Experiences and Perceptions of Barriers to Health Services for Elderly in Rural Namibia: A Qualitative Study

Gert Van Rooy1, Pempelani Mufune1,†, and Elina Amadhila1

Abstract

We investigate barriers to accessing health facilities (e.g., transportation and cost of services) and health service delivery barriers (e.g., timeliness of services scheduling of appointments, language) that the literature suggest are operative. Semistructured interviews were utilized with respondents in three purposefully selected regional research sites in Namibia. All questions were translated into local languages. It is found that although many senior citizens appreciate the use of modern health care and are exempted from paying health care consultation fees, they still prefer to use traditional health medicine because of the long distance to health care facilities, which when they decide to travel translates into high transportation costs. Referrals to hospitals become very expensive. There is a need to consider the unique issues (extended family system) affecting access to health care for elderly people in Namibia to achieve equitable access to health care services.

Keywords

elderly, barriers to health access, rural Namibia

Introduction

According to the United Nations Department of Economics and Social Affairs, the population of the world is aging rapidly and this is so in low-income countries including those in Africa (Xavier Gómez-Olivé, Thorogood, Clark, Kahn, & Tollman, 2010). Thus, all countries will be obliged to deal with aspects of an aging population. In Namibia, these issues are dealt with in the country’s Vision 2030—a document that supposedly guides the country’s future. Among the objectives of Namibia’s Vision 2030 is to achieve equity in health care for all Namibians including the older adults. The vision is that

The elderly citizens are acknowledged and well esteemed for their past contributions to the development of our country. In their old age they are well cared for and remain happy senior citizens in a safe and loving environment. (Government of the Republic of Namibia, 2004, p. 116)

The elderly are treated with dignity. Legislative, economic and social structures are in place to eliminate marginalization and peace and equity between people of different ages prevail, and the elderly are given their due honour and respect. (Government of the Republic of Namibia, 2004, p. 117)

According to Vision 2030, there are several things that Namibian society must do to achieve this vision. First, it should meet the objective of ensuring that quality services (particularly health services) are made possible by increased funding for social services and human resource development. Second, it should enhance support for the older adults, and finally, it should increase pension payment to ensure good quality of life for the older adults.

The barriers to achieving Vision 2030 may be experienced to a severe degree in rural regions because of long distances, poverty, and lack of transportation. Sub-Saharan Africa (SSA) has both a high disease burden and a growing number of poor people. What is more is that

older populations in SSA are deemed to be at particularly high risk of ill-health and disability from age-related chronic noncommunicable disease (CNCD), due to a lifetime of exposure to conditions of deprivation and a growing prevalence of modifiable CNCD risk factors. (Aboderin, 2011)

Older persons are believed to lack access to even basic health care and, crucially, to have less access to services than

1University of Namibia, Windhoek, Namibia
2To the memory of Professor Mufune who passed away during the revision process of this article

Corresponding Author:
Gert Van Rooy, Social Science Division: Multidisciplinary Research Centre, University of Namibia, 340 Mandume Ndemufayo Avenue, Windhoek, Namibia.
Email: gvanrooy@unam.na
do younger age groups—suggesting an element of age-related exclusion (Aboderin, 2011). For these reasons, the elderly people might be socially excluded from clinics and other health facilities, thereby defeating the goal of equal access to health care.

The implementation of Namibia’s “Vision 2030” objectives faces several barriers (Van Rooy et al., 2012) with regard to elderly people. Lack of understanding of the extent to which these barriers are operative in Namibia will reduce the potential for Vision 2030 to be achieved. This article investigates the experiences and perceptions of elderly people as they try to access health care facilities and services in rural Namibia. More specifically, we investigate structural barriers to accessing health facilities (i.e., transportation, physical barriers, facility accessibility, cost of services) and health service delivery process barriers (i.e., timeliness of services scheduling of appointments, language, feeling respected, and health provider knowledge) that the literature suggest are operative. To ensure health for all citizens, Namibia has to address rural–urban health disparities that characterize the country’s health system. This implies identifying barriers faced by rural residents. Although research in other countries show insights into barriers that rural people face, there have been few such studies in Namibia and there is need for greater specificity about perceptions of health care by elderly people. The rationale for the article is that knowing the barriers elderly people face in accessing the health care system may contribute to policy formulation that allows greater access to health for all. Moreover, literature demonstrates that a lack of access to health care affects individual’s health status (Goins, Williams, Carter, Spencer, & Schindler, 2011). Semistructured interviews were appropriate for the study because the aim of the study is to explore thoughts, and probing techniques are allowed (Cooper & Schindler, 2011). Semistructured interviews unfold in a conversational manner offering participants the chance to explore issues they feel are important (Longhurst, 2009). Semistructured interviews allow the researcher to follow his or her own thoughts, and probing techniques are allowed (Cooper & Schindler, 2011). Semistructured interviews were appropriate for the study because the aim of the study is to explore and investigate. It is the participant’s history and experience that decided which topics were important in the

