When Dementia is mistaken for Witchcraft: An Integrated Missional Public Health Framework for Addressing Elder Abuse and Dementia Stigma in Rural Zambia

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DOI: https://doi.org/10.51244/IJRSI.2026.1315PH00130

Received: 05 July 2026; Accepted: 10 July 2026; Published: 20 July 2026

ABSTRACT

The burden of dementia in sub-Saharan Africa (SSA) is growing, with estimates projecting an increase from 2.13 million cases in 2015 to 7.62 million by 2050. However, limited research exists on dementia within this region, particularly concerning cultural beliefs and stigma affecting persons living with dementia and their caregivers. Behavioural changes associated with dementia are frequently attributed to supernatural causes such as witchcraft, curses, and ancestral retribution, leading to social exclusion, neglect, dispossession, and violence. In Zambia, dementia occurrence remains poorly documented due to low community awareness and a shortage of skilled healthcare providers capable of recognising and diagnosing the condition. What remains unknown is how the increasing burden of dementia intersects with prevalent witchcraft accusations. This article addresses this gap through an interdisciplinary approach grounded in critical medical anthropology, missio Dei theology, and Ubuntu philosophy, enabling examination of the Zambian context wherein dementia symptoms are perceived as evidence of witchcraft. The paper presents the Missional Public Health Dementia Response Framework (MPHDRF), developed through conceptual analysis and integrative literature review. This six-pillar, theory-informed and evidence-informed conceptual intervention framework encompasses community dementia literacy, church-based awareness, healthcare capacity building, traditional leader engagement, caregiver support systems, and policy and legal protection. The framework provides a culturally appropriate and potentially actionable means of alleviating dementia-related witchcraft accusations and safeguarding the wellbeing of older persons in rural Zambia.

Keywords: Dementia, witchcraft, Zambia, older adults, missional public health, stigma, elder abuse, Ubuntu

INTRODUCTION

Background

Dementia constitutes one of the greatest public health challenges of the twenty-first century. Despite the growing burden, many countries remain inadequately prepared to provide comprehensive dementia prevention, diagnosis, treatment, care, and support.

Sub-Saharan Africa presents a distinct epidemiological profile. The pooled prevalence of dementia in Africa is estimated at 4%, with slight variation across estimates from West, East and Central Africa (Johnson et al., 2025).

Population growth and ageing will likely produce the greatest future increase in dementia incidence and prevalence in sub-Saharan Africa (Mataa et al., 2024). This research gap carries important implications for policy development, healthcare planning, and protection of vulnerable older adults.

Problem Statement

Dementia is a growing public health concern in sub-Saharan Africa, with prevalence projected to increase from 2.13 million cases in 2015 to 7.62 million by 2050 (Chigangaidze et al., 2026; Wakawa et al., 2025). More than 65% of Zambian health workers mistakenly believe dementia is a normal part of ageing (Mataa et al., 2024), while patients and caregivers experience 57% and 62% unmet care needs respectively (Simushi et al., 2024).

The crisis extends beyond healthcare deficits. What remains critically unknown is how the increasing burden of dementia intersects with prevalent witchcraft accusations, and how integrated, culturally appropriate interventions can address both the healthcare and social dimensions of this crisis.

Significance of the Study

Stigma associated with dementia and beliefs in witchcraft throughout sub-Saharan Africa have been well documented in the literature (Brooke & Ojo, 2020; Adebisi & Salawu, 2023; Chigangaidze et al., 2026). This research aims to fill this gap through development of the Missional Public Health Dementia Response Framework (MPHDRF).

The significance of this study is threefold. Third, it contributes to the global discourse on dementia care in resource-limited settings by demonstrating how interdisciplinary approaches can address complex health challenges.

The MPHDRF is founded on three interconnected theoretical underpinnings: critical medical anthropology, missio Dei theology, and Ubuntu philosophy. The MPHDRF, however, argues that without engagement with theological discourse, community participation, traditional leadership, caregiver support, and legal protection, meaningful and sustainable stigma reduction remains unattainable.

Methodological Approach

This article employed an integrative literature review and conceptual analysis to develop the Missional Public Health Dementia Response Framework (MPHDRF). The review was designed to support conceptual framework development rather than to estimate intervention effects or conduct a formal systematic review or meta-analysis.

Search Strategy and Period

The literature search covered publications from 1 January 2010 to 10 July 2026, with selected foundational works published before 2010 retained where necessary to establish key theoretical, theological, legal, or conceptual foundations. The final search and reference update was completed in July 2026.

Electronic searches were conducted in PubMed, Scopus, Web of Science, and Google Scholar. Search terms were used individually and in combinations appropriate to each database. Core search concepts included:

Search combinations were adapted to the requirements of individual databases. Examples included “dementia AND witchcraft AND sub-Saharan Africa,” “dementia stigma AND Zambia,” “elder abuse AND witchcraft accusations,” “dementia AND church OR faith-based intervention,” “dementia AND Ubuntu,”.

Grey Literature and Policy Sources

Because peer-reviewed literature on dementia, witchcraft accusations, and elder abuse in Zambia remains limited, the review also included relevant grey literature and primary policy and legal documents. These sources included publications and documents from the World Health Organization, Alzheimer’s Disease International.

Legal and policy documents included Zambia’s Witchcraft Act, Chapter 90, the Mental Health Act No. 6 of 2019, the National Health Strategic Plan 2022–2026, and relevant global dementia policy documents. Such sources were not treated as equivalent in evidentiary weight to peer-reviewed empirical research.

Inclusion and Exclusion Criteria

Priority was given to peer-reviewed empirical studies, systematic reviews, scoping reviews, meta-analyses, authoritative policy documents, legislation, and reports from recognised international or national institutions.

Screening and Selection of Sources

The screening process occurred in stages. Sources clearly unrelated to dementia, witchcraft-related beliefs, elder abuse, health-system capacity, theological or cultural frameworks, or policy and legal protection were excluded at this stage.

Because the purpose of the review was interdisciplinary conceptual integration rather than exhaustive effect estimation, the study did not employ a formal meta-analytic quality-scoring system. Peer-reviewed empirical and review literature was prioritised for substantive scientific claims, while primary legislation and official policy documents were prioritised for legal and policy analysis.

