabwe ministry of health and child care advocates for women to give birth in health facilities, the reality in rural areas like Buhera presents a different picture. There are several barriers affecting women in accessing healthcare which includes geographical inaccessibility, financial constraints, shortage of healthcare workers and many others. Chirwa (2021) also noted that high mortality rates are also the order of the day in rural Zimbabwe as women end up giving birth in their homes, as well as consulting midwives. It also continues to be a challenge due to weak healthcare system in Zimbabwe which lakes funding, staffing and poor resource allocation, therefore this research aims to investigate the challenges faced by women in ward 14 Buhera in accessing healthcare, evaluating the impacts of these barriers and suggest possible strategies that can be adopted to improve healthcare provision for women.

1.4 Research Aim

The main aim of this project is to assess the barriers to healthcare access among women in Zimbabwe, and develop actionable solutions that can enhance their access to essential health services.

1.4.1 Research objectives

i. To examine factors that obstruct rural women from accessing healthcare facilities in Buhera District ward 14.

ii. To assess the impact of poor access to healthcare facilities by women in Ward 14, Buhera District.

iii. To evaluate strategies that can be adopted to improve healthcare provision for women in Buhera Rural District

1.5 Research questions

I. What are the factors obstructing rural women from accessing health care facilities in Buhera, District, Ward 14?

II. What are the impact of poor access to healthcare facilities to women in ward 14

III. What are the strategies that can be given towards ensuring efficient health care provision in Buhera?

1.7 Significance of the study

The study aims to promote gender equality and women empowerment. Griffin (2021) states that, over many decades, the UN have made significant progress in advancing gender equality, including through landmark agreements such as the Beijing Declaration and Platform for Action, Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the implementation of SDG 3(good health and wellbeing) SDG 5 (Gender equality) and SDG10 (reduced inequality). This study is crucial to the policy makers, NGOs, local authorities and the community itself.

1.7.1 Policy makers

This study offers crucial, evidence-based insights that can aid policymakers in enhancing healthcare access for rural women in Buhera District by identifying specific barriers and proposing contextually appropriate, solution-focused interventions (Gilson et al., 2017). It offers a basis for developing efficient, gender-sensitive health policies that solve the particular economic and cultural difficulties women experience hence enhancing decision-making and advancing equitable resource sharing Moreover, the study backs Zimbabwe's general health policy objectives defined in the Zimbabwe National Health Strategy (2021–2025), which gives top priority Equity and access for marginalized populations (Ministry of Health and Child Care [MoHCC]), 2021). By helping to create inclusive healthcare systems, the research also corresponds with international agreements like Sustainable Development Goals 3 and 5 which calls for United Nations, 2015; good health and gender parity.

1.7.2 NGOs

Especially for those working to improve women's health and advance fairness in rural areas, this research is really pertinent to non-governmental groups (NGOs) active in the health and development sectors. The study gives NGOs context-specific knowledge required to modify their programs to local circumstances by identifying the particular hurdles that prevent women in Buhera District from getting healthcare services. It guides the creation of culturally sensitive and responsive health programs, hence facilitating better community involvement and resource distribution (Ataguba, 2015). Furthermore supporting outcome-oriented planning and evaluation, the study assists NGOs match their efforts with Zimbabwe's health needs and worldwide development objectives like SDG 3 (good health and well-being) and SDG 5 (gender equality) (United Nations, 2015). Consequently, it improves the effectiveness, relevance, and sustainability of NGO projects designed to reduce healthcare access disparities in underprivileged areas.

1.7.3 Local authorities

Because it offers local, evidence-based data on the main barriers keeping women from using healthcare services, this study is really helpful to Buhera District local governments. Highlighting these particular problems like poor infrastructure, socio-cultural constraints, and poverty helps local authorities design more focused and successful health programs. Inclusive and participatory

decision-making is also advocated by the research, which inspires community participation particularly from women in determining healthcare solutions. Furthermore, it improves local governments' ability to coordinate their efforts with more general national health policies and global goals, including Zimbabwe's National Health Strategy (2021–2025) and Sustainable Development Goals (United Nations, 2015; MoHCC, 2021). This strengthens their capacity for equal, community-driven healthcare services.

1.7.4 The community

This study helps the local people in Buhera District to voice their healthcare problems and so guarantee that their needs are considered in the development of healthcare policies and plans. By highlighting hurdles such financial restrictions, poor infrastructure, and cultural practices, the research empowers the community to demand better healthcare services tailored to their specific requirements. Additionally, the study promotes community engagement by asking women and members to proactively contribute to shape healthcare solutions (Chikodzi et al., 2020). By connecting local issues to world frameworks like the Sustainable Development Goals (SDGs), the study enhances community ownership of healthcare outcomes essential for the sustainability of advancements in healthcare delivery (Ndlovu & Moyo, 2018). This participatory method can result in more inclusive, pertinent, and successful healthcare interventions that better match the community's priorities.

1.8 Scope of the Study

The research is carried out in Buhera District ward 14, Zimbabwe, in Manicaland province. Zimbabwe national census (2022) noted that Buhera district is a rural area with a total population of approximately 665 952. The district is characterized with communal and commercial farming areas, with the majority of the population engaging in subsistence farming and vending. The terrain is flat, with some hilly areas, and the climate is subtropical, with hot summers and mild winters. This setting was used because the area is one of the districts in Manicaland Province that was found to be having high rates of diseases. This study will assess barriers faced by women in accessing healthcare services Buhera district ward 14 in Zimbabwe. The research mainly focuses on women of reproductive age. Data will be collected over a period of six months. Additionally, this research might also choose to use some research tools and methodologies to collect data but

not others. Instruments such as questionnaires were used to limit the expenses and time taken in conducting the research.

1.9 Definition of key terms

1.9.1 Health Access

According to WHO (2023), Health Access refers to the ability of individuals or groups to obtain health care services when needed, without facing financial hardship, and with reasonable ease of access. McGraw-Hill (2024) also defined health access as the ability of a person to receive health care services which is a function personnel and supplies and affordability of those services. Healthcare, therefore refers to the ability of individuals to obtain health services when they are needed

1.9.2 Maternity mortality

WHO (2020) described maternity mortality as a death of a woman during pregnancy, childbirth or within 42days of the termination of pregnancy from causes related to or aggravated by the pregnancy or its management.

1.9.3 Gender equality

Refers to state in which individuals of all genders have equal rights and responsibilities in all aspects of life. Gaidzanwa (2015) stresses that achieving gender equality requires more than policy frameworks; it demands changes in social attitudes and community-level involvement. This aligns with Sustainable Development Goal 5, which calls for the empowerment of women and the establishment of equal opportunities globally (United Nations, 2015).

1.9.4 Socio economic barriers

Refers to obstacles that individuals or groups face due to their social and economic circumstances. In Zimbabwe, scholars like Mawere and Mubaya (2015) note that socio-economic barriers are especially pronounced in rural areas, where poverty, gender inequality, and underdeveloped infrastructure combine to hinder women's access to basic healthcare services.

1.9.5 Community healthcare

Refers to non-treatment based services delivered outside hospitals and clinics focusing on maintenance, protection and improvement of health status in population groups and communities. In rural parts of Zimbabwe, such as Buhera, community healthcare is vital due to the scarcity of formal medical facilities. As noted by Mutasa and Mukurazhizha (2021), improving community health structures can significantly expand service coverage and address health disparities by incorporating local knowledge and promoting grassroots participation.

1.10 Chapter summary

In summation, healthcare for women continues to be a developmental problem which needs the world's attention. Healthcare for rural women has been disregarded for many years hence the need to address the troubles surrounding health access for women. High degrees of mortality rates, high birth rates due to unavailability of family planning pills to mention but a few. Initiatives recommend via the authorities are to be analyzed as women are still locating it tough to get right of entry to healthcare offerings.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter focuses on the conceptual framework, theoretical framework and literature review. This chapter is also going to review existing literature on barriers affecting women in accessing healthcare services. The literature review is going to be guided by the objectives of the study as stated in the previous chapter.

2.2 Conceptual framework

The conceptual framework for assessing barriers to healthcare access among women in Buhera illustrates a cause-and-effect relationship between various barriers (independent variables), intervention strategies (mediators), and the outcome (dependent variable). The framework shows that multiple interlinked barriers negatively affect women's access to healthcare. However, targeted and context-appropriate interventions can mediate these effects, ultimately leading to better healthcare utilization and outcomes. Figure 2.1 shows the conceptual framework of the study.

Figure 2.1 Conceptual framework

2.3 Factors obstructing rural women from accessing health services

2.3.1 Poor Infrastructure

Globally, Poor infrastructure is a major challenge which hinders rural women in accessing health care especially in low and middle income countries. Bazeley (2022) argues that, Sub-Saharan Africa suffers from the world's most pronounced crisis in human resources for health, 36 of the 57 countries that now face infrastructure shortages are in Africa .A study carried out by Griffin (2020) in rural Malawi reviewed that, hospitals and clinics are still scarce and requires one to travel long distances where they are available. According to the Zimbabwe Infrastructure Report (2019) Deterioration across all major infrastructure services in the country has been marked over the past decade, reflecting poor maintenance and limited new investment in key infrastructure such as power, transport and health services. Proper healthcare provision services are difficult due to lack of reliable public transport. Most of the women's health is in emergencies like childbirth, but these institutions are far from the public for example, in Buhera there is one hospital which is Murambinda Mission Hospital which also sometimes lack electricity, running water and essential medical equipment. Huggins (2019) stated that most women often go to the hospital, but the

distance is very long hence healthcare provision is inefficient in such cases. Poor road networks make the facility difficult to access, and the lack of maternity homes at the hospitals for pregnant women causes problems as some women give birth at home, and the health problems of the mother or child which are not revealed may lead to death.

2.3.2 Broadband Access

While the use of telehealth services was already becoming more popular and widespread at the beginning of 2020, measures implemented in response to the COVID-19 pandemic accelerated this growth (WHO, 2019). WHO(2020) further noticed that Broadband internet has changed healthcare worldwide by allowing telemedicine which includes remote consultants, diagnosis and monitoring for example the teladoc in U.S. Unfortunately, many areas lack access to broadband internet and experience slow internet speeds, both of which are barriers to accessing telehealth services (POTRAZ, 2020). A Peterson Center on Healthcare and Kaiser Family Foundation report, stated that 7% of people in metropolitan areas did not have access to internet at home in 2019, while 13% of people in non-metropolitan areas lacked access, compared to their urban counterparts, rural individuals are nearly two times more likely to lack broadband access. In Zimbabwe, POTRAZ (2020) noted that clinics like Rushinga and Muzarabani cannot offer virtual consultations because there is no internet whilst hospitals like Parirenyatwa can use WhatsApp and zoom for follow ups. In Buhera district area most parts have no network and people have no access to smart phones, hence failure to access healthcare.

2.3.3 Workforce Shortages

Lack of skilled workers in the health sector has led to an imbalance between health personnel and the patients. A shortage of healthcare professionals in rural areas of the U.S. can restrict access to healthcare by limiting the supply of available services. WHO (2021) noted that, As of March 2021, 61.47% of Primary Care Health Professional Shortage Areas (HPSAs) were located in rural areas. A similar study carried out in Uganda reviewed that, lack of hospital staff and hospital equipment has had an effect on women's healthcare provision. In Zimbabwe, Low salaries and lack of incentives in the public sector is the driving force of staff retention throughout the country. This is further highlighted by Chimbari (2019) who states that health care workers in Zimbabwe work with minimum pay and write that this wage theft has resulted in high retention of workers.

Healthcare workforce shortages impact healthcare access in rural communities, For instance at Murambinda Mission Hospital where there is a limited number of doctors and a lot of patients. Gilson (2019) also noted one measure of healthcare access is having a regular source of care, which is dependent on having an adequate healthcare workforce. Muchahiwa (2020) also argues that workforce shortage affect healthcare services at large.

2.3.4 Poor Health Literacy

Health illiteracy is also another barrier which obstructs women from accessing healthcare services. Berkman (2018) propounded that globally, poor health literacy is associated with increased hospitalizations, poor disease management, low medication adherence and higher mortality rates. Wolf (2019) also noted that, in developed countries such as United States, limited health literacy costs the healthcare system billions annually and disproportionately affects vulnerable populations, including women, the elderly and non-native speakers. Regionally, UNICEF (2021) propounded that in Sub-Saharan Africa, low health literacy is a major barrier to maternal and child health, leading to preventable deaths and poor uptake of services such as antenatal care and immunization. Poor health literacy in rural areas is also a hurdle in Zimbabwe. Limited information and formal education cause women's knowledge of reproductive health, family planning, and disease prevention to be poor, the Ministry of Health and Child Care (2019) observed. Chirwa (2021) also supported that low antenatal care attendance, delayed presentation at clinics, and low adherence to medical treatments are all caused by poor health literacy. Further eroding public confidence levels were misinformation and cultural misunderstandings about illnesses like HIV/AIDS, according the ZimStat (2020). Poor health literacy in Buhera is also preventing women from getting healthcare. Chirwa (2021) also noted that limited access to formal education and inadequate dissemination of health information have contributed to misconceptions about maternal health practices and vaccine hesitancy.

2.3.5 Social Stigma and Privacy Issues

Globally, in rural areas, because there is little anonymity, social stigma and privacy concerns are more likely to act as barriers to healthcare access. Rural residents can have concerns about seeking care for mental health, substance abuse, sexual health, pregnancy, or even common chronic illnesses due to unease or privacy concerns. WHO (2021) noted that, in many conservative

societies, women avoid seeking care due to fear of judgement from community members or healthcare providers. Nyblade (2019) further supported that privacy concerns further deter access particularly in rural areas where confidentiality can't be guaranteed. Regionally, UNAIDS(2020) noted that in Sub-Saharan Africa, stigma attached to HIV and tuberculosis remains prevalent, discouraging women from accessing testing or treatment services. In rural Zimbabwe, social stigma is also affecting health access. UNAIDS (2023) noted that in rural Zimbabwe, people living with HIV/AIDS may skip antiretroviral treatment appointments to avoid being seen at clinics. UNFPA ZIMBABWE (2021) propounded that in Buhera and other communities, Women and youth are reluctant to approach clinics for contraceptives or STI treatment due to lack of confidentiality.