**The Health Care System in Namibia**

During the apartheid era, Namibian health system was fractured on racial grounds. Gaps in access to health care existed not only between rural and urban dwellers but also between rich and poor, and these reflected presence or absence of White populations. In the last two decades of independence in the year 1990, Namibia improved access to health care facilities for its non-White populations. The country has upgraded its primary health care system to make it more responsive to the needs of many in the population. Its total expenditure on health stood at 7% of gross domestic product and only 30% of total health expenditures are private expenditures. Out-of-pocket expenditures as a proportion of private health expenditure are only 18%, the second lowest among African countries, surpassed only by South Africa (Gustafsson-Wright et al., 2011). The overall orientation of public health services is toward primary health care, where the focus is on community health, preventative measures, and treatment that can be provided relatively easily, cheaply, and quickly (Van Rooy et al., 2012). Most of these services are provided through public clinics, outreach points, and district public hospitals. Medicines are generally affordable due to highly subsidized flat user fees. Despite these achievements, there is a critical shortage of health professionals, especially in rural areas, and public health facilities suffer long waiting times. The public sector has an average of more than 7,000 patients per registered doctor and 947 patients per registered nurse. The doctor–patient ratio is lowest in the Khomas region with an average of 3,129 people per doctor, and highest in the Ohangwena region with 22,144 people per doctor. The Zambezi region has one doctor per 12,000 people and one nurse for every 2,400 people (Gustafsson-Wright et al., 2011). It also has the highest HIV prevalence rate in Namibia.

A user fee for those younger than the age of 60 is N$4.00 on first visit and thereafter N$2.00 for follow-up. Recipients of state social grants including pensioners, that is, people older than the age of 60, are exempted from paying fees for medical services at public hospitals, in a government move to bring more relief to the disadvantaged groups. The initiative to provide free medical care to pensioners, people living with disabilities, and orphans and vulnerable children (OVC) in all government health facilities comes through the realization by the government that paying medical fees has become expensive for these people as they frequent medical centers. Pensioners must produce their pensioners’ cards to prove their age.

**Method**

The study used a qualitative methodology approach. The methodology was designed to elicit perceptions of health care delivery held by the older adults living in rural Namibia. This study relied on semistructured interviews as a research method. A semistructured interview is a verbal interchange between two people where one person, the interviewer, attempts to elicit information. Although interviewer prepares a number of questions well in advance, semistructured interviews unfold in a conversational manner offering participants the chance to explore issues they feel are important (Longhurst, 2009). Semistructured interviews allow the researcher to follow his or her own thoughts, and probing techniques are allowed (Cooper & Schindler, 2011).
various interviews. The semistructured interviews are important as they help to give exact information that the researcher is looking for in the study. Examples of items used in the interview schedule were, to mention but a few, as follows: What is your understanding of health and health-related issues? What are your health needs, do you access health care in the same way as everyone else in your family and community? Please describe the different kinds of health service and/or medical care you know about or have accessed/received. This can include modern health care (professional sector), traditional health care (healers and indigenous practices), and self care in the family. What are your feelings about each of these services and why do you have these feelings? According to you, what factors make it difficult for a person to access health care; what are the obstacles you face in accessing health care?

Sample and Site Selection

Purposive sampling was utilized in choosing the respondents and the three regional research sites in Namibia. Sarantakos (2005) has referred to purposive sampling where the researchers purposely choose subjects who, in their opinion, are relevant to the project. The choice of participants is guided by the judgment of the investigator, and for this reason, it is also known as judgmental sampling. In this study, the participants were chosen on the basis that they were 60 years old or older and were utilizing a health care facility.

The selection of the sites was primarily based on the objective of the broader study. We included the following criteria:

- Must have a health clinic or health care center, which in Namibia is the first entry point for seeking health care.
- Health service must be provided to the public by the Ministry of Health—or by a nongovernmental organization subsidized by the government.

The regions selected were Zambezi (Chetto, Kabbe, and Sibbinda Clinics), Kunene (Etanga, Okangwati, and Opuwo Clinics), and Omusati (Tsandi, Omagalanga, and Anamulenge Clinics). Research assistants were social science graduates with some experience in data collection for the Multidisciplinary Research Centre, University of Namibia. They were brought together in Windhoek for a 1-week training workshop. All questions were translated into Oshiwambo (the language of the Omusati region), Silozi (the most widely spoken language of the Zambezi region), and Otjiherero (the language of the Kunene region).

Research measures. Interviews were conducted with 34 respondents over the age of 60 years, which is the official age in Namibia in qualifying for a pension (see Table 1).

| Characteristics                  | Zambezi region | Kunene region | Omusati region |
|----------------------------------|----------------|---------------|----------------|
| Sex                              |                |               |                |
| Female (15)                      | 8 (53.3%)      | 3 (20.3%)     | 4 (26.7%)      |
| Male (19)                        | 11 (57.9%)     | 5 (26.3%)     | 3 (15.8%)      |
| Education                        |                |               |                |
| No education                     | 5 (26.3%)      | 3 (37.5%)     | 2 (28.5%)      |
| Some primary                     | 10 (52.6%)     | 2 (25.0%)     | 4 (57.1%)      |
| Complete primary                 | 2 (10.5%)      | 3 (37.5%)     | 1 (14.3%)      |
| Secondary school but not Grade 12| 2 (10.5%)      | —             | —              |

Research procedures and assistants. Three teams were involved in this research. Each team consisted of a research site coordinator from the Multidisciplinary Research Centre (MRC), a research assistant, and three interviewers who were temporarily employed by the MRC. Owing to the sensitive nature of the topic as well as linguistic considerations, it was decided to use Oshiwambo-speaking research assistants as interviewers in the Omusati region, Silozi-speaking assistants in the Zambezi region, and Otjiherero-speaking assistants in the Kunene region. The sex of the interviewers was varied to match that of the respondents.

Data Analysis

All interviews were audiotaped and transcribed in full by the interviewers. The transcribed interviews were given unique identifier codes. All interview transcripts were analyzed using the qualitative data analysis software Atlas ti. by the research assistant who was employed at MRC at the time.