Thematic Synthesis

The selected literature was organised and synthesised around five interconnected domains:

Thematic relationships across these domains were then examined to identify the mechanisms through which dementia symptoms may progress from cognitive and behavioural change to cultural interpretation, fear, suspicion, accusation, exclusion, delayed healthcare, and potential abuse.

Development of the MPHDRF

The MPHDRF was developed through an iterative process of thematic synthesis and conceptual mapping. Recurrent problems identified in the literature were matched with corresponding intervention needs. This process generated six complementary intervention domains:

The six pillars were subsequently examined through the complementary lenses of critical medical anthropology, missio Dei theology, and Ubuntu philosophy.

The MPHDRF should therefore be understood as a theory-informed and evidence-informed conceptual framework, not as an empirically validated intervention model. Its development through interdisciplinary literature synthesis provides a foundation for future participatory co-design, pilot implementation, and mixed-methods evaluation in rural Zambian communities.

Theoretical Foundations

Critical Medical Anthropology

Critical medical anthropology provides a methodological lens for understanding the cultural construction of illness and the influence of power relations on health outcomes. A lack of biomedical knowledge, coupled with pervasive supernatural explanatory frameworks, leads to the interpretation of dementia symptoms as malevolent occurrences rather than indicators of neurodegenerative processes (Chigangaidze et al., 2026).

Missio Dei: Theological Foundations for Holistic Healing

The missio Dei provides a theological framework for understanding God's mission as encompassing holistic healing—physical, psychological, social, and spiritual. The missio Dei framework challenges reductionist approaches that separate spiritual concerns from physical and social wellbeing, insisting instead that authentic Christian mission addresses the whole person in their full context (Mkhonto & Hanssen, 2018).

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XIII Issue XV July 2026 | Issue on Public Health

Within the Zambian context, the missio Dei provides a theological mandate for the church to engage with dementia as both a medical and spiritual crisis. The missio Dei thus provides the theological foundation for the church-based awareness pillar of the MPHDRF.

Ubuntu Philosophy: Human Dignity and Communal Responsibility

Ubuntu is an African philosophical doctrine grounded in the concept "I am because we are," encompassing values such as compassion, family cohesion, survival, dignity, and respect (Madigele, 2024). This relational ontology carries important implications for approaches to dementia care.

Adopting an Ubuntu-informed perspective effectively contests the exclusion and violence of witchcraft allegations. This aligns with the communal orientation often observed in African societies and offers a culturally congruent approach to caregiving that may diverge from individualistic care paradigms.

The Pathway from Dementia Symptoms to Witchcraft Accusations

Cultural Interpretation of Cognitive Decline

In many African societies, illness and misfortune are understood within frameworks encompassing spiritual, ancestral, and supernatural dimensions (Brooke & Ojo, 2020; Adebisi & Salawu, 2023). Instead, these symptoms are frequently interpreted as evidence of witchcraft, curses, or ancestral punishment (Brooke & Ojo, 2020).

A scoping review of studies from SSA countries found that stigma was largely rooted in cultural beliefs linking dementia to witchcraft, curses, or ancestral punishment (Chigangaidze et al., 2026). While some associated dementia with normal ageing, others linked neurodegenerative behaviours with witchcraft or curses, resulting in individuals suspected of having dementia being isolated from the community, neglected, dispossessed of assets, killed, or denied medical care (Aballa et al., 2025).

These findings suggest that stigma is not simply a product of misinformation but is embedded within culturally meaningful explanatory systems (Chigangaidze et al., 2026). Consequently, interventions relying exclusively on biomedical education may prove insufficient unless.

Consequences: Isolation, Neglect, Violence, and Death

The consequences of these cultural interpretations are severe. The systematic review on dementia stigma in SSA concluded that cultural beliefs linking dementia to witchcraft lead to social exclusion, neglect, dispossession, and violence, especially targeting older women (Chigangaidze et al., 2026).

A systematic review and meta-analysis of elder abuse in SSA found a pooled prevalence of 46.73%, with physical abuse being the most common type (Gedfew et al., 2024). Consequently, affected individuals face increased exposure to discrimination, delayed treatment, and interpersonal violence (Brooke & Ojo, 2020; Chigangaidze et al., 2026).

In Zambia, a 70-year-old woman was axed to death by four unknown men in Chienge district, Luapula Province, after being suspected of practicing witchcraft (Zambia Monitor, 2024). In Kafue District, an 84-year-old woman was beaten after a prophet accused her of using witchcraft to kill an infant (News Invasion 24, 2024).Such reported cases illustrate the potentially severe consequences of witchcraft accusations against older persons and reinforce the need for stronger preventive, protective, and community-based responses.

The Conceptual Pathway

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XIII Issue XV July 2026 | Issue on Public Health