2.3.6 Knowledge gap

While numerous studies have identified general barriers affecting rural women's access to healthcare across Zimbabwe such as financial limitations, cultural practices, long distances to health facilities, and poor infrastructure there remains a limited body of localized research that specifically investigates these factors within Buhera District, particularly at the ward level. Most available literature tends to generalize findings across broader rural contexts, failing to capture the unique challenges and lived experiences of women in Buhera.

Additionally, there is insufficient exploration of how intersecting factors like gender roles, household decision-making, literacy levels, and traditional beliefs specifically influence health-seeking behaviors among women in Buhera's rural communities. These social determinants often differ across regions, and without tailored research, interventions risk being ineffective or culturally misaligned.

Moreover, data on women's own perceptions, priorities, and coping strategies in response to these barriers is scarce. Understanding women's voices and their everyday realities is essential for designing community-based, needs-driven healthcare solutions. Furthermore lacking empirical data evaluates how women's access in this area is affected by health system-related problems including staff attitudes, availability of female health workers, and quality of care.

This lack of specific, context-sensitive insights emphasizes a major information deficit that has to be solved via more study. Fulfilling this need would help create more efficient, culturally sensitive,

and environmentally friendly healthcare programs targeted to address the particular obstacles women in Buhera confront.

2.4 Impact of poor access to healthcare by women

Poor healthcare access affects women's health worldwide often leading to avoidable diseases and deaths. According to the World Health Organization (2019), preventable consequences associated with pregnancy and delivery cause the deaths of about 810 women every day; most of these deaths take place in poor countries. Women without access to basic services like antenatal care, contraception, and competent birth assistance are more likely to have serious health problems. Moreover, variations in access imply that many women with mental health conditions or chronic illnesses go undiagnosed or untreated, therefore causing long-term health decline (UN Women, 2020).

Systemic variables including underdeveloped infrastructure, financial hardship, and cultural beliefs that often restrict women's decision-making authority make these problems even more visible in the sub-Saharan African region. Women in rural areas all over Africa typically encounter challenges including transportation issues, costly healthcare expenses, and stigmatization by healthcare providers, according to Tessema et al. (2020). These obstacles cause high maternal death rates, bad reproductive health, and susceptibility to diseases like HIV. Children born to mothers without medical assistance are more prone to develop health and developmental issues even while the negative outcomes are not limited to women alone.

Rural women in Zimbabwe, particularly Buhera District, face even greater obstacles. Results from the 2015 Zimbabwe Demographic and Health Survey (ZDHS) show a marked difference between urban and rural access to medical care; women in rural areas are significantly less likely to give delivery in health facilities. Several linked problems, including poor road networks, lack of transportation, understaffed clinics, and cultural restrictions make it difficult for women to seek timely care in Buhera Ward 14. Consequently, chronic diseases go unmanaged and maternal mortality remains high (MoHCC, 2021).

Furthermore, women frequently bear the burden of caregiving in these areas. Limited access to professional care forces women to personally care for ill family members, therefore stealing time from education or income-producing activities. This worsens poverty, gender inequality and

restricts their social-economic mobility. Mberengwa and Moyo (2018) note that these structural impediments not only impair personal health but also impede community growth and so perpetuate gender inequality. Finally, the inability to solve healthcare access for women has ripple effects that damage national efforts towards health equality and sustainable development.

Knowledge gap

Despite extensive research conducted all over and locally on the effects of inadequate healthcare access, there is clearly little of targeted investigations looking at these effects inside unique local contexts, especially in rural regions like Zimbabwe's Buhera Ward 14. While a lot of the current research highlights national health measures including maternal mortality rates and service coverage (WHO, 2019; ZDHS, 2015), it often misses the complicated interaction of local cultural habits, economic challenges, transportation problems, and gender dynamics that alone define women's healthcare experiences in rural regions.

Moreover, although health research often uses the Social Determinants of Health (SDH) paradigm, there is little evidence of its contextualized application in rural Zimbabwe. Studies seldom provide workable, community-based solutions addressing the unique needs and limitations women in such situations confront. Consequently, policy solutions are sometimes broad and might not adequately solve the underlying reasons behind healthcare inaccessibility. This research intends to close this gap by doing a solution-oriented, local evaluation of the obstacles preventing women's access to healthcare in Buhera, therefore enhancing both scholarly understanding and legislative development.

2.5 Strategies to improve healthcare provision

2.5.1 Strengthening community based health education programs

Bringing healthcare facilities closer to people has become a proven strategy to increase access especially in remote or underprivileged areas on a worldwide level. According to the World Health Organization (2018), models of community-based healthcare provide essential connections between official health systems and underprivileged populations. One of the most successful strategies has been the participation of community health workers (CHWs) people educated to provide basic healthcare, encourage wellness, and direct patients through the healthcare system.

CHWs have helped to make healthcare available to remote communities in several areas of sub-Saharan Africa. Oftentimes enhancing antenatal care uptake and lowering avoidable fatalities, they provide services including maternal health assistance, vaccination knowledge, and family education. Perry et al. (2017) also found that trust is developed, cultural obstacles are decreased, and health-seeking behaviors improve when CHWs are integrated inside the communities they serve in nations like Rwanda and Ethiopia.

In Zimbabwe, particularly in rural districts like Buhera, the national health strategy acknowledges the importance of community-level interventions. Nevertheless, their efficacy is constrained by issues like insufficient supervision, uneven implementation, and resource restrictions (MoHCC, 2021). These obstacles are clear in Buhera Ward 14 in the form of low clinic attendance and bad maternal health indicators. Growing and enhancing CHW programs in Buhera might solve these shortcomings. Women, especially those with mobility or financial difficulties, would get more consistent support by training local volunteers to offer fundamental care and education inside the communities. CHWs can also act as a bridge between homes and clinics, guaranteeing timely referrals and better health results. Moyo (2020) suggests that CHWs are vital in reducing service gaps in rural Zimbabwe if correctly equipped and encouraged.

2.5.2 Mobile health outreach services

For individuals in difficult-to-reach areas across the world, mobile outreach programs have become a primary means of healthcare distribution. Usually employing mobile units or health teams that visit far-off villages, these services provide vital benefits including maternal care, immunization, chronic disease screening, and health education. The World Health Organization (2016) says that in regions without access or where traditional health facilities are lacking, these outreach initiatives are especially beneficial.

Mobile health services have greatly enhanced the use of health care in many developing nations. For instance, Kassam et al. (2019) argued that mobile clinics have enhanced antenatal care and family planning access in rural regions of Uganda and Nigeria, particularly among women who experience financial, logistical, and cultural challenges. Awofeso (2020) also said that areas with little infrastructure and large distances between villages and hospitals would see the most advantages from these services.

Mobile health outreach has been introduced in many communities in Zimbabwe to bring healthcare to underprivileged groups. Often in conjunction with NGOs, initiatives directed by the Ministry of Health and Child Care (MoHCC) employ mobile teams to provide child vaccinations, maternal health care, and public health education (MoHCC, 2021). But obstacles like fuel shortages, poor funding, and restricted resources typically restrict these efforts.

For rural communities like Buhera Ward 14, where the hospital is far and transportation options are limited, mobile outreach offers a pragmatic and affordable approach of enhancing healthcare access. Women in these regions often find it difficult to get to health centers, particularly in severe weather or crises. Setting up a consistent schedule of mobile clinic visits would help to guarantee availability of important health services like prenatal care, screenings, and contraception right inside their neighborhoods. This strategy might help early detection of health problems and lower avoidable diseases.

2.5.3 Infrastructure development

The cornerstone of any workable healthcare system is health infrastructure, which is also vital for ensuring that medical services are accessible, safe, and effective. Globally, poor roads, inadequate health facilities, and unreliable utilities have been cited as a major obstacle, particularly in underdeveloped and rural regions. According to the World Health Organization (2010), healthcare systems battle to provide even basic services without essential infrastructure, which puts populations at increased risk of preventable illnesses and death.

According to Kruk (2010), extending and enhancing healthcare infrastructure can considerably improve service delivery. For instance, the creation and updating of clinics, upgrades to transportation networks, and providing of vital amenities like electricity and clean water have resulted in higher use of maternal health services, better illness prevention, and better health outcomes (Peters et al., 2018). Furthermore, Campbell (2019) also noted that access to water and sanitation in health institutions has been linked to decreased rates of infection and maternal mortality.

Rural areas in Zimbabwe sometimes have severe structural shortcomings. Many health centers run without enough space, basic equipment, or a consistent power and clean water supply (MoHCC, 2021). These challenges are especially serious in areas like Buhera District, where bad road

maintenance and lacking clinic facilities impede both patients and healthcare personnel. Women in Ward 14 of Buhera sometimes have to travel long and challenging distances to get to remote clinics, which discourages prompt care-seeking particularly during pregnancy or crises. Seasonal rains make roadways unusable, therefore isolating settlements even more. Building new clinics, updating old ones, expanding transit access, and setting up solar power systems would help lower these physical impediments, promote health service use, and boost maternal and child health in the area by enhancing local infrastructure.

2.5.4 Empowerment of women

Empowerment of women is generally recognized as a primary tool to improve health results and broaden healthcare access. According to the World Health Organization (2019), women who have more social, financial, and political control over their lives are more likely to make wise judgments about their own health and that of their families. Access to education, income-generating opportunities, and active leadership and decision-making positions define this empowerment.

Women's limited independence and reliance on others limit their capacity to seek medical care when necessary in many low-income areas. According to studies from Asia and Africa, women with little education, economic restrictions, or limited social mobility are less likely to utilize maternal and reproductive health services (Ahmed et al., 2015; Pratley, 2016). Programs that promote women's education, financial independence, and leadership positions, on the other hand, frequently lead to increased usage of health services like antenatal visits and facility-based deliveries.

Traditional gender expectations and economic disparities continue to limit women's capacity to independently make health decisions in Zimbabwe. Many rural women depend on male partners or family members to obtain funds or permission to seek medical facilities, therefore slowing or preventing timely treatment, according to the 2015 Zimbabwe Demographic and Health Survey (ZDHS). Women in Buhera Ward 14 often run across comparable obstacles stemming from poverty, poor educational attainment, and cultural expectations. Many cannot make health-related decisions without male approval, and few have financial means to independently access care. Improving this situation might be done by means of savings cooperatives, community leadership opportunities, and health awareness campaigns that empower women. Better health outcomes and

less gender-based differences in healthcare access result from empowered women's greater propensity to look for medical care for themselves and their children.

2.5.5 Subsidized Healthcare Policies

Around the world, the exorbitant cost of healthcare continues to be one of the main barriers preventing low-income communities from accessing prompt medical attention all around the globe. Many governments have implemented subsidized healthcare programs to solve this, with the goal to reduce or eliminate user costs. Especially for underprivileged groups like women, these financial aid systems are crucial in enhancing fairness and broadening healthcare access. Offering financial protection through subsidies is critical for reaching Universal Health Coverage and lowering healthcare-related poverty, according to the World Health Organization (2010).

Case studies from countries like Thailand and Rwanda demonstrate the success of such interventions. Evans (2015) noted that, In Thailand, a national healthcare coverage program implemented in 2002 led to significant improvements in maternal and child health, while also reducing financial strain on household. Lu (2019) also propounded that, In Rwanda, government-subsidized health insurance schemes have helped increase the use of maternal health services and contributed to a drop in maternal deaths. These examples highlight how removing financial barriers encourages more people to seek preventive and curative care.

In Zimbabwe, while certain public health services are officially free for vulnerable populations such as pregnant women and children under five many barriers persist. Due to underfunding and poor implementation, patients still face challenges such as medication shortages and informal charges. The Zimbabwe National Health Strategy (2021–2025) points out that rural communities, including women in remote areas, struggle to access affordable care due to costs associated with transportation, treatment, and supplies.

In Buhera Ward 14, where poverty is widespread, most women cannot afford even basic healthcare expenses. Hidden costs and the lack of financial support discourage many from seeking timely medical attention. Introducing targeted, well-managed subsidies that cover a broader range of costs including transport, medication, and maternal supplies could significantly enhance access and health outcomes for women in the ward.

2.5.6 Knowledge Gap

Although various strategies have been proposed and implemented across Zimbabwe to enhance access to healthcare in rural settings, there remains a notable lack of specific research focused on how these approaches function within Buhera Ward 14. Most studies and health policies address broader regional or national challenges, without fully considering the distinct social, economic, and infrastructural conditions that exist in this ward. While interventions such as mobile health outreach, subsidized services, women's empowerment, and improved infrastructure have shown success in other regions, limited evidence exists on their local relevance or adaptability in Buhera. For instance, there is little data on how local customs, transport limitations, and educational barriers impact the actual effectiveness of these solutions when implemented at the community level.

Moreover little research has been done on community involvement in healthcare planning and service delivery in Buhera. Not much is known about local women's views of these tactics or how energetically they help to shape them. Moreover often missing are ideas from important stakeholders including conventional leaders, medical professionals, and local governments, hence impeding the matching of projects to local requirements and expectations. This discrepancy highlights how critical it is to do local, participatory research to find the most appropriate and successful approaches for Buhera. Ward 14. Efforts to raise women's access to healthcare may remain misdirected or futile without this knowledge, therefore underlining the pressing need for context-specific data to direct focused and long-lasting initiatives.