After reviewing the interview transcriptions, analysis of interview data began with coding into broad categories dictated by the interview questions. Emerging issues and themes were coded using open coding in Atlas ti. and an inductive framework approach. The categories were refined through repetitive review of the data. During this process, subcategories or new categories were identified and analysis continued until no new categories emerged. For example, after all the interviews were coded, codes were examined to identify related concepts and families of related themes were formed, creating a structure of issues that had a common theme. Content and thematic analyses were the main techniques for data analysis. In the findings section, illustrative comments are presented in quotes for the various themes.

Ethical Considerations

Permission was granted by the Ministry of Health and Social services to conduct the research at health clinics, health centers, and intermediate hospitals of the selected regions.
Results

The Need for Health Care

Many of the older people in our sample recognized their need for health care. This was not only in terms of formal health care as such but also in terms of environment and lifestyle need that are important to health promotion. This was the case for both males and females. One pensioner talked of medicine and nutrition in this manner, “I need strong medication, I need a balanced diet especially fruits and vegetables to give me enough vitamins; I need clean water, electricity, a toilet at home so that I keep myself clean” (Tsandi/Omusati Male Pensioner, 65 years). In the same vein another argued, “My health needs are: to be given proper treatment, cleanliness (clean place), healthy food (macaroni, meat and cool drinks) and work according to the doctor’s instructions” (Opouwo/Kunene female pensioner, 80 years or older). Another combined medicine and sanitation, “I need medicine from the clinic that will help me get better. I also need water and a toilet at home to keep my surrounding, myself and my clothes clean to prevent contagious diseases” (Omagalanga/Omusati female pensioner, 77 years). “I do not have a toilet and a shower at home—I also need good medication as well as health education lessons” (Tsandi/Omusati female pensioner, 80 years or older).

Older people access health care in the same way as most people in Namibia. They make use of public health services, that is, clinics, health centers and district hospitals that are mostly provided by the government. Those who live far from health facilities have to use cabs:

I and my family access the clinic in the same manner as everyone else, we all use a taxi when coming to the clinic because the distance is far. The only difference is that some make use of Otupi clinic and I come to Tsandi clinic. Within the community some have their own private transport. (Tsandi/Omusati female pensioner, 80 years and older)

Others who cannot afford a taxi or who live near health facilities use other means such as walking or riding bicycles or donkeys, “I access health care in the same way as a lot of people in my community, some walk and those with bicycles will ride their bike. I walk, or sometimes use a private car” (Tsandi/Omusati female pensioner, 66 years).

Yes, I access health care the same as everybody in my family. We use the clinic all the time. My family members are the people who take me to the hospital when I am sick—they care for my health. (Kabbe/Zambezi male pensioner, 65 years)

Understanding of health care. Most of the older adults we talked to appreciate use of modern medical services. “Medication is important in life though in the past we relied on traditional herbs” (Chetto/Zambezi male pensioner, 64 years).

I always use modern health care as they have the materials and the equipment to check my blood pressure and they have the medication. Traditional health care—I used it without understanding. I lost most of my money and cattle as they gave me herbs that never helped. (Tsandi/Omusati female pensioner, 80 years and older)

A lot of the older adults seem familiar with what happens at health care centers:

Nurses give the patients checkups with equipment and count tablets for them to use until they get better. If you do not feel better, you have the opportunity to go back and pay. If the nurses see that you need the assistance of a doctor, they then refer you to the state hospital. Traditional doctors treat with herbs and the payment depends on the sickness. It is just too expensive and if you go for follow up, you still pay. (Omagalanga/Omusati male pensioner, 64 years)

Many of them contrasted what happens in modern health care services with what happens in traditional health care services:

We believe that black magic medicines are very strong, but the problem is that they have no dosage. You can sometimes overdose yourself and die. Private or modern health care is well equipped and quick but is very expensive. We cannot afford it. (Kabbe/Zambezi male pensioner, 60 years)

If I have a disease in my body, they will examine me on machines and they will detect my problem—where I am sick. It is not like traditional healers who don’t know how to do it. Other patients say they don’t get real help from hospitals—they trust witchdoctors. (Sibbinda, Zambezi male pensioner, 64 years)

Traditional healing is good but I really don’t like it. I think it just brings conflict among family members. Modern health is better than traditional healing. One does not have to ask where to get a certain herb or traditional healer but with the hospital, one knows where to find it (location). (Sibbinda/Zambezi female pensioner, 63 years)

Traditional healers are very expensive and their medicine does not work. (Chetto/Zambezi female pensioner, 65 years)

The reliance on modern health care facilities does not mean that traditional health care systems are entirely shunned:

Some traditional herbs do really work but the problem is we get them far deep in the forests. This means walking long distances. The other problem is that sometimes for the medicine to work, one requires leaving it in the water for at least three days. This causes a delay in the treatment and the person can get worse. It is good but it takes time and some of the procedures are complicated. (Chetto/Zambezi female pensioner, 73 years)

I am an old man and most of my life I have used traditional medicine way before I even knew about this modern health. We
had different kinds of medication for each disease and it’s a cheap method. It does not require money only knowledge and energy and anyone could do it as long as you know the use of the medicine. (Chetto/Zambezi male pensioner, 79 years)

Traditional health care is very important and useful and a lot more helpful. I use it because of my strong cultural beliefs. When I was growing up, we never had clinics; we depended on the forest for all our healing. I do like it because it helps. Now that they have brought a clinic, I use both. (Chetto/Zambezi male pensioner, 64 years)