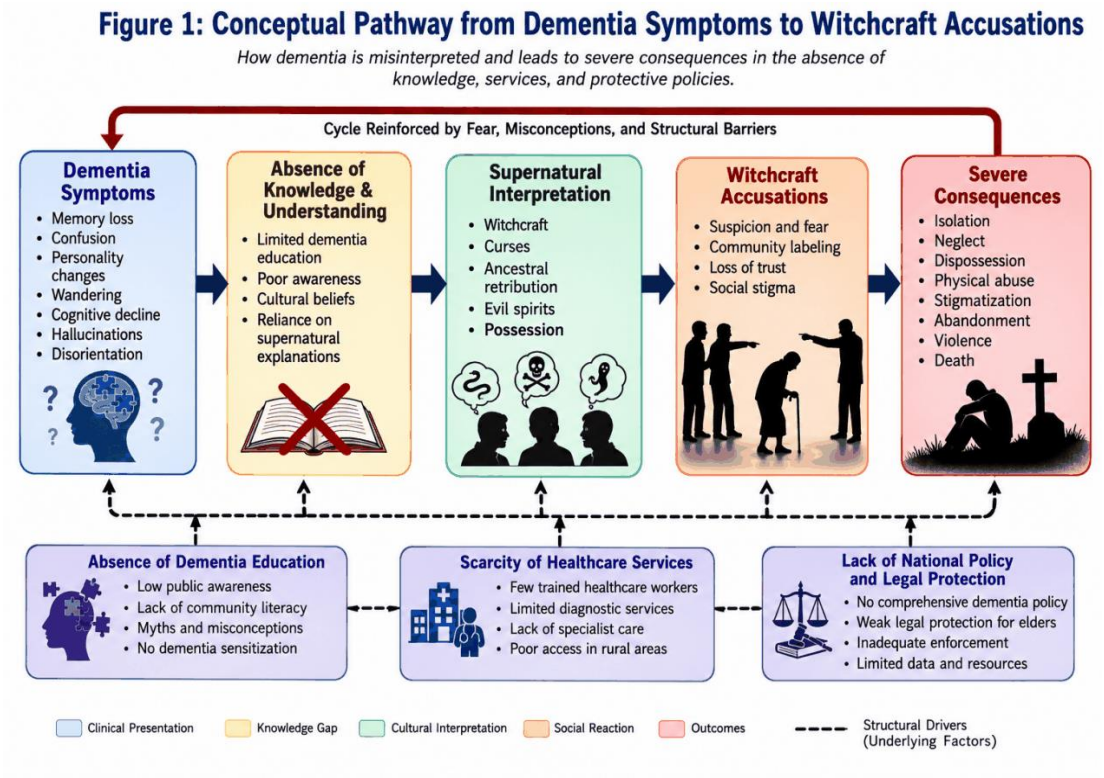


Figure 1. Conceptual Pathway from Dementia Symptoms to Witchcraft Accusations

As illustrated in Figure 1, the proposed conceptual pathway begins with dementia-related symptoms, including memory loss, confusion, personality changes, wandering, cognitive decline, and hallucinations. Figure 1 therefore illustrates how neurodegenerative symptoms may be transformed, through cultural interpretation and structural vulnerability, into a broader public health, social, and human rights crisis.

Dementia, Ageing, and Health Systems in Zambia

The Demographic Imperative

Zambia's older population is growing, and with it, the prevalence of risk factors that lead to dementia. These demographic shifts will place increasing strain on families and communities already struggling to provide care.

Healthcare System Deficiencies

Zambia's healthcare system faces multiple challenges in addressing dementia. Most Zambians will progress through their dementia journey without the opportunity to be seen by a neurologist or any other medical personnel with the necessary skills to diagnose dementia (International Association for Hospice and Palliative Care, 2025).

Community health workers (CHWs) are widely utilised across SSA to improve healthcare access, particularly for HIV services, and may represent an untapped resource for dementia screening and care (Mataa et al., 2024). However, such initiatives remain limited in scale.

The Alzheimer's Disease and Related Dementias in Zambia (ADDIZ) association, founded in 2016, provides caregiver meetings, counselling, dementia care training, and educational events (Alzheimer's Disease International, n.d.). The mean proportion of unmet needs for patients with dementia was 57%, while that of caregivers was 62% (Simushi et al., 2024).

The Witchcraft Act and Legal Protections

Zambia has a Witchcraft Act (Chapter 90 of the Laws of Zambia) that criminalises accusations and related offences (Zambia Law Development Commission, 2018). A 2018 review conducted by the Zambia Law

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XIII Issue XV July 2026 | Issue on Public Health

Development Commission examined the continuing relevance and adequacy of the Witchcraft Act and recommended legislative reconsideration in light of contemporary social and legal realities (Zambia Law Development Commission, 2018).

The Mental Health Act No. 6 of 2019, which repealed the Mental Disorders Act of 1949, establishes a framework for mental health care in Zambia (Republic of Zambia, 2019). A communication challenging Section 4 of the Zambia Mental Health Act of 2019 has been submitted to the African Commission on Human and Peoples' Rights, arguing that the Act allows courts to override individuals' decisions if they are deemed to lack "mental capacity," violating the will and preferences of the individual (Southern Africa Litigation Centre, 2025).

Biblical and Missiological Operationalisation of the Framework

The theoretical foundations of missio Dei and Ubuntu have already been established in Section 3. Three practical convictions guide this operationalisation: the enduring dignity of persons with dementia as bearers of the imago Dei, the church's participation in God's holistic mission of healing and reconciliation, and the communal responsibility to protect vulnerable persons rather than exclude them through fear, stigma, or accusations of witchcraft.

The Imago Dei and the Dignity of Persons with Dementia

The doctrinal foundation for the protection of persons with dementia is grounded in the imago Dei—the notion that all human beings are created in the image of God. The implication of imago Dei is that all human beings, despite diminished cognitive abilities and disease processes, deserve dignity and care that reflects their uniqueness (Swinton, 2012).

This theological conviction directly challenges the dehumanisation that accompanies accusations of witchcraft. The imago Dei means that no amount of cognitive decline can strip the person of the essential status of being made in the image of God.

The Church's Healing Mission in Practice

Building on the theological foundations established in Section 3.2, the missio Dei finds practical expression in the church's engagement with dementia care. The church's mission is carried out through education, advocacy, pastoral care, and partnership with healthcare providers.

Educating congregations about dementia as a neurodegenerative condition, distinguishing it from supernatural causation (Mkhonto & Hanssen, 2018)

Providing spiritual support to persons with dementia and their families, including those accused of witchcraft (Swinton, 2012)

Challenging harmful beliefs about dementia and witchcraft from the pulpit and in community engagement (Mkhonto & Hanssen, 2018)

Collaborating with healthcare providers, traditional leaders, and community organisations to develop integrated responses (Mkhonto & Hanssen, 2018)

Significant potential exists for the church to promote dementia awareness and reduce stigma. These South African examples offer transferable lessons for Zambia, where the widespread presence of churches makes this a potentially important intervention point.

Ubuntu-Informed Communal Responsibility

Building on the philosophical foundations of Ubuntu in Section 3.3, this section explores the practical theological implications for dementia care. Ubuntu's core values of compassion, family solidarity, survival, respect, and

dignity provide an ethical framework for dementia care. This framework aligns with African cultural values and actively opposes harmful practices (Madigele, 2024).

This article presents an Ubuntu-inspired approach to dementia that promotes the inclusion of people with dementia in the community, not their exclusion. This perspective actively speaks against exclusionary practices and violence, which violate the tenets of Ubuntu. The Ubuntu concept provides a methodological model for dementia care in Africa, based on compassion, empathy, and commitment to community-centred caregiving (Madigele, 2024; Chigangaidze et al., 2026).