2.6 THEORETICAL FRAMEWORK

The Social Determinants of Health (SDH) theory, as promoted by the World Health Organization (WHO, 2008), stresses that health outcomes are strongly influenced by the conditions in which people are born, raised, live, work, and age, not only by biological or personal factors. The theory posits that the fundamental drivers of health are social, financial, environmental, and political infrastructures including income levels, education, gender roles, healthcare access, housing quality, and employment status. One of the main presuppositions of SDH is that differences in health are mostly avoidable and arise from systematic inequalities in resource allocation and chance. Marmot (2010) also observed that the theory assumes rather than depending just on the

health system, improving health outcomes calls for a multi-sectoral strategy integrating efforts from education, transport, housing, and economic development industries.

The SDH theory provides a helpful framework for examining women's limited access to healthcare in Zimbabwe's Buhera district, especially in rural wards like Ward 14. Poverty frequently impacts women in Buhera, therefore limiting their capacity to pay for medical treatments or travel. Low degrees of health illiteracy and schooling also make it difficult for them to make wise choices about their health or see the necessity for quick treatment. Furthermore, the geographical isolation of many villages, coupled with poor infrastructure, presents a serious obstacle to physically reaching healthcare facilities. Chirwa (2021) also noticed that cultural practices and gender-based power imbalances also constrain women's autonomy in seeking medical help. All of these factors are recognized within the SDH framework as critical contributors to health inequities. By applying the SDH theory, it becomes clear that sustainable improvements in healthcare access for women in Buhera require addressing not only service availability but also the broader socio-economic and structural factors that create and sustain health inequalities. Figure 2.2 shows social determinants of health which was designed by WHO.

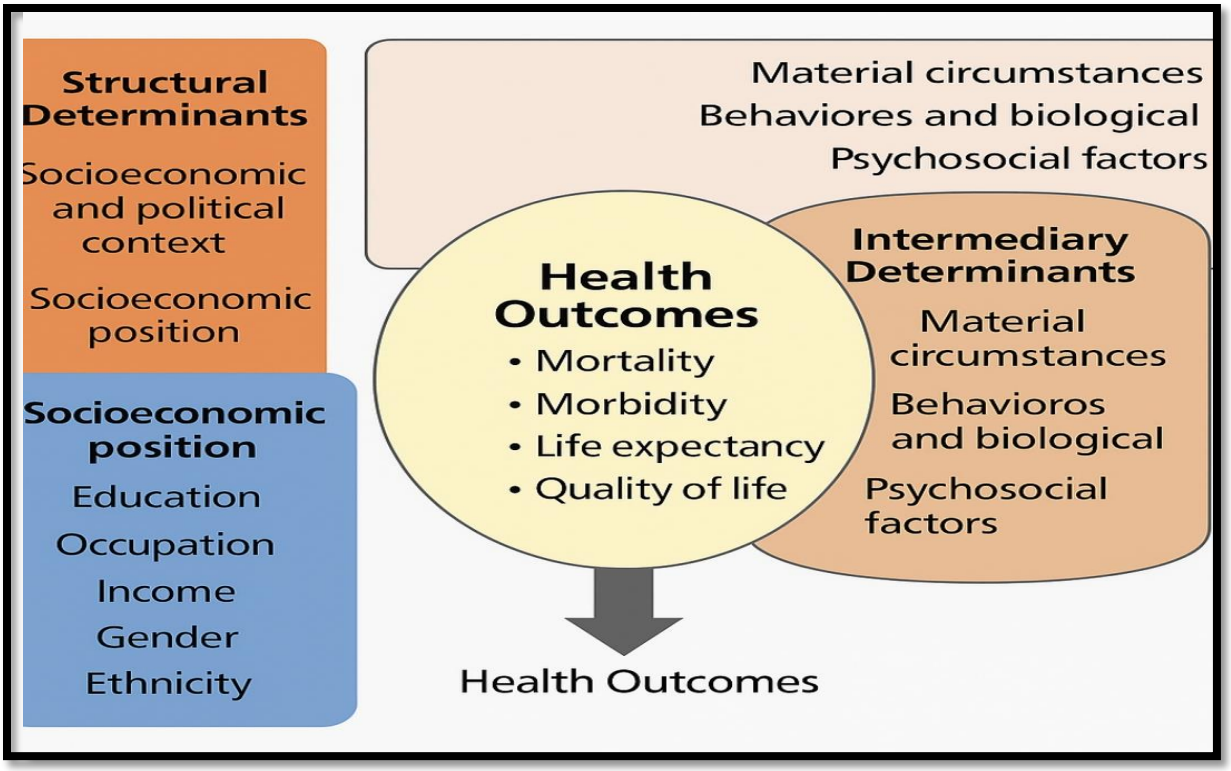

Figure 2.2: Social Determinants of Health by WHO

2.7 Conclusion

This chapter looked at what other authors have written about the subject bringing out the factors affecting rural women health access and also some strategies that can be adopted to improve healthcare provision for women in Buhera. This research also managed to look at the Theoretical Frameworks associated with the research as well as the general analysis of the research.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

This chapter covers areas including the research design used, and considers the sampling techniques as well as data collection methods relied in the study. The target population, ethical issues considered and the limitations of the study are also highlighted. Qualitative and quantitative data analysis techniques used in organizing the information collected are discussed in this chapter as well. The various ways through which the information was acquired from the participants are also among the issues discussed hereunder.

3.2 Description of study area

The study is conducted in Buhera District ward 14 which is located in Manicaland province, Zimbabwe. Zimbabwe national census (2022) noted that Buhera district is a rural area with a total population of approximately 271 92 people and a total of 10 089 women in ward 14. The district is characterized with communal and commercial farming areas, with the majority of the population engaging in subsistence farming. The terrain is flat, with some hilly areas, and the climate is subtropical, with hot summers and mild winters. This setting was used because the area is one of the districts in Manicaland Province that was found to be having high rates of diseases. The ward was also chosen because many people who reside in the area are from the apostolic sect that does not allow visiting hospital thereby increasing challenges faced by women in accessing healthcare. The district has some healthcare facilities including a General hospital and several rural clinics, hence despite the availability of healthcare facilities, the district still faces challenges related to healthcare access. Figure 3.1 shows the study area map.

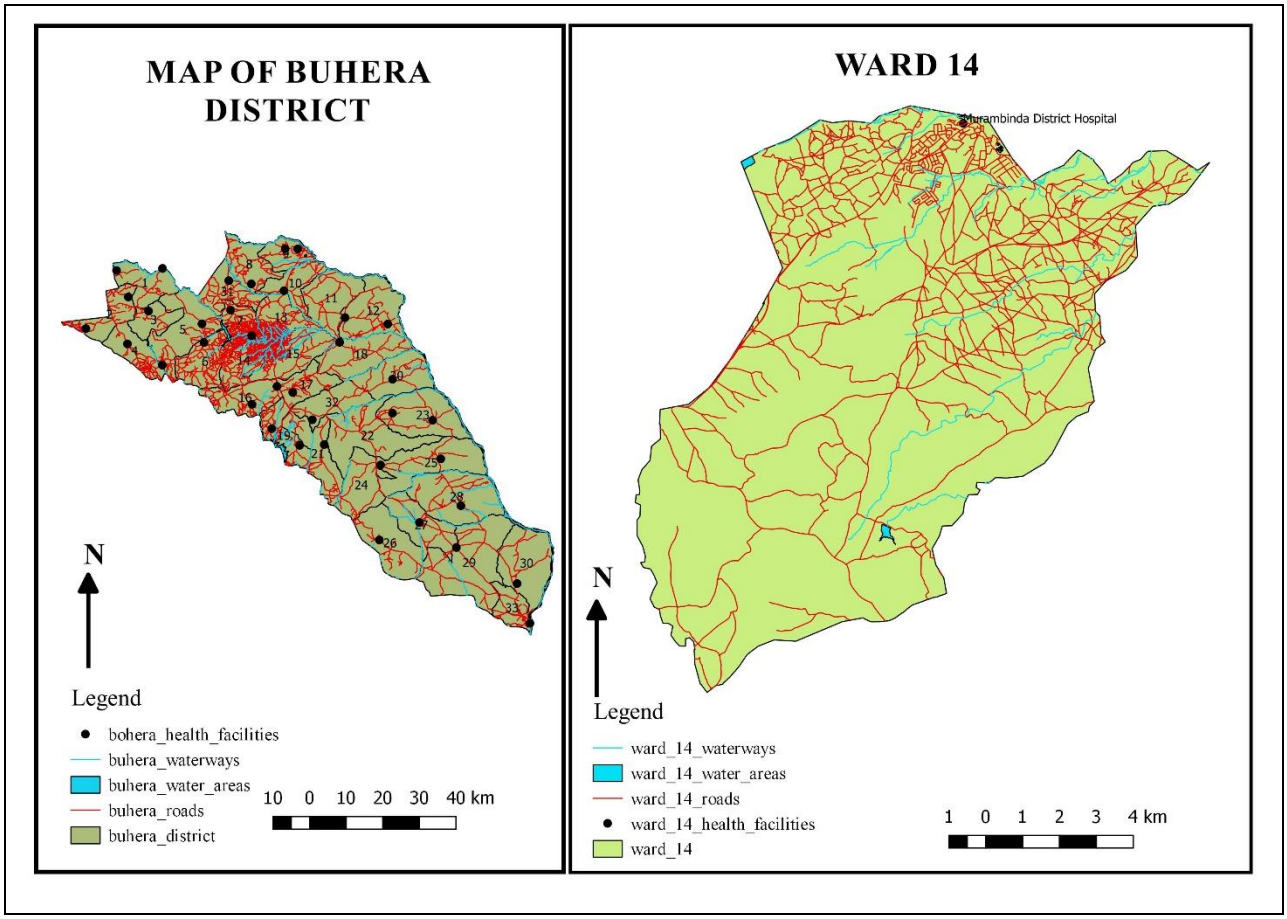

Figure 3.1: Study map showing Ward 14, Buhera District

3.3 Research Design

An exploratory research approach will be used in this study. It especially fit for exploring events that are not well known or where there is little extant data. The exploratory design will allow this study to discover the fundamental reasons influencing women's healthcare access in Buhera and generate understanding of their attitudes, activities, and difficulties. Cresswell (2015) observed that exploratory research design suits when a problem is poorly known or when the body of literature available is circumscribed in context-specific depth. This layout is adaptable and permits open-ended inquiries and techniques of data gathering that may produce fresh ideas and hypotheses for additional research.

3.4 Research Approach

This study uses both qualitative and quantitative methods targeted at elucidating the intricate, context-specific hurdles women encounter in getting healthcare. Bryman (2019) has characterized a qualitative approach as one that depends on words rather than quantitative measures in gathering and evaluating data. The research therefore employed an interpretive approach, which is inductive and constructionist in character, by adopting this approach. Six-six women from Buhera will be chosen using purposive sampling to ensure diversity in characteristics like age, marital status, and healthcare experiences. Questionnaires, semi-structured in-depth interviews, and focus group discussions (FGDs) will help women to voice their own experiences and points of view. Qualitative data will be analyzed using thematic analysis, identifying key themes related to socio-cultural, economic, and informational barriers and quantitative data will be analyzed through the use of regression analysis. This design will provide rich, detailed insights into the factors preventing women from accessing healthcare, offering a foundation for developing context-specific solutions to improve healthcare accessibility in Buhera.

3.5 Target Population

The research targets women in Buhera district ward 14 between the ages of 15-49 from rural area and also the key informants which includes the ministry of women affairs, Murambinda Mission Hospital staff, as well the District Health Coordinator. Zimbabwe national census (2022) noted that Buhera district is a rural area with a total population of approximately 665 952 and a total population of women in ward 14 is approximately 10 089. According to the 2017 inter-censual demographic survey, approximately 49% of Zimbabwean's female population falls within the 15-49 age group therefore

49% of 10 089

= 4 944 is the target population. The district is characterized with communal and commercial farming areas, with the majority of the population engaging in subsistence farming and vending.

3.6 Sample size

This research used Cochran's sample size formula to determine a suitable sample size. The formula was used to provide a foundation for determining the optimal number of participants required to achieve reliable and representative results.

$$\frac{n = z^2 \,.p.\,(1-p)}{0{,}12}$$

Where n = required sample size

Z= z-score (1, 96 for 95% confidence level)

p= estimated proportion of the population (0, 5 when unknown)

e= margin of error (0, 12 for 12%)

n = (1, 9)^2.0,5.0,5/0,12^2

=3,8416.0,25/0.0144

=0, 9604/0, 0144

=66, 7

=67

Therefore, the estimated sample size is approximately 67 with a margin of error of 0, 12%. In this study, a 12% margin of error was adopted due to a combination of practical constraints and the exploratory nature of the research. The target population in Buhera District Ward 14 is relatively small (4,944 individuals), and while a lower margin of error (such as 5%) is statistically ideal, achieving the required larger sample size would have been resource-intensive and logistically unfeasible due to geographical challenges in accessing remote rural households, limited financial and human resources available for fieldwork, time constraints imposed by the academic research calendar and Cultural or societal barriers that may restrict access to female respondents. Using a 12% margin of error allowed the study to remain methodologically sound while remaining feasible within the given constraints. Moreover, this research is intended as a baseline assessment, not a

conclusive statistical analysis, and thus prioritizes identifying broad patterns and barriers over precise estimations.

3.7 Sampling Techniques

This qualitative study adopted purposive sampling to select participants who are most knowledgeable and directly affected by barriers to healthcare specifically, women aged 15–49 residing in Buhera Ward 14. Purposive sampling is ideal for exploratory research where the goal is to gain in-depth insights from individuals with lived experiences relevant to the study topic (Etikan, Musa, & Alkassim, 2016). This technique allows the researcher to deliberately select participants based on predefined criteria, such as age, location, or specific health challenges. Additionally, key informants such as healthcare workers, community health volunteers, and local leaders may be included using key informant purposive sampling to gather broader contextual understanding of systemic healthcare challenges in the ward.