Traditional healers are where we go from the clinic. If the clinic doesn’t find any sickness, you go to healers who mix herbs for you. If you believe in the church you go there for prayers to be healed. (Okangwati/Kunene male pensioner, 64 years)

Sometimes the use of traditional health care is forced by circumstances. This is so because the further away a health care facility in terms of distance from the patient’s house, the higher the probability of opting for traditional medicine. The quote below illustrates,

We are using herbs because the clinic is too far from where we are staying. We are left with no other options rather than use medicines from nature. We also get them for free. Some of the medicines from nature are

- Omininga: to treat stomach pain;
- Omuhama: for all the diseases;
- Omutati: for stomach pain;
- Omitunga Imbara: Medicine that helps when women experience problems with pregnancy. (Etanga/Kunene female pensioner, 81 years)

**Structural Barriers**

Geography, distance, transportation, logistics, and time: More remote areas have greater problems of access to medical care due to distance, bad roads, and transportation problems. These issues become more acute for those who are older adults and cannot easily walk to health centers:

I am old and it is not easy to walk long distances. Wild animals such as elephants and buffaloes always prevent us from accessing health care. Since we walk long distances we could easily run into these animals. Even very sick people are forced to stay at home. (Chetto/Zambezi male pensioner, 64 years)

Lack of reliable road infrastructure is a well-recognized difficulty: “Our main problem here is our roads they are not in good condition. We need good road infrastructure really. Some people do not know what the clinic is, they just use herbs” (Etanga/Kunene male pensioner, 64 years). “It is difficult to cross rivers in rainy seasons” (Okangwati/Kunene male pensioner, 66 years).

Most people walk to clinics, health centers and hospitals. But walking is not easy at a certain age, “I am old now and I need someone to assist me to go to the clinic to get my medicine for high blood pressure” (Tsandi/Omusati female pensioner, 80 years and older).

We use bicycles if we have people that are very sick. It is difficult for us to walk when there are elephants around. And money is a problem as one might be sick but do not have money for transport. There was a man that was sick for two weeks but we did not take him to the clinic as our bicycle had problems. (Tsandi/Omusati female pensioner, 80 years and older)

For those who live far from health facilities, distance presents a special problem: “I travel a long distance from my house to the clinic which takes a very long time to reach. I am also old and cannot walk long distances. I really need support to get to the health facility” (Tsandi/Omusati male pensioner, 65 years). “When a person gets too old, then you will not be able to walk” (Omagalanga/Omusati male pensioner, 64 years). “I am very old. I am 88 years and it takes me a lot of time walking to the clinic” (Omagalanga/Omusati male pensioner, 88 years). Some see difficulties because the young ones they rely on are not there, “I am very old and when my grandchildren go to school, I have a tough time getting to the clinic on my own” (Tsandi/Omusati male pensioner, 78 years).

Not everyone who is aged said they experience problems walking to the clinic:

No, I don’t experience this difficulty, but I think it happens to children and the physically challenged. I am an old woman I feel pain in my leg. I walk with a stick which helps me to reach where I am going. This is how I came to the clinic today. (Omagalanga/Omusati female pensioner, 77 years)

**Process Barriers**

*Health costs.* Financial constraints pose considerable barriers to accessing needed health among the older adults in Namibia. Most older adults in Namibia grew up during apartheid times when Blacks were discriminated against. Hence, many have very little education and never had a chance to be formally employed and if they were once employed, they were long out of work. Namibia is unusual among southern African countries in having an old-age pension system, and individuals currently receive approximately 45 Euros per month equivalent to 600 Namibian dollars. These sums are not much; however, they help the older adults face what would be otherwise formidable financial obstacles. The financial difficulties that the older adults in Namibia face must be seen in this context.
Long distances from the clinic translate into transportation costs and the “further the village, the higher the cost” (Sibbinda/Zambezi female pensioner, 66 years).

Transport cost is N$15 to go to and from the health center; the total is N$30. I walk for one hour and 30 minutes just to get to the road yet all the way to the clinic is 40 minutes by car. (Tsandi/Omusati male pensioner, 65 years). “The transport fee is N$20.00, it takes almost four hours” (Sibbinda/Zambezi male pensioner, 64 years). “The clinic is far. It took me more than an hour and thirty minutes” (Chetto/Zambezi female pensioner, 61 years).

Hospitals and clinics do charge:

Most people do not access the health facility because of lack of money to pay for consultation, which is N$4 during the week and N$20 during the weekend for all Namibians. No payment for medications. These costs are not acceptable because we cannot afford to pay. (Opuwo/Kunene female pensioner, 80 years and older)

Pensioners are, however, exempted from these payments. “I do not pay, I am a pensioner” (Omagalanga/Omusati male pensioner, 88 years). “I do not pay at the clinic as I am a pensioner. I also do not pay for any of the other services” (Tsandi/Omusati male pensioner, 65 years). Why then do the older adults complain about consultation fees and related payments at clinics? This is because in rural Namibia, they are expected to use their pension money to help their children and grandchildren:

Money is the problem. I am the only one that gets money in this household from the pension and the whole family survives on that. Even though one can be treated without paying the consultation fee, it cannot be made into a habit. We pay N$4 for consultation fee and since we are poor, it is not all the time that we pay this. In my culture we lived on wild fruits and honey and hunting. This is how we survived in the San community but now one cannot hunt without a permit. (Chetto/Zambezi male pensioner, 79 years)

When two of my grandchildren fell ill at the same time, I didn’t have money for both of them. I asked the nurse if I could pay just for one and the other to get treated for free. He agreed to help and they were treated. (Chetto/Zambezi female pensioner, 65 years)

I never stay with money after I get paid. I buy food and pay my debts and also school fees for my children and grandchildren. I end up being left without any penny. If I fall sick I nicely ask the nurse to get free treatment because there is no money at all. (Chetto/Zambezi male pensioner, 80 years and older)

This is not acceptable at all. I only have few cattle yet have to pay for everyone in the family if they are sick. At the end of the day I am left with nothing. (Etanga/Kunene male pensioner, 64 years)

It is in this context that many older adults complained, “I really struggle with clinic fees and the transport fee. If my pension money finishes then I cannot pay the clinic fees. Transportation is a problem” (Omagalanga/Omusati female pensioner, 77 years).