The Missional Public Health Dementia Response Framework (MPHDRF)

Rationale for an Integrated Framework

Stigma and beliefs in witchcraft in relation to dementia have been reported in existing studies in SSA (Brooke & Ojo, 2020; Adebisi & Salawu, 2023; Chigangaidze et al., 2026). The MPHDRF addresses this gap through a holistic approach that brings together public health, medical anthropology, theology, and community engagement.

Current interventions have mainly been directed towards biomedical education or isolated community awareness campaigns. The framework is premised on the fact that accusations of witchcraft associated with dementia result from a combination of factors including cultural understanding of illness, lack of biomedical knowledge, healthcare system shortcomings, structural marginalisation of older adults, and absence of a concerted community response (Brooke & Ojo, 2020; Adebisi & Salawu, 2023; Chigangaidze et al., 2026). An integrated response should therefore address these interacting factors across multiple levels.

Justification for the Six Pillars: The six pillars were derived through integrative synthesis of the literature reviewed in this study. Church-based awareness responds to the significant influence of religious institutions on community beliefs and practices. Traditional leader engagement recognises the authority of customary governance structures in rural communities. Caregiver support systems respond to the documented high prevalence of unmet needs among families providing dementia care. Together, these pillars provide complementary interventions operating across individual, community, institutional, and policy levels, creating a comprehensive response to a multi-dimensional problem.

The MPHDRF should therefore be understood as a theory-informed and evidence-informed conceptual framework rather than an empirically validated intervention model. The next stage of research should involve participatory co-design with persons living with dementia, caregivers, community health workers, church leaders, traditional authorities, healthcare professionals, and legal or policy stakeholders in selected rural Zambian communities. A pilot implementation could initially test one or two pillars—such as community dementia literacy and church-based awareness—before evaluating the feasibility, acceptability, cultural appropriateness, and preliminary outcomes of the complete six-pillar model.

Alignment with National and Global Health Priorities

The MPHDRF can be operationally situated within Zambia's National Health Strategic Plan 2022–2026 (Republic of Zambia Ministry of Health, 2022), particularly its broader commitment to quality universal health coverage, decentralised service delivery, strengthened primary healthcare, and improved responses to non-communicable conditions. Community health workers could support early recognition and referral, while district health systems could coordinate with churches, traditional leaders, social welfare services, and civil society organisations.

At the global level, the MPHDRF is consistent with the World Health Organization's Global Action Plan on the Public Health Response to Dementia, originally adopted for 2017–2025 and extended by the World Health Assembly in 2025 to 2031 (World Health Assembly, 2025). Its distinctive contribution is to contextualise these global priorities within rural African settings where dementia symptoms may be interpreted through witchcraft-related explanatory frameworks. The MPHDRF therefore functions as a contextual implementation framework

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XIII Issue XV July 2026 | Issue on Public Health

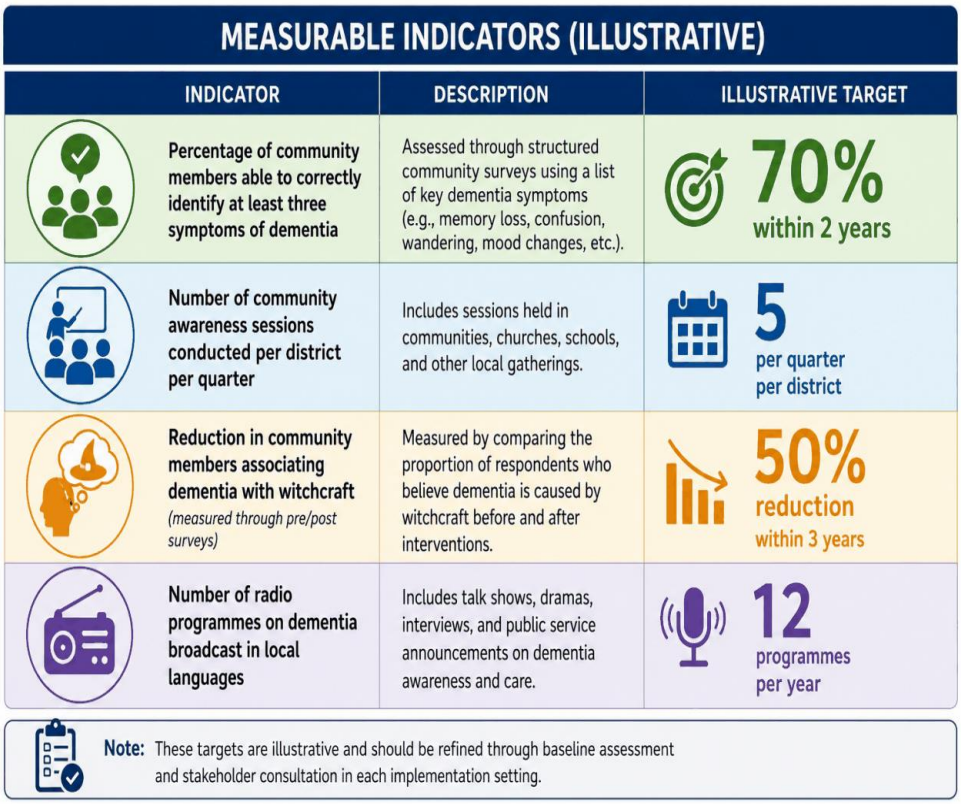
through which national and global dementia priorities may be translated into culturally responsive, multisectoral action in Zambia.

The Six Pillars of MPHDRF

Pillar 1: Community Dementia Literacy

Culturally appropriate education about the symptoms, causes, and progression of dementia must be delivered through accessible channels—community meetings, radio programmes, drama groups, and health fairs. It is insufficient to merely present biomedical information; effective education must engage with existing beliefs and offer alternative explanations that make sense within the local worldview (Brooke & Ojo, 2020; Adebisi & Salawu, 2023).