3.8 Data collection instruments

The study adopted data collection techniques that allows the collection of in-depth information and used tools consistent with the techniques adopted. Questionnaires, key informant interviews and a focus group discussion were used in gathering information of barriers to healthcare access among women in Buhera ward 14.

3.8.1 Questionnaire

Questionnaires were distributed to 67 women in Buhera District ward 14. These were distributed in such a manner that the respondents had enough time to fill them and express themselves freely without rushing and also without the bias of the researcher's presence. Crossman (2023) states that, questionnaires can be used without direct personal contact with the respondent that is without the help of the interviewer. The questionnaire was designed into three section which includes demographic data, healthcare access and suggestions for improvement (See Appendix 1).

Demographic information includes age, marital status, education and occupation was included in the questionnaire. Such information provided context to the responses and allowed for the analysis of patterns and correlations between demographic factors and healthcare access for example higher education levels leads to better health seeking behaviours (Creswell, 2018). The next section has

questions on factors affecting women from accessing healthcare including the finances, infrastructure and culture. Impacts of poor access to healthcare were also included in the questionnaire. The final section invites respondents to propose solution to the challenges identified. Open ended questions encourages women to share their ideas on enhancing healthcare access such as policy changes, community based initiatives and many others. Bader (2020) noted that research questionnaires are a mix of close-ended questions and open-ended questions.

Russel (2018) argued that questionnaires are less time consuming, low to no cost and generates a large amount of data. This gave the respondents an opportunity to exhaust their views freely knowing that they would not be identified with the questionnaire. However, questionnaires have a disadvantage since respondents might skip or ignore some questions, or avoid sensitive questions and can also be biased opinions from people with strong interest on the topic , so the researcher saw a need in cooperating other instruments like observations and key informant interviews.

3.8.2 Key Informant interviews

Key informant interviews were used to collect data from 4 of the study's key informants. The interview included the ministry of women affairs, Murambinda mission hospital general staff, District health coordinator and community leaders. Patton (2015) emphasizes that key informant interviews allow researchers to explore complex issues in depth, uncovering motivations, beliefs and contextual factors that might be missed in surveys. Berg and Lune (2017) also noted that key informant interviews can adapt to the informant's knowledge, allowing follow up questions and clarifications that improves data richness.

Face to face interviews were conducted with 3 key informants who were available at their work places. The district health coordinator was interviewed via electronic means, on WhatsApp since he was not available at his work place. An interview guide designed for key informants was used as an instrument of research in both the face to face and online interviews and it consisted of questions relevant to the topic of barriers to healthcare access among women in Buhera (see appendix 2), however key informants may only provide information from their own perspective which may not be representative of the larger population, hence incorporation of other instruments is essential.

3.8.3 Focus Group Discussions (FGDs)

The research used focus group discussions in order to obtain broad range of perspectives on why women in Buhera ward 14 are facing challenges in accessing healthcare services and as well as looking for solutions that can be imposed to minimize the barriers. Maxwell (2023), notes that FGDs make use of **g**roup interactions to produce data and insights that would be less accessible without the interactions found in the group. There were four FGDs and each group had 16 participants .The two focus group discussion were held in an informal way which enabled participants to freely participate in the discussion.

A focus group discussion guide was utilized by the researcher as a tool during data collection. The researcher asked questions to the respondents and during the process the researcher was able to hear the voices of respondents. Each FGDs composed of 16 people. The FDG interview guide included the factors affecting women, impact of the poor access as well as proposed solutions (see appendix 3). A written consent form was provided to the respondents before they participated, however FGDs may leads to some participants dominating the discussion while others may remain silent hence lacking diverse perspectives, therefore use of different instruments is important.

3.9 Data analysis and Presentation

This research used both qualitative and quantitative to analyze the collect data. Both qualitative and quantitative data were analyzed using Microsoft word excel and content analysis. Data was then presented using bar graphs, pie charts and was presented in descriptive ways so that the basic findings of the research would be interpreted and justified.

3.9.1Quantitative data analysis

Data will be collected using tools like questionnaires, FDGs, interviews for key informants. Checking of errors and missing values will also be done. Descriptive statistics, including percentages and frequencies will be computed to provide an overview of the data, facilitating the identification of trends or patterns (Field, 2018). The study will also use Microsoft word and excel to make bar and pie charts for visual presentation of the results. Pallant (2020) noted that these descriptive statistics offer a general understanding of the data, allowing for the identification of central tendencies and variances, which are crucial for comprehending the fundamental characteristics of the dataset.

3.9.2 Qualitative data analysis

The research utilized the thematic analysis because it helped her in identifying themes that are important to the study. Information collected from interviews and the FGDs was analyzed manually using thematic analysis since the data cannot be quantified. The data was therefore coded manually into various thematic areas according to study objectives. Thematic analysis involves classifying patterns and themes within qualitative data as defined by Braun and Clarke (2020).

The transcripts containing data collected and audio recordings from the interviews conducted were thoroughly examined so as to identify patterns in the data. The patterns identified became the major themes of the findings and under those major themes, sub themes were identified. For example, on the objective of highlighting the challenges militating against women in accessing healthcare services in Buhera, a theme such as economic challenges was identified. From that theme, subthemes such as human resource challenge, financial constraints, and infrastructural and material challenges were observed. The findings were then presented in a narrative form and interpreted in relation to the women rights-based perspective and the reviewed literature, trying to draw comparisons.

3.10 Ethical consideration

This research used ethical considerations which includes informed consent, confidentiality, voluntary participation and respect for cultural sensitivity. Ethics are defined as meeting the requirements and standards of conduct of a given profession or group (Babbie, 2019). Ethics are important in a research because they help in the protection of rights and welfare of the study participant. This section constitutes of the research ethics that the researcher utilized.

3.10.1 Informed Consent

To ensure that participants' right to informed consent is guaranteed, the research drafted an information sheet and an informed consent form to be read, understood and signed by the participants so as to provide proof of their consent to participate in the study. The participants were allowed an opportunity to ask for clarification in areas they did not understand so that they consent to the study having understood its purpose without deception. Hence, detailed information on the purpose of the research was provided to the participants, and informed consent forms were provided and filled by the participants without coercion. It is important to provide informed

consent because it builds trust among respondents and they make informed decisions (Houghton et. al., 2010). This is vital in my study area because trust plays a pivotal role in their community.

3.10.2 Confidentiality

This research obliged to give guarantee to the clients that any information they are going to provide will be kept confidential and that if they let out any information that is to be written down, pseudo names will be used in placement of their real names. The implementation of measures to protect participant's details and privacy throughout the research process will be made, including hiding data and securely storing of personal data. Kaiser (2021) also noted that confidentiality involves safeguarding participants' private information throughout the research process. Confidentiality is an important ethic when dealing with clients because every client has the right to have their information kept confidential therefore this research observed that.

3.10.3 Voluntary participation

All of the researcher's sample subjects were interviewed out of their own will having agreed to the information about the purpose of the study. They were also accorded their rights to withdraw from participation at any point during the interview sessions if they wanted to. Hence interviewed women and key informants were allowed to participate without coercion and also allowed to withdraw from participation whenever they deem necessary.

3.11 Chapter summary

The chapter focused on presenting the methods used by the researcher in collecting data. The researcher used a qualitative method of collecting data. The population that was being targeted was women in ward 14 and also the key informants. It also focused on data collecting methods which included key informant interviews, questionnaires and also focused group discussions. Ethical considerations were also taken note of and the researcher made us of informed consent, voluntary participation and also confidentiality. The study used purposive sampling and a sample of twenty people. The following chapter is going to be focusing on presenting data and discussion of findings.

CHAPTER FOUR: DATA ANALYSIS, PRESENTATION AND DISCUSSION

4.1 Introduction

This chapter presents the analysis, interpretation and presentation of data collected from participants regarding the barriers affecting women's access to healthcare services in Buhera District ward 14. The data was analyzed using both qualitative and quantitative methods. Data will be presented inform of pie charts, tables and graphs.

4.2 Response Rate

The study distributed 66 questionnaires to women in Buhera District ward 14. Out of 66, some could not respond. 50 were successfully completed and returned, yielding response rate of 76%. This high response rate indicates a strong level of engagement from participants and contributes to the reliability of the findings. Figure 4.1 shows the response rate.

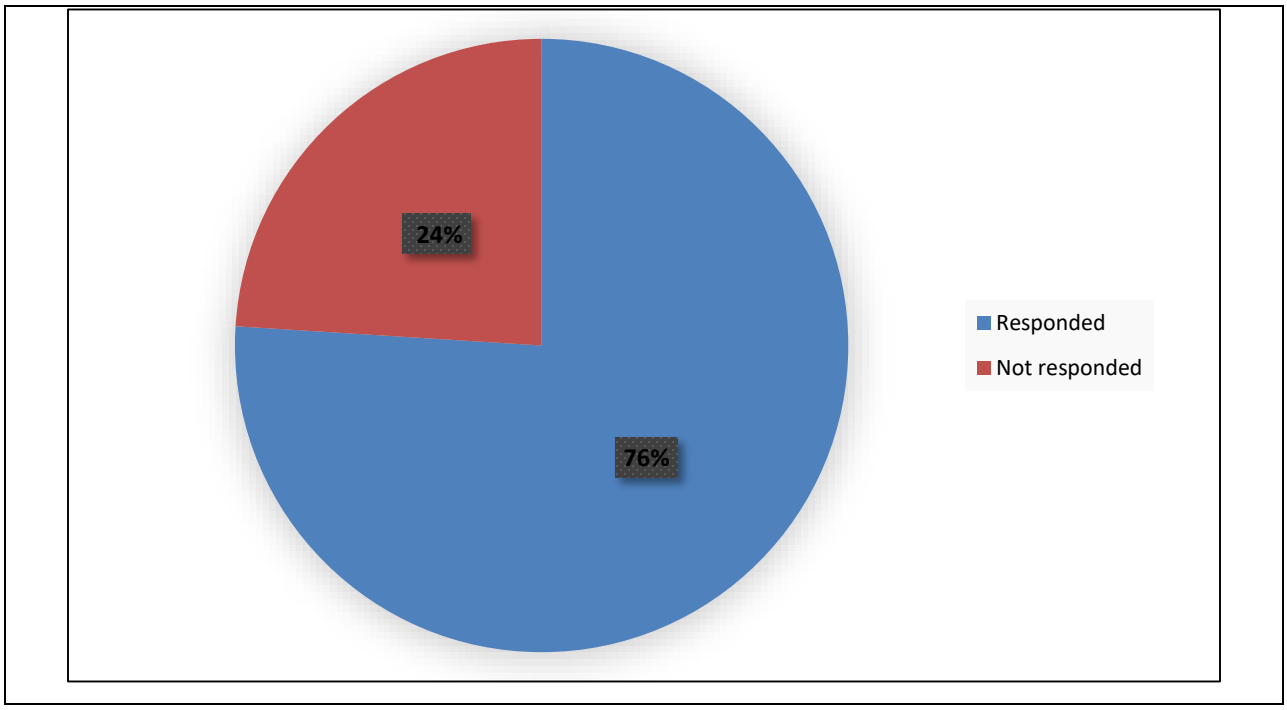

Figure 4.1: Questionnaire response rate (N=66)

As shown in figure 4.1, the response rate for the questionnaires was 76%, 24% could not return due to several reasons. Some participants indicated that they were too busy with domestic and farming duties to complete the questionnaire. A few potential respondents were unable to read and

write, making it difficult for them to understand and complete the forms. Some women also showed reluctance or disinterest in participating due to suspicion about the purpose of the research and also others were not available at the time of data collection due to travel, illness and other personal commitments, however the study continued with 76% response rate.

4.3 Demographic Characteristics

This section presents and discusses the demographic profile of the 50 women who participated in the study, focusing on age, educational level, marital status and occupation. These variables are important in understanding the social and economic contexts that shape access to healthcare services in Buhera District ward 14. Table 4.1 shows demographic information of women in Buhera ward 14.

Table 4.1: Demographic information of women in Buhera ward 14

VARIABLE	CATEGORY	FREQUENCY
1.Age	15-24	13 (26%)
	25-34	19 (38%)
	35-44	13 (26%)
	45-49	5 (10%)
2. Marital status	Single	12 (24%)
	Married	28 (56%)
	Divorced	5 (10%)
	widowed	5 (10%)
3. Educational level	Primary	18 (36%)
	Secondary	25 (50%)
	tertiary	7 (14%)
4. Occupation	Employed (Formal)	10 (20%)
	Self-employed	15 (30%)
	unemployed	25 (50%)

4.3.1 Age Distribution

As shown in fig 4.2, all 50 respondents fell within the reproductive age group of 15-49. The highest concentration of participants was in 25-34 age group, making up a percentage of 38. This reflects a majority of women in their peak reproductive and economically active years. According to WHO (2018), Women in this age bracket are more likely to seek maternal health services, family planning and treatment for reproductive health conditions. Their experiences are critical in assessing healthcare access barriers. The widespread across reproductive age groups allows more understanding of the challenges faced across different life stages.

4.3.2 Marital Status

More than half of the respondents (56%), were married, while 24% were single and 10% each were divorced and widowed. Marital status often influences decision-making power, economic dependency and healthcare-seeking behavior. Married women may rely on spouses for financial support or permission to access healthcare, while divorced and widowed women may face increased economic and emotional challenges. Single women, particularly the young, may delay seeking services due to stigma and fear of judgement, especially for reproductive health issues (Mutambara et al., 2022).

4.3.3 Educational Level

The study revealed that 50% of respondents attained secondary education, 36% completed primary education and only 14% reached tertiary. Education plays a vital role in influencing health-seeking behavior. Women with higher levels of education are more likely to access and utilize health services (Gouda & Powles, 2015). They tend to have better awareness of disease prevention, understand medical information clearly and make informed decisions regarding treatment options. The dominance of primary and secondary levels indicates moderate literacy, which may affect understanding of medical instructions, awareness of available services and ability to advocate for their health needs. Conversely, low education levels are associated with delayed or non-utilization of services, particularly rural areas (UNESCO, 2015). The limited number of tertiary-educated women also reflect broader systematic issues in rural education access which also directly affects healthcare access.