I paid N$10.00 because I did not bring my card with me. The driver of the transport that I came with to the clinic asked for N$50.00. I only paid N$40.00 because I had a N$50.00 and needed to pay the remaining N$10.00 at the clinic. (Etanga/Kunene female pensioner, 68 years)

Sometimes, charges depend on the discretion of health workers. Thus, “when the previous nurse was here, it was ok. As long as you came you would get treated” (Chetto/Zambezi female pensioner, 64 years).

Health costs mount when people are referred to higher or better health facilities. Ideally, cases are referred from primary level at the clinic all the way to tertiary level at referral hospital (Matengu, Mufune, Kontio, & Machingura, 2011). Thus, the clinic is the entry point in the health system and its main functions comprise the provision of basic health services, treatment of common diseases and basic emergencies, and other primary health care provisions. The health center, larger than the clinic but smaller than a district hospital, is the next point in referrals. These do admit patients, can have a maximum of 10 beds, and provide inpatient care for short illnesses and normal deliveries up to a maximum of 48 hr. Those in urban areas do not admit patients but provide day care services. The main advantage of health centers is that they are regularly visited by a medical practitioner (doctor). The next point in the referral chain is the district/intermediate hospital. It is the ultimate referral point at the district level. Its functions include providing comprehensive care (preventive curative and rehabilitative) on 24-hr basis. The regional hospital provides regional specialized health services and functions as a referral hospital for the relevant region. Finally, the referral hospital serves as a national tertiary referral hospital for the whole of Namibia. Its main functions are to handle all tertiary referral care cases from all hospitals in Namibia (Shivute, Maumbe, & Owei, 2008).

One problem with the referral services in the form of health centers and district hospitals is that they are even more remote from the villages they serve. It so happens that older adults are more in need of specialized services and care. They are the ones who normally get referred to health centers and district hospitals. This, however, is expensive. Thus, the district hospital at Katima Mulilo is more than 200 km away from Chetto. When the older adults are referred to Katima Mulilo, they
have to go with someone (usually a family member) to look after them. This again requires money. It is in this context that one elderly person said, “We cannot go to Katima as it is far and most of the time we cannot afford to go” (Chetto/Zambezi male pensioner, 64 years). Similarly, “There are also times when patients cannot access the service they are looking for and such patients end up going back home without treatment because Katima is very far” (Chetto/Zambezi male pensioner, 79 years). The same issue arises with regard to Etanga Clinic which is 180 km from Opuwo health center. “If the facility that I usually access cannot perform the services that I need I go back home and use the medicines from the nature. Sometimes if I have money I go to Opuwo hospital for better treatment” (Etanga/Kunene female pensioner, 68 years).

Cognitive (knowledge and communication) barriers. These include patient’s beliefs and knowledge of disease, prevention, and treatment, as well as the communication that occurs in the patient-provider encounters. We discuss these barriers under the following subheadings: language, appointments, convenience of service, security and number of staff, provider attitudes, confidentiality, and availability of medicine.

Language difficulties. We found differences with regard to language and communication among the three research sites. Few people can speak Kwedom, the San language spoken in Chetto. The San people are the most marginalized in Namibia; consequently, few San people have education enabling them to be health providers in Namibia. Therefore, the health providers at Chetto come from other areas. The older adults at Chetto reported language difficulties:

If there is no one to translate at the clinic, there is no way communication can take place between the nurse and the patient. I cannot talk to the nurse because she does not speak our language. The other problem is money. If a person has a lot of kids and they are sick, it means more money as well. (Chetto/Zambezi female pensioner, 64 years)

The new nurse is young and she doesn’t seem to know her tablets very well. She is doing her job but maybe if there was someone to help. She can explain but not too much because she does not speak our language. (Chetto/Zambezi male pensioner, 64 years)

Lack of communication is experienced from here [clinic] to the main state hospital. (Chetto/Zambezi female pensioner, 65 years)

Language is really a barrier for most of us in Chetto because we don’t speak the same language as the nurse. Therefore it is not always easy to talk with the nurse, especially if counselors are not available to translate. (Chetto/Zambezi male pensioner, 64 years)

Obstacle is language because we speak different languages, so mostly we speak through the interpreter. (Chetto/Zambezi male pensioner, 79 years)

Appointments. Appointments are fixed mutually arranged upon agreements for a meeting or engagement. In the rural context of Namibia, appointments “are new things.” Many appreciate getting a service without appointments, “the service was good. I did not have an appointment and I did not stay for a long time since there weren’t patients at the clinic” (Omagalanga/Omusati male pensioner, 64 years). “He is good—no appointment, you just go straight in, he will start treating you” (Kabbe/Zambezi male pensioner, 62 years). “The service was very good. I did not make an appointment” (Etanga/Kunene male pensioner, 67 years). “I did not have an appointment and the time I spent here was about 2 hours. It was not overcrowded” (Tsandi/Omusati male pensioner, 65 years). “The service was good as the nurses treated me well. I did not have an appointment” (Omagalanga/Omusati female pensioner, 77 years). Some complained of both appointments and health providers not keeping appointments, “making appointments is bad enough, but they don’t follow them” (Sibbinda/Zambezi male pensioner, 64 years). “I did not have an appointment and it really took a long time. I have been here for 3 hours already today and I am not yet done” (Tsandi/Omusati male pensioner, 65 years).