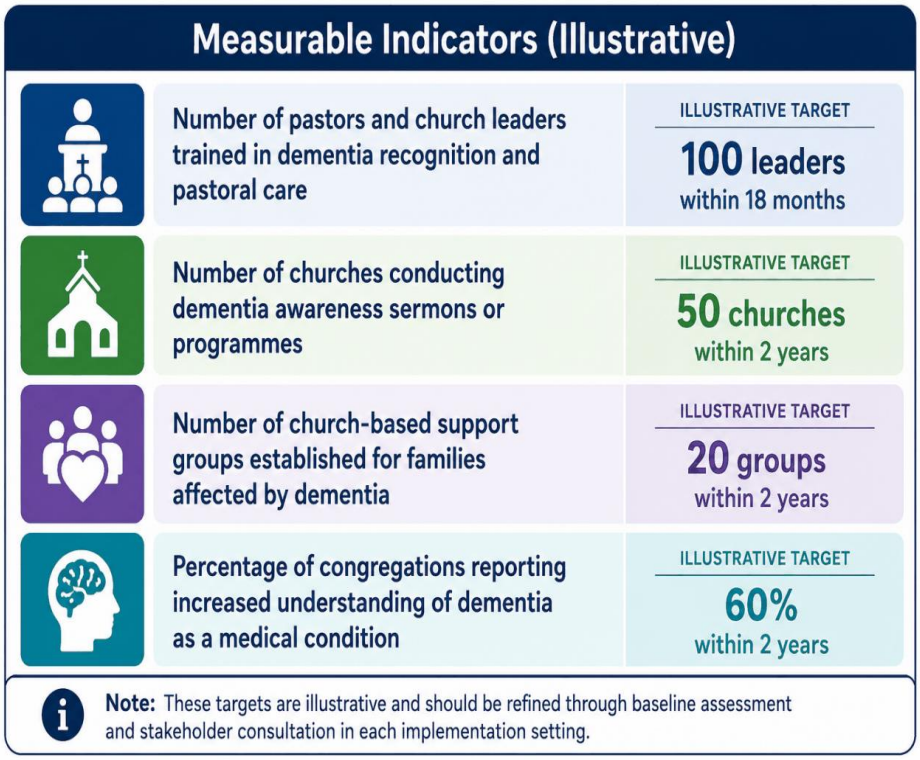
The educational challenge is highlighted by the lack of knowledge about dementia among community members in rural Kenya (Aballa et al., 2025) and the belief among more than 65% of health workers in Zambia that dementia is a normal part of ageing (Mataa et al., 2024). An action research project in the Democratic Republic of Congo demonstrated that a community education programme providing objective information on dementia led to "a dramatic positive change in attitudes and behaviour towards dementia sufferers, both by their families and by community members in general" (Harris & Dunia, 2025).



Pillar 2: Church-Based Awareness

Churches are uniquely positioned to offer dementia education through sermons, Bible studies, and pastoral teaching that distinguishes between neurodegenerative illness and supernatural accusations, while affirming compassion and dignity (Mkhonto & Hanssen, 2018). Training for pastors.

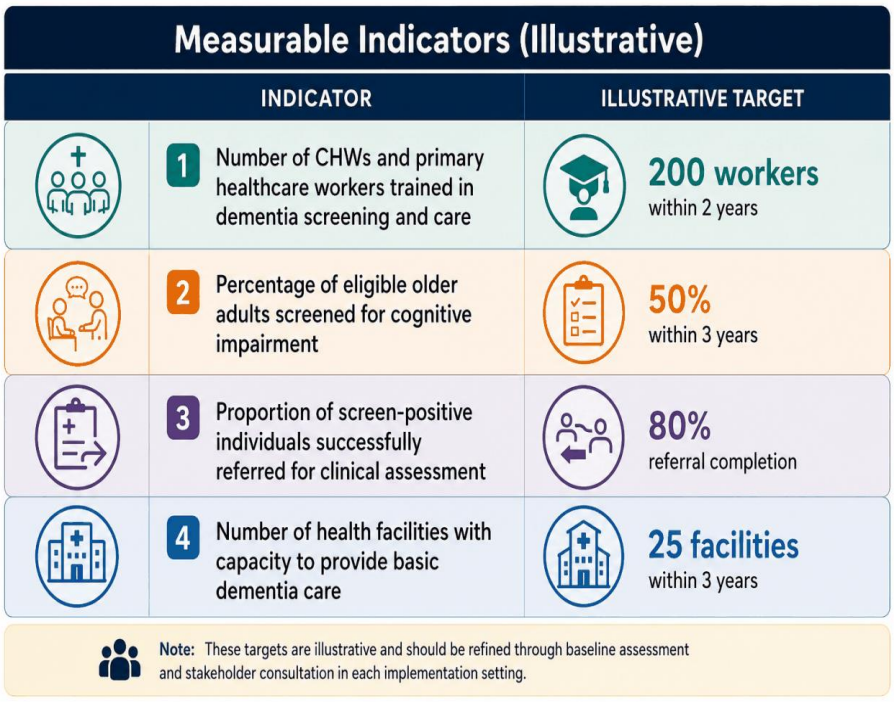
The church's role extends beyond education to advocacy. The widespread presence of churches in Zambian communities makes this pillar a potentially important intervention point (Mkhonto & Hanssen, 2018). Faith-based dementia education programmes have demonstrated the value of involving churches and faith communities to support dementia education efforts (Chigangaidze et al., 2026).



Pillar 3: Healthcare Capacity Building

Primary healthcare workers must be trained to identify dementia, communicate diagnoses sensitively, and provide basic management and referral (Mataa et al., 2024). Training should include culturally competent communication, recognition of dementia symptoms, and understanding of local beliefs regarding cognitive decline (Mkhonto & Hanssen, 2018).

The pilot programme using CHWs to screen for dementia in Zambia provides a promising model to be scaled up (Mataa et al., 2024). Nurses in South Africa have emphasised the importance of healthcare providers knowing local culture and language to be accepted in communities (Mkhonto & Hanssen, 2018).