4.3.4 Occupation status

The data shows that 50% of the respondents were unemployed, 30% were self-employed and only 20% had formal employment. High unemployment levels among women point to economic vulnerability, a significant barriers to healthcare access. Economic empowerment is strongly linked to improved health outcomes because when women have financial independence, they are more likely to prioritize and access healthcare for themselves and their families (World Bank 2019). Self-employed women, mostly in informal sectors like vending or farming may struggle with inconsistent income, limiting their ability to afford transportation, consultations or medications. The low level of formal employment further reflects limited access to job-related health benefits or medical aid schemes.

The demographic profile of respondents highlights a population of primarily young to middle aged women with moderate educational attainment and high economic dependence. These factors collectively influence women's ability to access and utilize healthcare services. Socio-economic conditions such as limited education and income along with marital dynamics can compound structural barriers, cultural beliefs and health literacy.

4.4 Factors affecting women from accessing healthcare services

Access to healthcare is influenced by a range of interrelated factors which are economic, cultural, infrastructural and institutional. Based on responses from participants and supported by existing literature, several barriers were identified in Buhera District ward 14. Figure 4.2 illustrates the factors that affects women from accessing healthcare and their impact level.

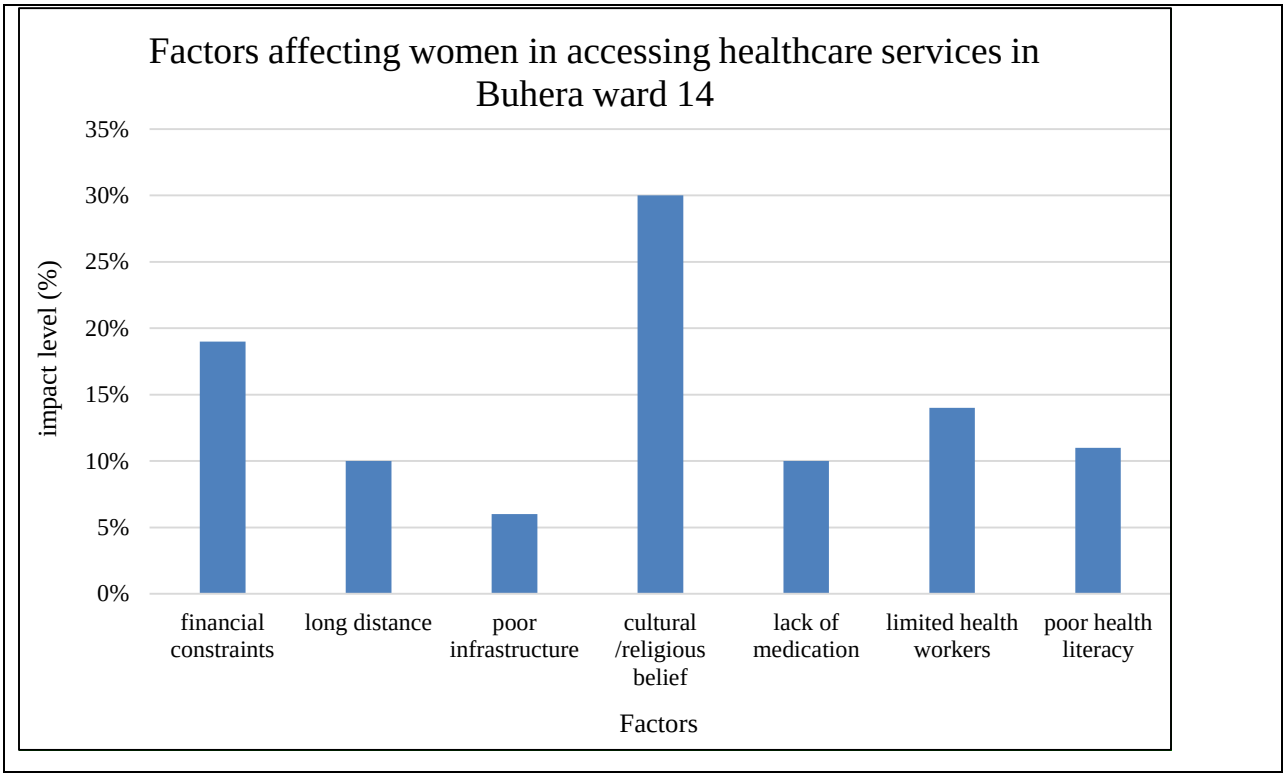

Figure 4.2: Factors affecting women in accessing healthcare Buhera ward 14 (N=50)

Figure 4.2 illustrates various barriers impacting women's access to healthcare services in Buhera District ward 14. The most significant factor identified is cultural and religious beliefs (30%), followed by financial constraints (19%) and limited health workers (14%). Less prominent, but still important are poor health literacy (11%), long distances (10%), lack of medication (10%) and poor infrastructure (6%).

4.4.1 Cultural and religious beliefs

Cultural norms and religious beliefs has resulted as leading barrier in factors that affect women's access to healthcare with a percentage of 30. In patriarchal society like Buhera ward 14, women often need permission from male family members to seek healthcare, which delays or completely prevents them from accessing services. A participant emphasized that, "My *husband has to agree first before I go to the hospital. Sometimes he says it's not necessary."* According to WHO (2016), cultural expectations and religious beliefs can limit women's autonomy in making health related decisions, especially in rural and traditional communities. Another participant also confirmed that, "*we are from the Johane Marange apostolic sect, we are not even allowed to visit the hospital".*

Johane Marange Apostolic church has a large following in Buhera and this religious sect holds strict doctrinal views that discourage or even prohibits members from seeking formal medical care, relying instead on spiritual healing, holy water and prayers. A key informant from the community explained, "*Many families here belong to johane Marange. They are told it's a sin to go to the hospital. Women are expected to deliver at home, even if there are complications."* This religious doctrine significantly impacts maternal and child health outcomes. This situation does not only violates women's right to health but also increases the risks of preventable complications and maternal deaths.

4.4.2 Financial constraints

Financial hardship which scored 19% is also a critical barrier to healthcare access for women in Buhera ward 14, where poverty levels remain high and economic opportunities are limited. The majority of households rely on subsistence farming, which is often vulnerable to droughts and poor yields, resulting in limited cash income. In this context, even seemingly minimal healthcare costs can be prohibitive. A participant described that, *"I didn't go to the hospital because I had no money for transport and medical bills. Even if the services becomes free, getting there still costs me something."* Though some health services in Zimbabwe are subsidized of free at public facilities, indirect costs such transport, food during travel and time away from informal work are often too much for women in low-income rural households. This aligns with findings by Ndlovu and Sikwela (2021), who noted that rural women in Zimbabwe face multi-layered economic barriers to healthcare, compounded by food insecurity and household poverty.

4.4.3 Limited health workers

The shortage of trained healthcare personnel is a notable barrier to accessing quality healthcare in Buhera ward 14, with 14% of participants mentioned it. Understaff at Murambinda hospital leads to long waiting times, poor patient-provider interaction and limited service coverage. This aligns with findings by Mushavi et.al (2020) who argue that rural Zimbabwe faces a critical human resource gap, especially in maternal and reproductive health services, clinics often rely on nurse aids or untrained staff to fill in when professional nurses are absent. A participant supported that, "*there's only few nurses at the hospital, and you can wait the whole day and still not be seen."* Taruvinga and Mutema (2021) noted that overworked staff tend to provide rushed consultations

and are more likely to overlook serious symptoms or engage in disrespectful behavior. Another participant confirmed that*, "the nurse shouted at me for coming late, but I had walked for hours, I didn't feel comfortable going back."* Such interactions discourage women from returning for follow-up visits or routine care, further undermining continuity of care and preventive health practices.

4.4.4 Poor health literacy

Poor health literacy is also another challenge which was mentioned by 11% of the participant's .In Buhera ward 14, many women have limited formal education, which affects their capacity to make informed health decisions, follow treatment instructions or navigate the healthcare system. One participant said, "*I didn't go to the hospital because I didn't know I was supposed to attend check-ups when I wasn't sick*." This comment reflects functional health illiteracy. Mhlanga (2020) also noted that rural women in Zimbabwe often lack access to accurate health information in their local language or at their literacy level. A local nurse also recounted that, "*some mothers come to the hospital only when they are in labor, not knowing they were supposed to come for checkups throughout the pregnancy."* This finding is supported by Tshuma and Nyoni (2023) who observed that lack of health knowledge contributes to poor adherence to antenatal and postnatal care schedules among rural Zimbabwean women.

4.4.5 Long Distance to Healthcare Facilities

Long distances between rural communities and health facilities is also another barrier to healthcare access in Buhera Ward 14 which scored 10%. Many women must walk long hours often over 5 km to reach the nearest clinic, a journey that is both physically demanding and unsafe, especially for pregnant women, the elderly, or those with young children. One woman shared that, *"The clinic is too far. I have to wake up before sunrise and walk the whole day. If I'm sick, I just stay home.* "This aligns with research by Maposa and Mavhundutse (2021), who found that long distances to healthcare facilities in rural Zimbabwe discourage early and regular health-seeking behavior, especially for maternal and child health services. According to Katsande and Dzingirai (2020), women in remote districts like Buhera often give birth at home or with traditional birth attendants because they cannot afford the physical journey or the cost of transport. Another participants also commented that, "*I delivered my baby at home because I couldn't make it to the clinic in time*,"

another woman reported. This situation reflects broader findings by Chimhowu et al. (2022), who highlight that geographic isolation, combined with poor road infrastructure, leads to spatial health inequality in rural Zimbabwe.

4.4.6 Poor Infrastructure

Although it was mentioned by a few (6%), poor infrastructure both within health facilities and in surrounding transport networks significantly limits women's ability to access quality healthcare in Buhera Ward 14. Clinics are often old, overcrowded, and lack basic amenities such as clean water, reliable electricity, and proper sanitation. Additionally, access roads are poorly maintained, making transportation to and from health centers difficult, particularly during the rainy season. A woman from the ward shared, *"Our clinic has no electricity. Sometimes, the nurse uses a torch or phone light to treat us at night. It's scary when you're giving birth in the dark*." This reflects findings by Muzamhindo and Chirwa (2021), who noted that the lack of adequate infrastructure in rural Zimbabwe severely compromises the quality and safety of care, especially for maternal and child health services. According to Chikowore and Banda (2022), some clinics in rural areas are staffed but under-equipped, turning them into "buildings without services," which discourages community members from trusting or utilizing them. A local health worker explained, "*We sometimes refer women to bigger hospitals, but there's no ambulance or fuel. Some don't make it."* These systemic failures often force women to resort to home-based remedies or seek care from traditional healers or untrained birth attendants, especially when labor begins at night or during bad weather.

Based on both qualitative evidence and quantitative data, cultural and religious beliefs (30%) stand out as the most critical barrier to healthcare access for women in Buhera ward 14.

4.5 Impact of poor access to healthcare by women in Buhera ward 14

Poor access to healthcare services significantly affects the well-being of women in Buhera ward 14. This rural area faces numerous challenges, including long distances, cultural and religious beliefs and inadequate medical infrastructure. These barriers contribute to high maternal mortality, delayed diagnosis and treatment, increased home deaths, emotional stresses, reduced quality of life and economic burdens on individuals and families. Figure 4.3 illustrates the impact of poor healthcare access on women in Buhera.

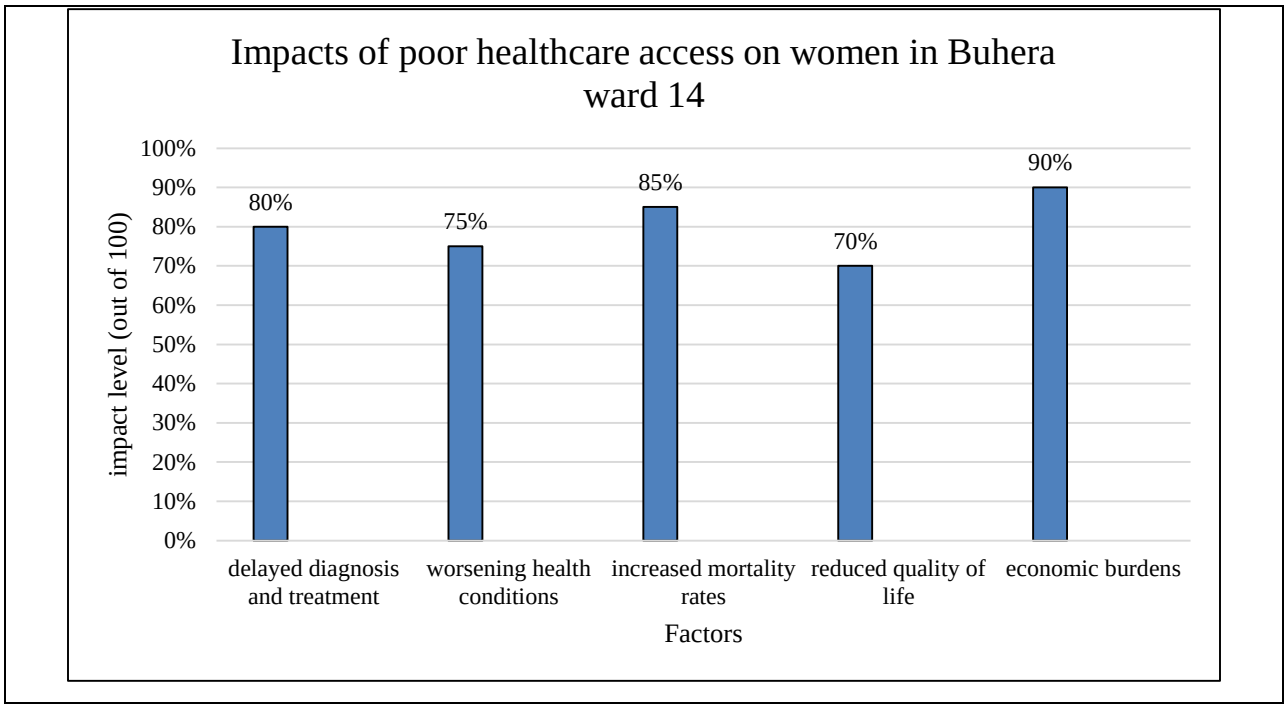

Figure 4.3: Impacts of poor healthcare access

Figure 4.3 illustrates the impacts of poor access to healthcare, with economic burdens ranked highest at 90%, followed by increased mortality rates (85%). Delayed diagnosis and treatment account for 80%, often resulting in advanced-stage illness. Worsening health conditions, rated at 75% while reduced quality of life at 70%. These percentages illustrates the urgent need for improved healthcare infrastructure, affordability and access in the region.