Convenience of service. Convenience of service is seen in terms of the length it takes to receive a service. “I spent about an hour because the clinic was not crowded” (Omagalanga/Omusati female pensioner, 77 years). “I came early and got helped quickly I didn’t wait that long because the queue was not long” (Etanga/Kunene male pensioner, 64 years). Many of the older adults are not reticent in complaining about the time it takes to get served: “He can spend two hours treating you” (Kabbe/Zambezi male pensioner, 64 years). “The hours depend on the number of people” (Sibbinda/Zambezi female pensioner, 64 years).

Some people don’t like these long queues. The nurses don’t pay attention to patients they are just on their own and taking time to help people. If you come without money they send you to the back of the queue even if you are the first. Nurses don’t help people after five, they say their time is over. (Okangwati/Kunene male pensioner, 63 years)

“The waiting time is too long especially on Mondays and Fridays” (Tsandi/Omusati female pensioner, 66 years). The older adults especially complained about the process of registration, “The registration process is too long even if there are not a lot of people” (Tsandi/Omusati male pensioner, 65 years). “The registration process was not that fast as there were a lot of people and there is only one person assisting with the registration” (Tsandi/Omusati female pensioner, 66 years). Although one person said, “no registration is done” (Sibbinda/Zambezi male pensioner, 62 years), another said, “there is a clerk who registers patients” (Sibbinda/Zambezi male pensioner, 67 years).

Convenience of service is also seen in terms of whether or not the clinic, health center, or hospital is overcrowded and/
or clean. Centers that are overcrowded and not clean are seen as inconvenient. The clinics in Omusati were said to be more convenient because “it was crowded but there were enough seats” (Tsandi female pensioner, 64 years) or as this male put it, “The place was clean as always and it was not overcrowded” (Tsandi/Omusati male pensioner, 65 years). “The clinic is not overcrowded” (Omagalanga/Omusati male pensioner, 88 years). Another one said, “No overcrowding” (Omagalanga/Omusati female pensioner, 80 years and older), “but there is no refreshment other than tap water outside the clinic.” The case was different in the Zambezi region facilities:

The seats are not so many and there are days when it gets crowded, especially Mondays and Fridays. The health center is clean inside and outside it is full of grass. It could be that work is too much for one cleaner. It could be a good idea if there was a male cleaner too. The center experiences water shortages. There are times when the health facility has to get water from the villages and this is inconvenient. (Sibbinda/Zambezi female pensioner, 64 years)

**Security and number of staff.** Complaints about overcrowding in part relate to shortage of staff. People in the Zambezi region reported a lack of security staff (and not necessarily security) at health care premises. “No security staff” (Kabbe/Zambezi male pensioner, 64 years). “I have never met the security; he only works in the evening. It is safe to come in the afternoon, there are no robbers here” (Chetto/Zambezi female pensioner, 69 years). In Omusati, there seem to be enough health staff, “there is enough staff, but young nurses are not doing their job on time as you will find the consultation room closed but there is no one inside” (Tsandi/Omusati female pensioner, 66 years). The case was vastly different in Chetto, “there is only one nurse” (Chetto/Zambezi female pensioner, 64 years). “I don’t think one nurse can do all the work, it would be better if they were two—she is sometimes not sure what medicine to give” (Chetto/Zambezi female pensioner, 75 years). “My only concern is the number of staff. We need at least two nurses so that when one is not here, the other one takes over” (Chetto/Zambezi male pensioner, 64 years). Staff shortages seem to be a problem in Kunene region as well, “people from Opuwo delay to send tablets and medicines to Etanga clinic. There is also lack of staff and lack of information” (Etanga/Kunene male pensioner, 67 years). “The clinic has only one nurse, whose parents are sick. This nurse also has other responsibilities as well. The clinic is the only one but there are many people” (Etanga/Kunene female pensioner, 68 years). Similarly, they complained that “there is no Doctor and no ambulance. There is also a lack of equipment” (Okangwati/Kunene male pensioner, 66 years).

**Provider attitudes.** Most older adults reported positive provider attitudes, “the nurses’ attitude is good but not all of them are like that” (Tsandi female pensioner, 79 years). “The nurses were friendly—they gave me all the necessary support and instructions” (Tsandi/Omusati, male pensioner, 64 years). “Their attitude [the staff] is good” (Tsandi/Omusati, male pensioner, 64 years). “They are friendly but very slow to finish with patients” (Tsandi male pensioner, 80 years and older). “Their attitude is very positive and the way they treat us shows that they are skillful” (Omagalanga/Omusati female pensioner, 80 years and older).

The health providers considered rude were the ones who had problems conversing in the local language, “three are ok, especially the principal nurse. He is a good man; he can treat a patient without paying. The rude one is the nurse who speaks English. He is not friendly at all” (Sibbinda/Zambezi female pensioner, 64 years). “Although we walk a long distance to get here, we have to wait long in queues; the nurses are just talking long stories while we are sitting here waiting” (Tsandi/Omusati male pensioner, 64 years).