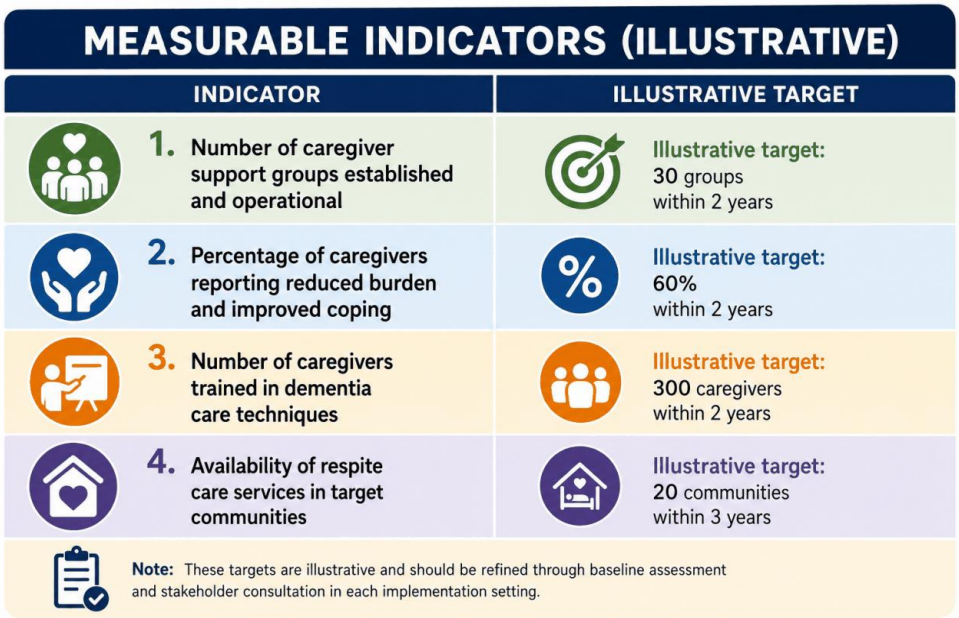


Pillar 4: Traditional Leader Engagement

Chiefs, headmen, and other respected community leaders can play an important role in shaping community norms and responses to accusations of witchcraft against older persons. Involving traditional leaders in dementia awareness, stigma reduction, safeguarding, and referral pathways may therefore strengthen community-level responses. Traditional leaders can model appropriate responses to cognitive and behavioural changes, challenge harmful witchcraft accusations, facilitate access to healthcare, and promote the protection of vulnerable older persons. Such engagement should emphasise accountability, non-violence, dignity, and timely referral for health assessment where cognitive impairment is suspected.

Pillar 5: Caregiver Support Systems

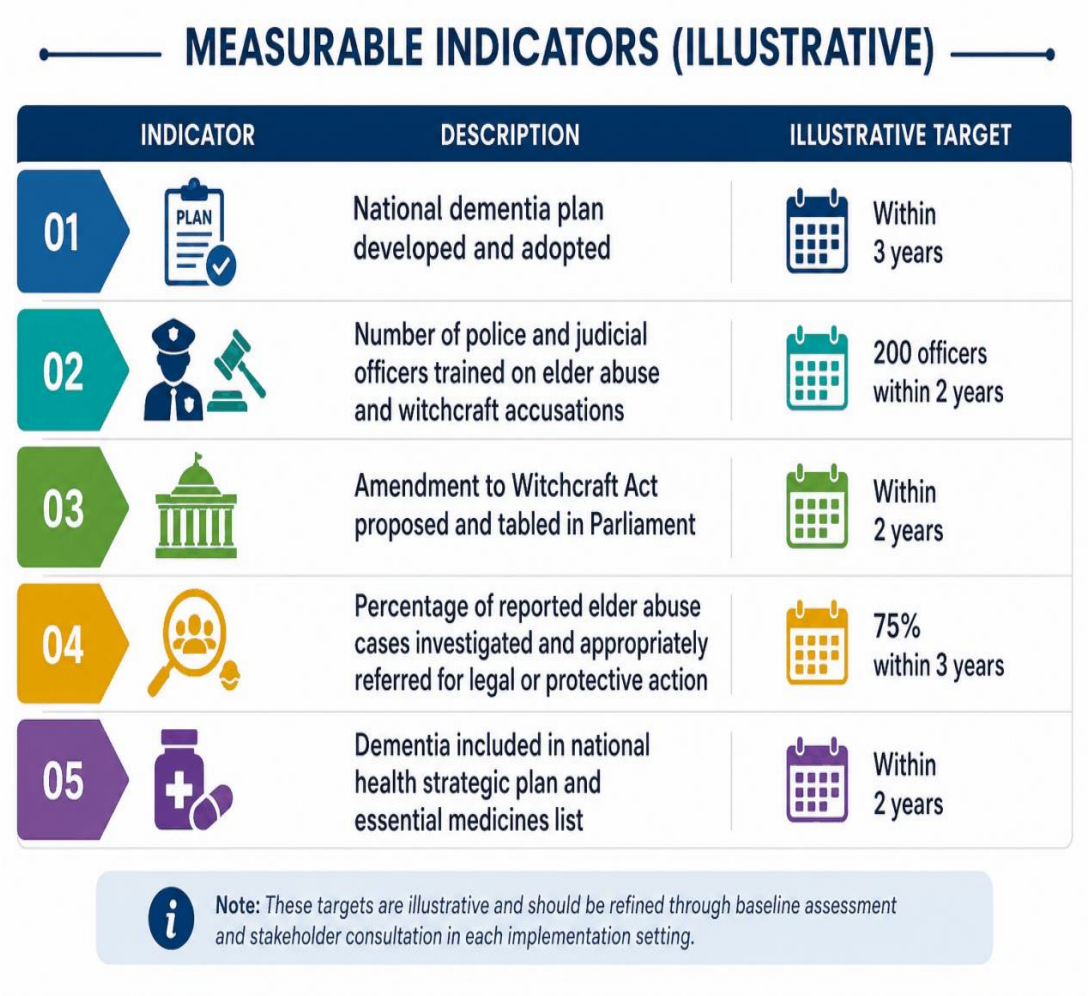
In Zambia, family caregivers bear the major burden of caring for people with dementia, with minimal support from formal health and social care systems (Simushi et al., 2024). Caregiver support systems should comprise practical education in dementia care, respite support, peer groups, and counselling. Support groups can assist caregivers in coping with courtesy stigma and provide a forum for sharing experiences and strategies while mitigating isolation (Aballa et al., 2025). They can also serve as vehicles for advocacy and community education. The World Health Organization's iSUPPORT programme for dementia caregivers has proven feasible and acceptable in Uganda (Gumikiriza-Onoria et al., 2024).