4.5.1 Economic Burdens on Individuals and Families

The most reported consequence of poor healthcare access was the financial strain it places on households, with a percentage of 90. Women and their families often resort to selling livestock, borrowing money, or using savings to cover transport, medication, and emergency services. Health issues that go untreated lead to prolonged illness or disability, affecting the woman's ability to contribute to household income and increasing dependency. One respondent commented that "*We end up selling goats or borrowing money just to take someone to hospital when it's too late. It affects the whole family*." This is supported by Chikowore and Banda (2022), who argue that limited access to timely care increases long-term household poverty and deepens economic inequality in rural Zimbabwe.

4.5.2 Increased Mortality Rates

High mortality rates also resulted as the most significant impact with 85%.Late or absent healthcare leads to avoidable deaths, especially among pregnant women, infants, and those with chronic conditions. Religious restrictions, cost, or long distances often delay care until the condition is beyond treatment. Many women die at home or during transit to distant hospitals. Another participant described that "*Some mothers die giving birth at home because they are not allowed to go to the clinic*." This finding echoes Muzamhindo and Chirwa (2021), who note that lack of timely access to maternal health services remains a leading cause of rural maternal mortality in Zimbabwe.

4.5.3 Delayed Diagnosis and Treatment

Another impact which was mainly mentioned by 80% of the participants was delayed diagnosis and treatment. When women delay going to health facilities due to fear, beliefs, or distance, illnesses that are treatable in early stages worsen. Conditions like infections, high blood pressure, or pregnancy complications are often diagnosed too late for effective intervention. One participant commented that, "*We only go to the clinic when it is really serious, but sometimes it's too late*." This reflects the Three Delays Model (Thaddeus & Maine, 1994), which identifies delays in deciding to seek care, reaching care, and receiving appropriate care as key contributors to maternal and child deaths.

4.5.4 Worsening Health Conditions

Closely related to delayed diagnosis, untreated illnesses, which scored 75%, often progress to advanced stages, resulting in complications that are more difficult and expensive to treat. This includes untreated STIs, postpartum infections, or unmanaged chronic diseases. A woman supported that, "*You get worse because you don't have money or transport. By the time you get help, the sickness is deep*." Murewa and Zinyemba (2021) found that in rural communities, the combination of poverty and low health literacy often results in delayed treatment-seeking, leading to more severe health conditions and increased demand on already strained health facilities.

4.5.5 Reduced Quality of Life

70% of participants also mentioned that poor access to healthcare is reducing their quality of life. Women whose health problems are unaddressed or badly handled have long-range effects like chronic pain, mobility problems, or mental anguish. Lower self-esteem and social isolation result from this decreasing of their capacity to handle everyday duties, nurture children, or engage in income-generating work. One participant said, "*I had discomfort for months even after delivery since I never returned to the clinic, I just stayed home*." Tandi and Muvengwa (2023) confirm that poor healthcare access affects not just survival, but the quality of daily life, productivity, and emotional wellbeing of rural women.

The study revealed that poor healthcare access in Buhera ward 14 leads to severe consequences, including economic burdens, delayed diagnosis, worsening health conditions and reduced quality of life. These effects are largely driven by late care-seeking, religious and cultural and others. While some scholars have examined individual barriers like distance and cultural beliefs, there remains a research gap in understanding how these factors interact and compound to produce long-term health and socio-economic effects, particularly from the perspective of women in rural and apostolic dominated communities, therefore this study evaluates that poor access to healthcare access mainly results in economic burdens and increased mortality rates.

4.6 Strategies that can be adopted to improve healthcare provision for women in Buhera

Improving women's access to healthcare in Buhera ward 14 requires a multifaceted approach that addresses both structural and socio-cultural barriers. Based on the findings of this study, several targeted strategies were identified as crucial for enhancing healthcare delivery and utilization. These proposed strategies includes strengthening community based health program, mobile outreach services, improving health infrastructure and staffing, women empowerment, subsidized healthcare policies, religious and cultural engagement as well increasing availability of medication. Figure 4.4 shows various strategies that can be adopted to improve healthcare access.

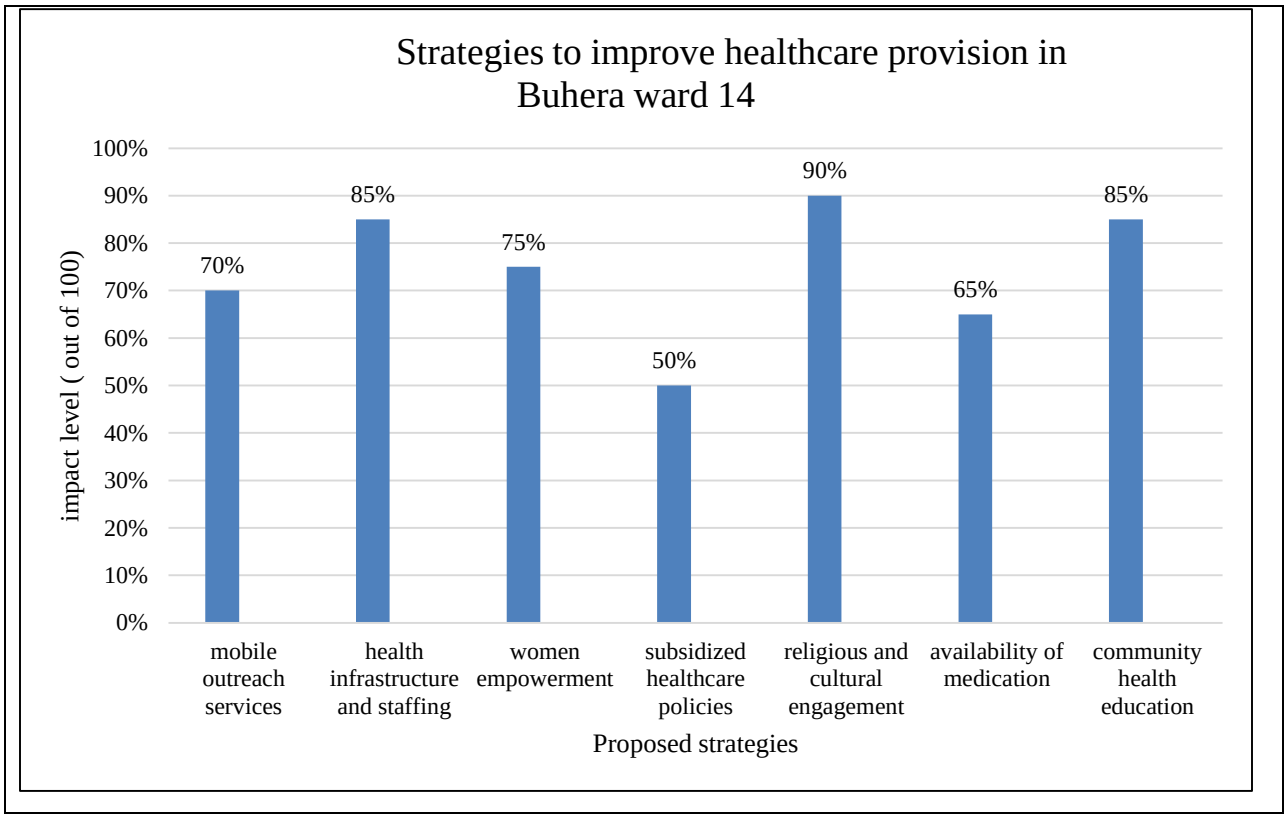

Figure 4.4: strategies to improve healthcare provision in Buhera ward 14 (N=50)

4.6.1 Religious and cultural engagement

Religious and cultural beliefs emerged as the most significant factor influencing healthcare access in Buhera Ward 14, with 90% of participants identifying engagement with religious and traditional leaders as a critical strategy. This is mostly the result of the supremacy of the Johane Marange Apostolic sect, which forbids members from receiving conventional medical attention. One respondent said, "*Our church does not allow us to go to the hospital, so we pray and offer holy water even when someone is bleeding*." This religious and cultural obstacle not only slows down treatment but also totally prevents some women from ever getting critical services. As Dzimiri and Machingura (2023) stress, working with religious leaders and culturally aware health messages is vital for enhancing health outcomes in such populations as it helps change deeply held beliefs without overt conflict.

This approach also matches the World Health Organization's (WHO, 2022) advice on culturally sensitive healthcare, which advises bringing conventional leaders into rural health initiatives to increase reach and credibility. Given the strong community influence of the sect, this method is

especially needed in Buhera Ward 14. Standard health treatments could keep being resisted or ignored without interacting with these cultural systems.

4.6.2 Strengthening Community-Based Health Education Programs

With 85% of the participants favoring it, strengthening community-based health education was emphasized as a major means of raising women's health results in Buhera. Many women showed little knowledge of fundamental health problems including chronic diseases, maternal problems, and early indicators of preventable diseases. One respondent shared, "*We didn't know the danger signs; we only went to the clinic when things were already bad.*" This illustrates a lack of health literacy, which contributes to delayed healthcare-seeking behavior and worsens disease outcomes. According to Murewa and Zinyemba (2021), enhancing health literacy through locally tailored education programs increases health service utilization and promotes preventive behaviors. Community health workers and peer educators are especially effective in rural areas where formal education is limited. Culturally relevant messaging and use of local languages also increase comprehension and acceptance of health information (WHO, 2022).

4.6.3 Improving Health Infrastructure and Staffing

Equally ranked with health education (85%), improving health infrastructure and staffing was seen as essential to service accessibility. Clinics in Ward 14 were described as overcrowded, under-resourced, and often lacking essential services such as maternity wards, electricity, and adequate medical personnel. A respondent noted, *"Sometimes there's only one nurse for the whole clinic, and no medication.*" This shortage reduces the quality of care and discourages women from returning for follow-up visits. Muzamhindo and Chirwa (2021) emphasize that rural health centers in Zimbabwe often operate with skeletal staff and deteriorating infrastructure, leading to high staff burnout and patient dissatisfaction. Investments in rural infrastructure, including transport and electricity, have been shown to improve both service delivery and patient outcomes (UNFPA, 2022).

4.6.4 Empowerment of Women

Empowering women emerged as a vital strategy for enabling autonomous health decisions which scored 75%. Many women in Buhera depend on male partners or family elders to approve health-related choices. One woman stated, "*If I have my own money, I can go to the clinic even if my*

husband refuses." This highlights how economic and social empowerment through education, income generation, and leadership opportunities can improve women's ability to access care independently. Tandi and Muvengwa (2023) argue that empowered women are more likely to utilize antenatal care, family planning, and child health services. When women have a say in household decisions, healthcare becomes a priority, reducing delays and complications.

4.6.5 Mobile Health Outreach Services

70% of participants mentioned mobile health outreach services as one of the key strategies to enhance healthcare access in Buhera ward 14. Mobile outreach services are essential in remote areas where long distances to clinics hinder timely access to care. Many participants rely on these services for immunizations, maternal care, and basic treatments. As one respondent explained, *"We only get help when the mobile clinic comes; otherwise, it's too far to walk*." This underscores the importance of taking services to the people rather than expecting them to travel. Chikowore and Banda (2022) found that mobile clinics effectively extend health coverage to underserved rural populations, especially when supported by community mobilization. These services reduce transportation costs and address seasonal barriers such as flooded roads during the rainy season.

4.6.6 Increasing Availability of Medication

Increasing availability of medications in hospitals and clinics is also another strategy that was mentioned by 65% of participants in the study. The credibility of healthcare institutions depends on access to life-saving medications. Many participants voiced annoyance at having to travel great distances only to be rejected because of medication shortages. A woman commented, "*You stroll all that distance and they say there's no treatment, what's the use?".* This may cause women to seek to traditional treatments or postpone upcoming visits, hence damaging faith in established medical institutions. Makoni and Zulu (2020) claim that regular medication access is both a medical need and a psychological motivator for care-seeking behavior. Women who know they would get treatment are more prone to visit clinics early and often.

4.6.7 Subsidized Healthcare Policies

Although recognized as vital, subsidized healthcare policies got the worst grade (50%). Some attendees said they turned to herbs or borrowing money when rates were too high. One remarked, *"Only if we cannot pay the hospital do we resort to herbs*." Although this shows resilience, it also

shows that financial restrictions still restrict access to excellent treatment. Sibanda and Moyo (2021) highlight how rural women particularly during pregnancy and delivery disproportionately bear out-of-pocket health expenses. Putting fee exemptions, health insurance plans, and government-sponsored maternal care initiatives into action helps to remove these obstacles and guarantee fair access. Participants in this study underlined the need of focused subsidies for needy groups, especially chronically ill people and pregnant women. Among low-income groups, subsidized care whether by means of cost exemptions, vouchers, or national health insurance programs helps greatly increase usage of health services.