**Confidentiality.** Confidentiality is supposed to be central to the relationship between the patient and their health care providers. It implies that the information on a patient is secure from others who are not supposed to know it. Confidentiality is risked by improper access to information. Many of our respondents in Omusati said that “confidentiality is there as only one person at a time comes into the consulting room” (Tsandi/Omusati male pensioner, 65 years). “Our consultations are done in private rooms” (Tsandi/Omusati female pensioner, 66 years). “Patient privacy is well protected” (Tsandi/Omusati male pensioner, 65 years).” The registration process was fast and the consultation was in a screening room so nobody heard what I told the nurse” (Omagalanga/Omusati male pensioner, 64 years). The case was different in the Zambezi region. One man said, “on that one (confidentiality) I do not know” (Kabbe/Zambezi male pensioner, 79 years). Others were more direct, “It is not confidential” (Kabbe/Zambezi male pensioner, 79 years). “No privacy—things are just done in front of other people” (Kabbe/Zambezi male pensioner, 60 years)

**Availability of medicine.** Respondents in Zambezi and Kunene regions were not shy in complaining about lack of medication.

Nurses are giving one tablet for more than one disease, e.g., eye problem, headache and leg problem. They also scream too much at the patients which is not good for patients with high blood pressure problems as this may kill them on the spot. (Opuwo/Kunene female pensioner, 80 years and older)

Medication shortages were explained as, “population is increasing rapidly. People are many and the medicine is becoming less” (Chetto/Zambezi male pensioner, 64 years).
Discussion

We set out to investigate the experiences and perceptions of older adults as they try to access health care facilities and services in rural Namibia. More specifically, we looked at structural barriers to accessing health facilities (i.e., transportation, physical barriers, facility accessibility, cost of services) and health service delivery process barriers (i.e., timeliness of services scheduling of appointments, language, feeling respected, and health provider knowledge). Our results confirm research in other countries (Aboderin, 2012; Goins et al., 2005; Van Rooy et al., 2012), showing that older adults experience multiple barriers to accessing health care. There are several things that we feel may be unique to Namibia. These are the reasons that in many Namibian cultures, older adults are traditionally revered and their advice is sought and respected. This is especially so in rural areas. It is in this context that almost all participants in this sample indicated that they access health care like all others where they live. It is also in this context that most older adults say that nurses treat them fairly and with respect. Their only complaints with health providers are those who address them using English (considered a foreign language). Limited health literacy, as well as linguistic and cultural barriers, may prevent the patient from understanding and acquiring the necessary knowledge to carry out therapeutic directions (Carrillo et al., 2011).

In rural Namibia, where incomes are scarce due to the harsh desert environment, pension funds are the only regular and reliable sources of income not only for the older adults but also for many households. The older adults in rural Namibia receive social pensions making them the only group with a reliable source of income in a situation of generalized poverty. The pension the older adults receive from the Namibian government help them to face what would be otherwise formidable financial obstacles. As a matter of fact, the money they receive helps many members of their families. What this means is that while many rural people experience the costs of transportation, medicines, and other services as high, for older adults, extended family obligations require them to pay for others. Thus, the older adults are not only valued and respected in traditional terms but also, in a situation of generalized poverty, their pensions make them crucial providers for their families. It is in this context that the older adults in Namibia complain about the cost of health care. Although not required to pay consultation fees at clinics, they do so for their grandchildren and other relatives in line with extended family obligations. They also bear the brunt of paying for transportation costs to clinics: “I never stay with money after I get paid. I buy food and pay my debts and also school fees for my children and grandchildren.” Sarantakos (2005) and Matengu et al. (2011) found that about 57% of the respondents in their sample did not have enough money for medication and women, specifically, did not seek medical attention because they could not pay for travel. Similarly, “financial constraints posed considerable barriers to accessing needed health care among study participants, including issues related to health care expense, inadequate health care coverage” (Goins et al., 2005, p. 210). People needing a wider range and depth of services (such as the older adults) incur higher costs in health care. This is demonstrated by Carrillo et al. (2011). In Namibia, where older adults’ pensions are shared with extended family, the costs of transportation, medicine, and other services can be prohibitive.

Most older adults do not experience overt age-based discrimination as such. They walk to health centers, as indeed do most ruralNamibians; however, for those older adults, this is a difficult task. The fact that they have to walk, ride bicycles, and hire taxis is no mean that their experience of health care is the same as others. Walking to hospital is much more difficult for them and “when my grandchildren go to school, I have a tough time to get to the clinic as I must go on my own.” The ability to traverse distances becomes imperative in obtaining health care. Without transportation, even a short distance to care can become an insurmountable problem. The opportunity for health care consumers to have a vehicle to transport them to a practitioner or facility is especially important in rural settings where distances are relatively great, roads may be of poor quality, and public transportation is seldom available (Chipp et al., 2011). The older adults choose to use traditional medicine instead of walking long distance to the clinic. This is consistent with the results of Etowa, Wiens, Bernard, and Clow (2007), who found that rural households utilize self-medication and traditional care closer to their residence. This is expected to reduce their cost of transportation and rigor of accessibility to distant modern health care services.

In the same context, Hwang et al. (2009) found that patients, staff, and health care providers cited distance as the most important reason for rural veterans failing to access health care.

Conclusion

There is a need to consider the unique issues affecting access to health care for older adults in Namibia to achieve equitable access to health care services. In particular, cultural factors such as the role of the extended family system must be taken into account. Thus, although government gives free health services to the older adults, because of the extended family system, the services are not experienced as free at all.