Pillar 6: Policy and Legal Protection

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XIII Issue XV July 2026 | Issue on Public Health

Zambia lacks specific legislation protecting older adults from abuse and neglect. Policy reform must include: specific legislation criminalising elder abuse; training for police and judiciary on elder abuse and witchcraft accusations; inclusion of dementia in national health priorities (Alzheimer's Disease International, n.d.); integration of dementia care into primary health services (Mataa et al., 2024); and protection for accused individuals, including access to legal representation. The development of a national dementia plan would provide a framework for coordinated action across health, social welfare, and community development sectors (Alzheimer's Disease International, n.d.).



The Intervention Pathway

The MPHDRF intervention pathway translates the conceptual analysis of dementia-related witchcraft accusations into a coordinated multi-level response. These pillars operate across four mutually reinforcing levels: the individual level, involving persons living with dementia and their caregivers; the community level, involving churches, traditional leaders, families, and community members; the health-system level, involving community health workers, primary healthcare services, and specialist referral; and the policy level, involving legal protection, national planning, and institutional accountability.

The pathway begins with the identification of dementia symptoms and the social risks created when such symptoms are interpreted as evidence of witchcraft. The anticipated outcomes include improved dementia literacy and early recognition, stronger referral and care pathways, increased caregiver support, reduced stigma and harmful witchcraft accusations, reduced elder abuse, and strengthened legal and policy protection. Because the MPHDRF has not yet been empirically validated, these outcomes represent intended pathways of change to be tested through participatory co-design, pilot implementation, and mixed-methods evaluation rather than effects already demonstrated.

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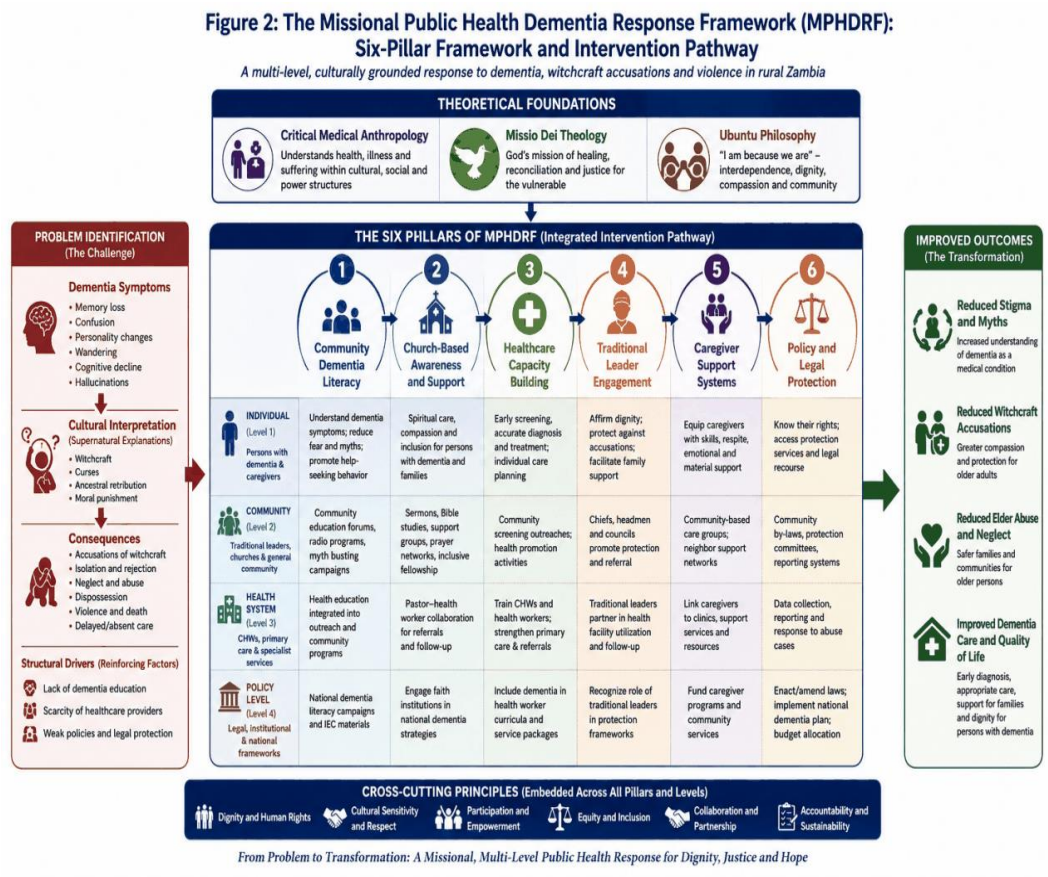

Figure 2. The Missional Public Health Dementia Response Framework (MPHDRF): Six-Pillar Framework and Intervention Pathway

DISCUSSION

Comparison with Existing Intervention Approaches

The MPHDRF represents a significant departure from existing intervention approaches to dementia-related stigma and elder abuse in sub-Saharan Africa. While these approaches have value, they suffer from several limitations that the MPHDRF addresses.

First, biomedical education alone fails to engage the deeply embedded cultural and spiritual frameworks through which dementia is interpreted in African communities (Chigangaidze et al., 2026). This represents a fundamental shift from a deficit model (communities lack biomedical knowledge) to an engagement model (communities have meaningful cultural frameworks that can be expanded and transformed).

Second, single-sector approaches have proven insufficient for addressing the complex, multi-dimensional nature of dementia-related stigma and elder abuse (Mkhonto & Hanssen, 2018). This multi-sectoral approach aligns with WHO recommendations for comprehensive dementia responses (World Health Organization, 2017).

Third, previous interventions have often neglected the theological dimensions of dementia care, despite the central role of religious beliefs in shaping community responses to cognitive decline (Swinton, 2012). This theological engagement enables churches to become active partners in stigma reduction rather than passive bystanders or, in some cases, contributors to harmful beliefs.