4.7 Discussion of Findings

The research showed many connected variables restricting women's access to healthcare in Buhera District Ward 14. The most visible barrier, cited by 30% of respondents, was cultural and religious beliefs, especially among the Johane Marange Apostolic sect, which forbids its members from seeking medical care. This result accords with Chitando and Togarasei (2019), who observed that apostolic doctrines often restrict women's reproductive rights and discourage modern healthcare use. Verbatim responses from participants underlined this problem with one woman observed: "*In our church, going to the hospital shows a lack of faith. We are taught to depend only on prayer*. This reveals how deeply rooted health habits are culturally, therefore they can overcome even life-threatening symptoms.

Another major obstacle was insufficient finances, which 19% of those polled noted. Most ward women are jobless or engaged in subsistence farming, therefore they lack enough money for medical costs or transportation. This supports Makinde et al. (2018) who underlined how poverty is a major predictor of subpar health outcomes in rural Africa. Among married women particularly, economic dependence also restricts independence in health choices.

Additionally found in the study was a major contribution of inadequate health infrastructure (6%) and few health workers (14%) to healthcare access. Mhlanga and Garimoi Orach (2021), who noted that rural Zimbabwean clinics frequently lack basic supplies, underlined the shortage of personnel and under-equipped facilities. One local respondent observed, "Even if you go to the clinic, you can be instructed to return because no nurse or no medicine is available." This results in prolonged delays in treatment and lowers community confidence in official health services.

Another obstacle was poor health literacy (11%), which hampered women's capacity to early detect health problems or negotiate the healthcare system. Underuse of preventative treatments and postponed care are connected with low health literacy, according to Nutbeam (2018). Moreover, large distances to clinics (10%) and lack of medicine (10%) were highlighted as significant obstacles, therefore supporting results by Ouma et al. (2019), who demonstrated that geographic obstacles substantially influence maternal health outcomes in rural regions.

Regarding effects, the repercussions were catastrophic. The most frequently reported results were increased mortality (85%), postponed treatment (80%), and deteriorating health conditions (75%). Furthermore extensively recognized were financial obligations (90%) on families, many of whom had to borrow money or sell cattle in quest of emergency treatment. These results support WHO (2020) data showing that restricted healthcare availability in low-income regions drives poverty and disease cycles.

On the good side, participants supported many ways for development. Notably supported were religious and cultural involvement (90%), health education initiatives (85%), and better infrastructure and personnel (85%). Emphasizing a multi-sectoral, community-centered approach, these tactics correspond with international best practices promoted by Gilson (2019) and Kuhlmann et al. (2017).

In short, the results of this research imply a complex, multidimensional problem needing focused treatments. Cultural standards, poverty, institutional flaws, and educational disparities all intersect to limit access to healthcare for women in Buhera. Addressing these obstacles and advancing fair healthcare delivery depends on a holistic, locally customized approach.

4.8 Chapter summary

With religious and cultural attitudes as well as financial difficulties surfacing as main influences, this chapter has looked at the major obstacles preventing women in Buhera District Ward 14 from accessing healthcare. These obstacles have far-reaching effects that exacerbate women's vulnerability and poor health results. Evidence-based solutions to these problems have also been discussed. The results in general underline the necessity of inclusive, culturally sensitive, and community-driven programs to raise rural women's access to healthcare.

CHAPTER FIVE: SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

The chapter considers how the recognized obstacles like financial, cultural, and systemic affect women's access to healthcare in Buhera District Ward 14. It also analyzes the influence of these impediments on women's health results and presents context-specific initiatives that may be put in place to boost access. This chapter helps to more generally comprehend the healthcare needs of rural women in Zimbabwe by linking the results of the research to current literature and therefore underlining policy, practice, and future research implications.

5.2 Summary of Key Findings

The investigation found a number of obstacles preventing women in Buhera District Ward 14 from accessing healthcare resources. Among these most visible is the impact of religious and cultural ideas particularly within the Johane Marange Apostolic sect which discourage believers from seeking regular medical care. Combined with financial restrictions, this cultural constraint presented a major barrier since many women lack the means to cover medical care, drugs, or transportation costs. Low health literacy, lack of medication, extended distances to healthcare centers, substandard infrastructure, and few health professionals are other obstacles. These variables are related and often reinforce one another, hence producing a complicated environment in which women are purposefully denied access to appropriate medical care.

The results of these obstacles are very extensive and rather disturbing. Among the most terrible results were found to be delayed diagnosis and treatment (80%) and higher mortality rates (85%). Many women said their quality of life was lowered and their health was getting worse, usually because of their lack of access to timely and suitable medical care. Furthermore, economic burdens on families (90%) were reported as a direct consequence of poor healthcare access, as untreated conditions often escalate into more serious illnesses requiring costly interventions. These effects not only influence single women but also have bigger consequences for community health and family well-being.

Responding to these obstacles, the research examined several approaches that might assist to enhance healthcare services for women locally. Religious and cultural participation (90%), boosting community-based health education (85%), and upgrading health infrastructure and

staffing (85%) were among the most well supported solutions. Other suggested techniques included female empowerment, mobile health awareness campaigns, sponsored healthcare policies, and improved medication availability. These approaches show a clear need for multifaceted, culturally sensitive, and community-driven projects addressing both structural and social determinants of health. The results strongly suggest that collaborative efforts among government, civil society, and local communities will be necessary to achieve significant advances in healthcare access for rural women.

5.3 Conclusion

The study concludes that religious and cultural restrictions, followed by economic hardships and weak healthcare systems, are the most pressing barriers to women's healthcare access in Ward 14. These challenges are deeply rooted in community norms and structural inequalities. The impacts of these barriers are far-reaching and deeply concerning. Furthermore, economic burdens on families were reported as a direct consequence of poor healthcare access. The findings showed that delayed diagnosis and treatment and increased mortality rates are among the most severe outcomes. However, with targeted, community-driven strategies that are culturally sensitive and inclusive, these barriers can be addressed. Empowering women, engaging traditional and religious leaders, and improving the quality and accessibility of health services are crucial steps toward equitable healthcare access.

5.4 Proposed Framework

Proposed Framework: Integrated Model for Enhancing Women's Access to Healthcare in Buhera District Ward 14

To address the complex and interrelated barriers affecting women's access to healthcare services in Buhera District Ward 14, this study proposes the Integrated Model for Enhancing Women's Access to Healthcare (IMEWAH). This framework adopts a holistic, community-driven, and multi-sectoral approach that focuses on both service delivery improvements and the socio-economic empowerment of women.

The Figure 5.1 represents the Integrated Model for Enhancing Women's access to Healthcare (IMEWAH). At the first is the core objective (enhancing women's access to healthcare), followed

by six interlinked components, each contributing to the goal. The circular flow and arrow indicates that these components are interconnected and must work together holistically for the model to be effective.

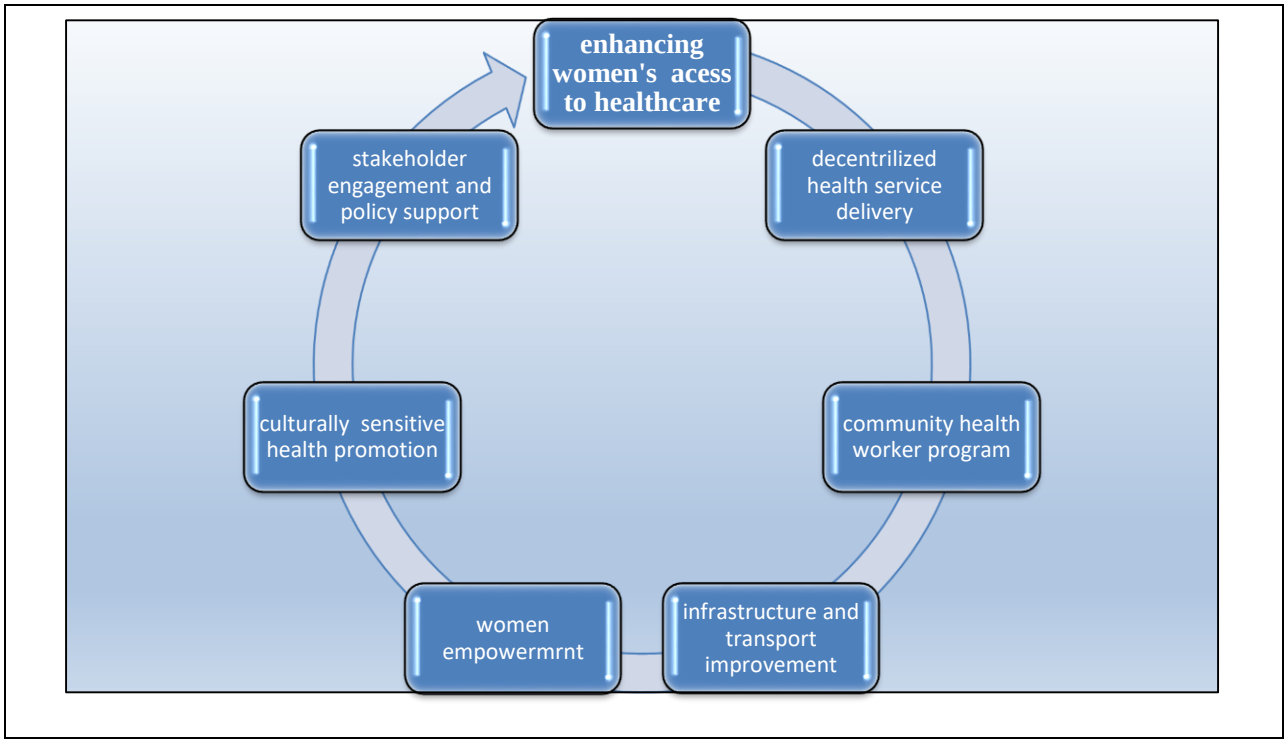

Fig 5.1 Proposed framework

This model illustrates that improving women's access to healthcare requires and integrated, community based and systematic approach. This circular, interconnected approach ensures sustainability and responsiveness to the local context. It acknowledges that improving healthcare access for women requires more than health sector reforms but it demands cross-cutting interventions that address education, infrastructure, economy, and cultural norms.

Component 1: Decentralized Health Service Delivery

- Establish mobile health clinics that visit remote communities on a regular schedule to provide basic healthcare, maternal services, and immunizations.

- Strengthen the existing rural clinics by equipping them with essential medicines, skilled health personnel, and maternal health equipment.

Component 2: Community Health Worker (CHW) Program

- Train and support local community health workers to serve as a link between communities and formal health services.

- CHWs will conduct household visits, deliver health education, and support maternal and child health interventions.

Component 3: Infrastructure and Transport Improvement

- Advocate for the improvement of road networks and footbridges in the ward to ease travel to health facilities.
- Introduce a community-managed emergency transport system, such as bicycle or ox-drawn carts, for urgent health cases, particularly maternal emergencies.

Component 4: Economic Empowerment of Women

- Collaborate with NGOs and government agencies to support women's access to microfinance, vocational training, and income-generating activities.
- Empowering women economically will reduce financial dependency and enable them to seek healthcare without delays.

Component 5: Culturally Sensitive Health Promotion

- Implement culturally appropriate health education programs using local languages and involving traditional leaders.
- Focus on dispelling myths and misconceptions surrounding reproductive health and encouraging preventive care.

Component 6: Stakeholder Engagement and Policy Support

- Encourage active participation of local leaders, policymakers, NGOs, and the community in healthcare planning and decision-making and advocating for policies that prioritize rural women's health needs and allocate resources equitably.

5.5 Recommendations

5.5.1 Policy Makers

Policy makers should prioritize the development of culturally sensitive health policies that accommodate religious beliefs while safeguarding women's rights to access healthcare. Given the

widespread economic challenges faced by women in Buhera District Ward 14, there is a strong need for subsidized healthcare programs, such as rural health insurance schemes or free maternal services, to ease financial burdens. Investment in rural infrastructure is also essential particularly in improving roads, clinic facilities, and access to emergency care services. Matsika et al. (2024) also noted that weak infrastructure remains one of the primary barriers to service utilization, therefore, the government agencies should invest in expanding rural road networks. Moreover, more qualified health professionals must be deployed to underserved areas, with the Government offering incentives such as rural hardship allowances, housing, and career development programs to attract and retain staff in remote locations.

5.5.2 Healthcare Providers

Healthcare providers have a critical role in enhancing access by strengthening community-based health education programs. These should aim to increase awareness about reproductive health, disease prevention, and the importance of early treatment-seeking behavior. Providers should also establish mobile health outreach services that can serve women in hard-to-reach villages with antenatal care, vaccinations, and health checkups. Health facilities should ensure consistent availability of essential medications and supplies, which are frequently reported as lacking in rural areas, leading to frustration and loss to follow-up (Health Times, 2024). Additionally, healthcare workers must be trained in culturally sensitive communication to better engage women from conservative religious backgrounds like the Johane Marange sect, where medical treatment is often discouraged.

5.5.3 Religious and Community Leaders

Religious and traditional leaders hold considerable influence in shaping community attitudes toward healthcare. They should be actively engaged in health dialogues and encouraged to support health-promoting messages within their congregations and gatherings. In particular, leaders from apostolic churches should work collaboratively with healthcare professionals to dispel myths and harmful beliefs that discourage women from seeking care. Their endorsement can help normalize the use of health services and increase trust between communities and health institutions. Leaders should use their platforms to promote positive messaging around women's health rights, discouraging stigma associated with illnesses such HIV and AIDS. A recent initiative in Kenya,

where religious leaders were trained to support maternal health campaigns, resulted in improved community attitudes and uptake of antenatal care services (UICC, 2024). In Buhera, where many women consult both biomedical and spiritual healers, fostering partnerships between traditional leaders and healthcare providers can help bridge gaps in understanding and reduce resistance to formal healthcare services. These leaders must be empowered with accurate health information so they can serve as champions of health equity and agents of behavioral change in their communities.