Limitations

The article acknowledges that only the older adults who were present at clinics were interviewed, whereas those who did not receive health care from health care facilities were excluded.
Implications of the Findings

Access to health care services for the senior citizens involves a lot of barriers that government, health care practitioners, and society may have overlooked, for example, the issue of distance. Long distances discourage visits to health care facilities and promote traditional health care, which charges higher costs. In most remote areas, where there is only one health care worker, he can close it at any time without any remorse to the patients and this leads to another barrier of noncompliance because of the time spent reaching the health facility and not receiving care on time.

Health service provision is mostly provided in the context of the medical model, to relieve pain and provide care, and no change has taken place to move away from this notion of providing care. There is a need for a paradigm shift from the medical model to the social model of providing care. Distance barrier could be solved with the introduction of mobile clinics in rural areas. One of the lessons learnt is that long-term commitment is required from both government and health organizations, alongside measures to enforce and evaluate the successful implementation of strategies.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research and/or authorship of this article: This research was funded by the European Commission Framework Programme 7: “Enabling Universal and Equitable Access to Healthcare for Vulnerable People in Resource Poor Settings in Africa” (Grant Agreement No. 223501).

References

Aboderin, I. (2011). Understanding and advancing the health of older populations in Sub-Saharan Africa: Policy perspectives and evidence needs. Public Health Reviews. Retrieved from http://www.publichealthreviews.eu/show/p/40

Aboderin, I. (2012). Aging and development in Sub-Saharan Africa: An APHRC Research Program.

Carrillo, J. E., Carrillo, V. A., Perez, H. R., Salas-Lopez, D., Natale-Pereira, A., & Byron, A. T. (2011). Defining and targeting health care access barriers. Journal of Health Care for the Poor and Underserved, 22, 562-575. doi:10.1353/hpu.2011.0037

Chipp, C., Dewane, S., Brem, C., Johnson, M. E., Warner, T. D., & Roberts, L. W. (2011). “If only someone had told me . . .”: Lessons from rural providers. The Journal of Rural Health, 27, 122-130.

Cooper, D. R., & Schindler, P. S. (2011). Business research methods (N. Jacobs, K. Harlow, & J. Bishop, Eds.) (3rd ed.). Berkshire, UK: McGraw-Hill.

Etowa, J., Wiens, J., Barnard, W. T., and Clow, B. (2007). Determinants of Black women’s health in rural and remote communities. Canadian Journal of Nursing Research, 39(3), 56-76.

Goins, R. T., Williams, K. A., Carter, M. W., Spencer, M., & Solovieva, T. (2005). Perceived barriers to health care access among rural older adults: A qualitative study. The Journal of Rural Health, 21, 206-213.

Government of the Republic of Namibia. (2004). Namibia Vision 2030. Windhoek, Namibia: National Planning Commission.

Gustafsson-Wright, E., Van Der Gaag, J., de Beer, I., de Wit, R., Jannes, W., Lammers, J., . . . Aulagnier, M. (2011). The Okambilimbili Health Insurance Project in Namibia: Great strides and lessons learned. Windhoek, Namibia: PharmAccess International; The Netherlands: Amsterdam Institute for Global Health and Development.

Hwang, K., Johnston, M., Tulsky, D., Wood, K., Dyson-Hudson, T., & Komaroff, E. (2009). Access and coordination of health care service for people with disabilities. Journal of Disability Policy Studies, 20, 28-34. doi:10.1177/1044207308315564

Longhurst, R. (2009). Interviews: In-depth, semi-structured. In K. Rob & T. Nigel (Eds.), International encyclopedia of human geography (pp. 580-584). Eugene, USA: Elsevier. doi:10.1016/b978-008044910-4.00458-2

Matengu, K., Mufune, P., Kontio, K., & Machingura, F. (2011). Strengthening community health systems for HIV treatment, support and care Ngweze area - Caprivi region: Namibia. Retrieved from http://h134.it.helsinki.fi/wp-content/uploads/2010/01/COBASYS-Ngweze-Namibia-June2011.pdf

Sarantakos, S. (2005). Social research (3rd ed.). New York, NY: Palgrave Macmillan.

Shivate, M. I., Maumbe, B. M., & Owei, V. T. (2008). The emerging ICT use patterns for health service delivery in Africa: Evidence from rural and urban setting in Namibia. In P. Cunningham & M. Cunningham (Eds.), IST Africa 2008 Conference Proceedings (pp. 1-19). International Information Management Corporation. Retrieved from www.IST-Africa.org/Conference2008

Van Rooy, G., Amadhila, E. M., Mufune, P., Swartz, L., Manman, H., & MacLachlan, M. (2012). Perceived barriers to accessing health services among people with disabilities in rural northern Namibia. Disability & Society, 27, 761-775. doi:10.1080/09687599.2012.686877

Xavier Gómez-Olivé, F., Thorogood, M., Clark, B. D., Kahn, K., & Tollman, S. M. (2010). Assessing health and well-being among older people in rural South Africa. Global Health Action, 3. doi:10.3402/gha.v3i0.2126

Author Biographies

Gert Van Rooy, senior researcher, is a social scientist. His Research interests include public health aiming at addressing equity of healthcare which is affordable, accessible and acceptable.

Elina Amadhila worked as a research assistant on the Enabling Universal and Equitable Access to Healthcare for Vulnerable People in Resource Poor Settings in Africa project from which this paper was drafted. She is currently a full-time PhD student at the University of Stellenbosch. Her research interests include social development and development finance.