The MPHDRF's Contribution to Knowledge

Interdisciplinary Integration: By synthesising critical medical anthropology, missio Dei theology, and Ubuntu philosophy, the framework demonstrates how these distinct disciplinary perspectives can be mutually reinforcing. This integration challenges the artificial separation of biomedical, cultural, and.

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Cultural Grounding: The framework's emphasis on traditional leadership engagement and Ubuntu-informed caregiving represents a significant departure from imported Western models of dementia care. This cultural grounding enhances the framework's relevance and potential for sustainability in African contexts.

Policy-Practice Nexus: The MPHDRF explicitly connects community-level interventions with policy and legal reform, addressing a gap in previous approaches that have often neglected the structural dimensions of dementia-related stigma and elder abuse.

Practical Operationalisation: The framework's measurable indicators and specific recommendations for legal reform (including illustrative policy options for legislative review) move beyond conceptual abstraction to provide actionable guidance for implementers.

Implications for Policy, Practice, and Research

Summary of Priority Actions by Stakeholder Group

The MPHDRF's six pillars translate into specific priority actions for key stakeholders. Table 1 summarises these recommendations.

Table 1. Priority Actions by Stakeholder Group

Stakeholder	**Priority Actions**
Healthcare Systems	Develop national dementia plan; train CHWs and primary care workers in dementia screening; integrate dementia into essential medicines lists and primary health services; establish geriatric units in provincial hospitals
Churches and Faith Communities	Develop dementia awareness programmes; train pastors in dementia recognition and pastoral care; challenge harmful beliefs from the pulpit; establish support groups; collaborate with healthcare providers and traditional leaders
Traditional Leaders	Model appropriate responses to dementia; challenge witchcraft accusations; facilitate healthcare access; address witch doctors' roles; advocate for older adult protection
Policy Makers	Enact elder abuse legislation; develop national dementia plan; invest in dementia research and healthcare capacity; ensure enforcement of existing protections including Witchcraft Act
Researchers	Conduct population-based prevalence studies; evaluate community-based interventions; test culturally appropriate screening tools; pilot MPHDRF implementation

Illustrative Amendments to the Witchcraft Act and Related Protection Measures

The persistence of witchcraft accusations and associated violence against older persons suggests that the existence of criminal prohibitions alone is insufficient. However, the Act could be strengthened to address contemporary forms of accusation-related harm, particularly where older persons and persons with actual or suspected cognitive impairment are exposed to violence, dispossession, forced displacement, neglect, or denial of healthcare.

The following provisions are proposed as illustrative amendment clauses for scholarly and policy discussion. They are not presented as final legislative drafting and would require formal review by the Zambia Law Development Commission, legal practitioners.

Proposed Legal Reform Pathway within the MPHDRF

These illustrative amendments would strengthen Pillar 6 of the MPHDRF by shifting the legal framework from a narrow prohibition of witchcraft-related conduct toward a more explicit prevention, protection, referral, accountability, and victim-support model. Instead, it focuses on conduct that can be legally assessed: accusation, incitement, violence, threats, dispossession, forced displacement, neglect, denial of healthcare, and other forms of abuse.

These proposals should be understood as an initial model amendment framework rather than final statutory language. Formal legislative drafting would require constitutional and human-rights review, consultation with affected communities and relevant stakeholders, and harmonisation with.

Research Agenda

Sub-Saharan Africa remains underrepresented in dementia research. Addressing this gap requires investment in research capacity, collaboration with community organisations, and culturally sensitive methodologies. Priority research questions include:

1. What is the prevalence and incidence of dementia in Zambia?
2. How effective are CHW-led screening programmes in identifying dementia in rural communities?
3. What is the feasibility and acceptability of the MPHDRF in pilot communities?
4. What are the most effective strategies for engaging traditional leaders in stigma reduction?
5. How do church-based awareness programmes impact community attitudes towards dementia?

Limitations

This article has several limitations that should be acknowledged. While the framework is grounded in existing evidence and theoretical perspectives, it has not yet undergone empirical validation through implementation research in Zambian communities.

Second, the article relies on secondary analysis of existing literature and publicly available data rather than primary data collection. This limits the depth of contextual understanding that might be achieved through ethnographic research, interviews with key informants, or community-based participatory methods.

Third, the illustrative policy and legislative reform options, while informed by the reviewed legal and policy literature, have not been formally reviewed through stakeholder consultation with Zambian legal experts or policy makers and are presented as scholarly proposals requiring further review.

Fifth, while the framework is designed for the Zambian context, its applicability to other SSA countries may vary depending on cultural, political, and healthcare system differences.

As a conceptual framework developed through integrative literature review and interdisciplinary synthesis, the MPHDRF is intended to provide a theory-informed foundation for future empirical investigation rather than evidence of intervention effectiveness. Its feasibility, acceptability, cultural.

These limitations suggest the need for future mixed-methods implementation studies that evaluate the MPHDRF's feasibility, acceptability, and effectiveness within rural Zambian communities. Such studies should include community engagement, participatory action research methods, and rigorous evaluation.

CONCLUSION

The growing burden of dementia, coupled with continuing reports of witchcraft accusations against older persons in rural Zambia, represents an important public health and human rights concern. This problem cannot be solved

by healthcare alone, education alone, or policy alone. The approach must be holistic, addressing the cultural, medical, theological, and structural dimensions of the crisis (Mkhonto & Hanssen, 2018; Swinton, 2012).

The Missional Public Health Dementia Response Framework (MPHDRF) proposed here offers a potential way forward. The MPHDRF is not presented as an empirically validated intervention; rather, it provides a structured foundation for future participatory co-design, pilot implementation, and mixed-methods evaluation in rural Zambian communities.

The MPHDRF is grounded in critical medical anthropology, missio Dei theology, and Ubuntu philosophy, integrating cultural analysis, holistic healing, human dignity, and communal responsibility.

Most interventions to date have been limited to biomedical education or isolated community awareness initiatives. This interdisciplinary approach constitutes the framework's unique contribution.

The future of dementia care in Zambia will depend on strengthening dementia-capable community and primary healthcare, referral pathways, specialist services, caregiver support, and protective systems, while simultaneously transforming the cultural and social narratives through which cognitive decline is interpreted. The Missional Public Health Dementia Response Framework proposed in this article suggests one possible pathway to this transformation.

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