5.5.4 NGOs and Donor Agencies

Non-governmental organizations and donor institutions should support local interventions that improve both healthcare access and women's socio-economic standing. This includes funding income-generating projects that empower women financially, thereby enhancing their ability to afford healthcare services. NGOs can also implement or support programs focused on improving health literacy, providing transport for medical emergencies, and promoting safe motherhood initiatives. Donor- funded initiatives should also focus on empowering women and promoting women and promoting accountability in healthcare governance (George, 2015). Additionally, they should play a key advocacy role in pushing for policy reforms that prioritize rural women's health needs.

5.5.5 Researchers and Academics

Researchers should undertake further studies to deepen understanding of how cultural and religious beliefs influence healthcare-seeking behavior, particularly in rural and apostolic communities. There is also a need to explore the perspectives of men and adolescents, whose views often shape health decisions within families. Longitudinal studies evaluating the outcomes of implemented strategies can help refine health interventions. Furthermore, researchers should develop culturally contextual models of health behavior that inform future policy and program design. Local academic institutions working with foreign researchers may also help to close information gaps and highlight local viewpoints within global health debate.

5.5.6 Women and Community Members

To improve local healthcare systems, women and community members are urged to participate actively in health education initiatives and village health committees. Women should also be encouraged via awareness campaigns and support groups to make educated decisions on their health (WHO, 2023). Their voices as crucial stakeholders are essential for promoting better services, demanding accountability from healthcare providers, and confronting cultural standards that impede access to treatment. Women must also be informed of their rights and entitlements under national health plans, including maternal care. This can be effectively done on local awareness campaigns, village meetings, and radio programs. Ultimately, developing a gender-equal and health-conscious society calls for both grassroots activism and solidarity among all society members

5.6 Chapter summary

Chapter Five gave a thorough synthesis of the results of the study, including suggestions based on the identified barriers impeding women's access to medical services in Buhera District Ward 14. The chapter started with a summary of main findings, which pointed to important challenges as financial limitations, religious restrictions, and insufficient infrastructure; effects of these challenges on women's access to medical care; and tactics to improve healthcare delivery. Based on these findings, a proposed framework, IMEWAH (Integrated Model for Enhancing Women's Access to Healthcare) was introduced. Finally, the chapter outlined specific recommendations for government, communities, NGOs, and policymakers aimed at improving equitable access to healthcare for women in rural Zimbabwe. The findings underscore the need for sustainable, context-specific solutions to bridge healthcare gaps and enhance the well-being of women in underserved areas.

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APPENDIX 1

QUESTIONNAIRE: A SOLUTON BASED ASSESSMENT ON BARRIERS FACING WOMEN IN ACCESSING HEALTHCARE IN BUHERA DISTRICT WARD 14

Section A: Demographic Information

Tick in the box the appropriate answer for you

1. What is your age?

AGE	
15-24	

25-34	
35-44	
45-49	

2. What is your Gender?

female		male	

3. What is your marital status?

Married		divorced	
single		widowed	

4. What is your highest level of education?

Primary	
Secondary	
Diploma	
Degree	

5. What is your occupation?

Employed (formal)

Self-employed

unemployed

Section B: Access to Healthcare

6. How often do you visit a health facility?

.....

7. How far is the nearest health facility from your home?

.....

8. What means of transport do you use to reach the health facility?

.....

Section C: Factors that obstructs women from accessing healthcare access

9. Have you ever failed to access healthcare services when you needed them? (Yes/No)

yes		no	

11. If yes, what were the reasons? (Tick all that apply):

Lack of money	
Long distance	
Poor roads/transport	
Limited health workers	
Poor treatment by health staff	
Long waiting times	
Cultural/religious beliefs	
Lack of medication or supplies	

10. Are health services affordable to you and your family? (Yes/No)

yes		no	

11. Have you ever been discouraged by family or community members from seeking healthcare? (Yes/No)

Yes		No	

12. Do cultural or religious beliefs influence your decision to seek healthcare? (Yes/No)

yes		no	

Section D: Impact of Barriers

13. 1= Strongly Disagree 2= Disagree 3= Neutral 4= Agree 5= Strongly Agree

Statement	**1**	**2**	**3**	**4**	**5**
I have missed important medical treatment because of distance or cost					
Poor access to healthcare to healthcare has negatively affected my health or that of my family					
I have had to rely on traditional remedies due to lack of access to clinics					
Delayed treatment has led to worsening of illness in my household					
Poor access has made it harder for me to manage pregnancy or child birth safely					
Children in my household have missed vaccinations or treatment due to poor access					
I experienced emotional stress due to difficulties in accessing healthcare services					
My economic productivity is being affected by limited access to healthcare					

14. How does poor access to healthcare affect your health and well-being?

Impact	Yes	No
Delayed diagnosis		
Increased mortality		
Worsening health conditions		
Economic burdens		
Reduced quality of life		

Section E: Solutions and Recommendations

15. What improvements would make it easier for you to access healthcare? (Tick all that apply):

More clinics nearby	
More trained healthcare workers Better transport options	
Reduced costs or free services	
Mobile health services	
Community health education	

16. What do you think the government or NGOs can do to improve access to healthcare in your area?

……
……..

17. Are you willing to participate in any community health program? (Yes/No)

yes		No	

18. What other suggestions do you have to improve women's access to healthcare in your ward?

……
……
……

CONSENT STATEMENT

I hereby consent to participate in this study and provide information. I understand that the information will be used solely for research purposes and will remain confidential.

SIGNATURE: _____

DATE: _____

APPENDIX 2

FOCUS GROUP GUIDE: A SOLUTON BASED ASSESSMENT ON BARRIERS FACING WOMEN IN ACCESSING HEALTHCARE IN BUHERA DISTRICT WARD 14

STRUCTURE OF THE FOCUS GROUP DISCUSSION (FGD)

Opening Session (5–10 minutes)

Welcome and Introductions

Introduce facilitator and note-takers.

Briefly explain the purpose of the discussion: to understand the relationship between income levels and food security within households.

GROUND RULES

Encourage respect for different opinions and equal participation.

Assure confidentiality—responses will not be attributed to individuals.

Explain how the data will be used for research purposes.

CONSENT

Obtain verbal or written consent for participation and recording (if applicable).

Section A: General Understanding

1. What types of healthcare services do women in this community usually need?

.....

2. Where do women usually go when they need healthcare services?

……..

Section B: Factors that obstructs women from accessing healthcare services

3. What challenges do women face when trying to access healthcare in this ward?

…….

……

……

4. How does distance or transport affect your ability to get healthcare?

…….

5. Are health services affordable for most women here? Why or why not?

…….

6. Are there cultural or religious beliefs that stop some women from seeking care?

……..

Section C: Impact of poor access

8. What happens when women are not able to get healthcare on time?

……

9. Have you seen or experienced situations where someone's health got worse due to delays or lack of care?

…….

10. How do issues like poor access to maternal care affect families and children in this community?

…….

Section D: Solutions and Improvements

14. What do you think can be done to improve women's access to healthcare services in this area?

……

15. What kind of support would help you or others visit clinics more easily?

……..

16. Are there community-based solutions that have worked or could work here?

…….

17. What advice would you give to health authorities or leaders to help solve these problems?

APPENDIX 3

SEMI STRUCTURED INTERVIEW FOR KEY INFORMANTS: A SOLUTON BASED ASSESSMENT ON BARRIERS FACING WOMEN IN ACCESSING HEALTHCARE IN BUHERA DISTRICT WARD 14

Section A: Background Information

1. Can you describe your role or involvement in the community or healthcare services?

.....
.....

2. How long have you been serving in this area?

……..

Section B: Barriers to women's access to healthcare

3. What are the key barriers women in Buhera Ward 14 face when accessing healthcare services?

……
……
……

……..

4. How do social and cultural beliefs affect women's decisions to seek healthcare?

……
……..

5. Are there specific economic or financial constraints that limit women's access to services?

……
……

6. What transportation or geographic challenges affect women in this ward?

……
……

7. Are healthcare facilities in this area adequately staffed and resourced to meet women's needs?

……

Section C: Impact of Poor Access

8. What have you observed as the health consequences of women not accessing timely or appropriate healthcare?

……..

9. How does poor access affect maternal and child health outcomes in this community?

……

10. Are there any social or economic impacts on families or the wider community due to limited healthcare access for women?

……'……

11. Do delays in treatment or lack of preventive care contribute to higher health risks or complications among women?

……..

Section D: Solutions and Recommendations

12. What practical solutions could be implemented to reduce these barriers?

……..

13. Are there successful interventions from other areas that could be adopted in Buhera Ward 14?

…….

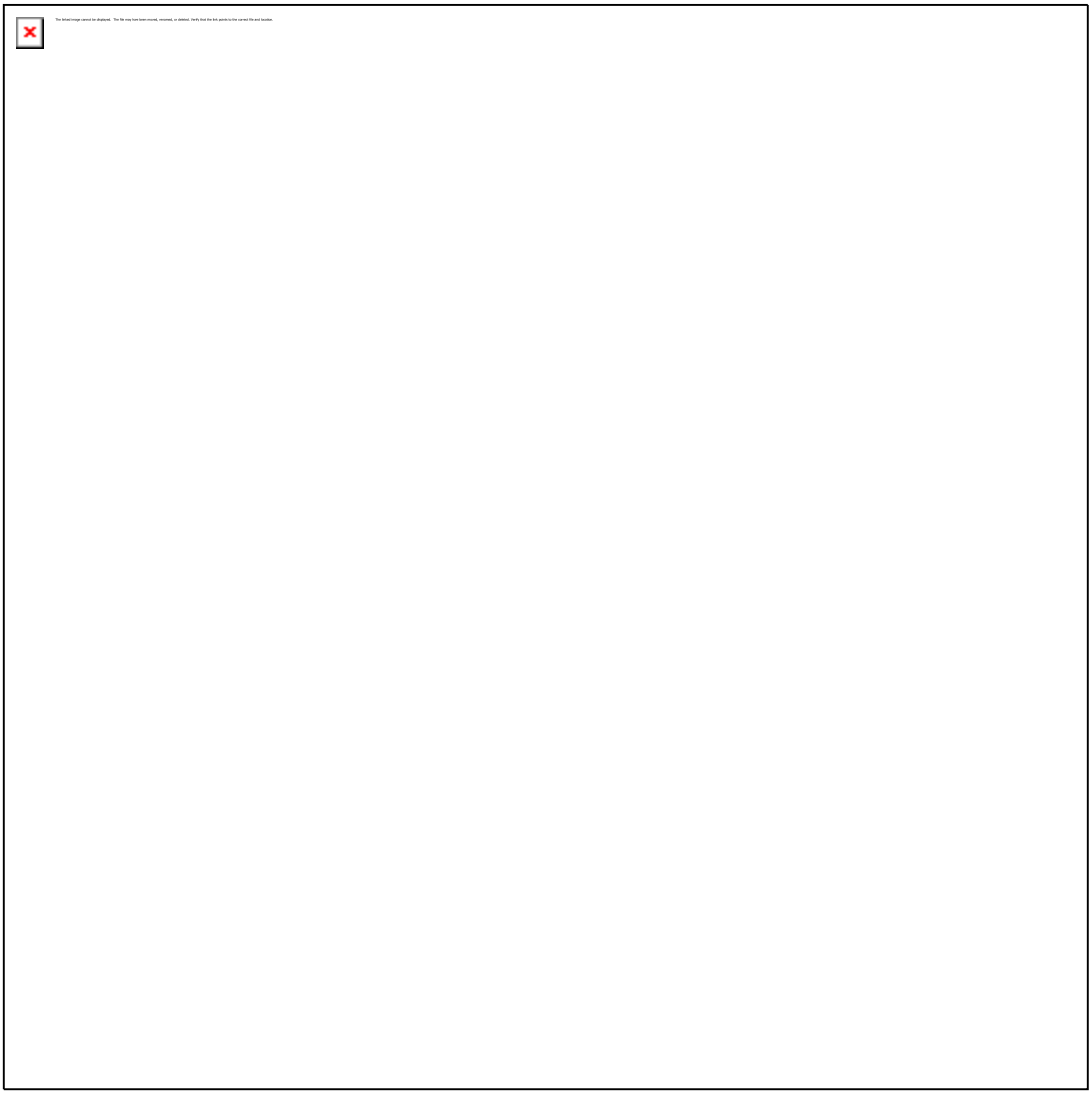
14. What role can local leaders, government, or external partners play in improving the situation?

……

15. What recommendations would you give for long-term, sustainable improvements in women's access to healthcare?

…….

TURNITIN REPORT



RESEARCH LETTER

OfficialCommunicationsshouldnotbeAddressedtoindividuals
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ZIMBABWE

MinistryofPublicService,LabourandSocialWelfare
DepartmentofSocialDevelopment
POBox50
Murambinda
Buhera

01 May 2025

TO WHOM IT MAY CONCERN

RE: PERMISSION GRANTED TO CONDUCT A SCIENTIFIC RESEARCH FOR DISSERTATION: MUFARO MABIKA B213628B: BINDURA UNIVERSITY OF SCIENCE EDUCATION.

Dear Sir/Madam

This letter serves to certify that the above named student is enrolled in Bachelor of Science Honors Degree in Development Studies and intends to carry out a research as part of the requirements needed in fulfilling her studies. Our office has no objection to this research.

Her research topic is **A solution based assessment of the barriers affecting women's access to healthcare services in Buhera District ward 14**. The information generated in the research will only be used for academic purposes.

Thank you for your cooperation

Yours faithfully

Mr T. MATIMBA

DEPARTMENT OF SOCIAL WELFARE
BUHERA DISTRICT OFFICE
01 MAY 2025
P.O. BOX 50, MURAMBINDA
ZIMBABWE TEL: 021-2339

A PICTURE SHOWING A STUDENT HAVING INTERVIEWS WITH WOMEN IN BUHERA DISTRICT WARD 14