

Knowledge and Uptake of Psychological Services by Adult Residents in Neshuro Growth Point, Mwenezi District

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Abstract

This study investigated the knowledge and uptake of psychological services among adult residents of Neshuro growth point, Mwenezi District. It aimed to inform strategies for enhancing social integration through applied psychology within Neshuro community. The research is based on the Health Belief Model (HBM), which argues that individuals' perceptions of susceptibility, severity, benefits and barriers to health behaviours influence their uptake of health-related services. Despite Zimbabwe's growing emphasis on mental health, psychological services remain underutilised, particularly in rural areas. The study employed a mixed-methods approach, combining quantitative and qualitative methods to examine the community's understanding of psychological services, factors influencing their utilisation and barriers to access. Quantitative data were collected through a questionnaire administered to 80 adult residents aged 18 and above from Neshuro growth point. Qualitative data were gathered through semi-structured interviews from 10 key informants, including local health workers, community leaders and social service professionals. Quantitative data were analysed using descriptive statistics to assess awareness levels and uptake patterns. Thematic analysis complemented by discourse analysis was used to analyse the qualitative data. Findings revealed low awareness of psychological services, with only 40% of respondents understanding their purpose. Chi-square tests highlighted significant associations between education levels and awareness ($\chi^2=12.47$, $df=3$, $p=0.006$). Thematic analysis identified stigma, cultural misconceptions and high cost as primary barriers. Discourse analysis further revealed how societal narratives perpetuate mistrust in formal psychological services. The study recommended targeted, culturally sensitive public health campaigns utilising trusted community leaders, integration of formal and informal healing systems and decentralised, affordable service delivery models to enhance psychological service utilisation in Zimbabwean growth points. As an innovative contribution, the study proposed the CACIM Framework, which offers a novel model for embedding formal psychological care within indigenous support structures.

Keywords: Psychological services, growth point, applied psychology, social integration, Health Belief Model.

Introduction

Mental health is an integral component of overall well-being, yet psychological services remain underutilised in many developing countries, particularly in rural areas of Zimbabwe (Patel & Thornicroft, 2019). Despite the country's growing recognition of mental health as a public health priority, the uptake of formal psychological interventions lags, constrained by factors such as stigma, cultural misconceptions and limited accessibility (Chibanda et al., 2016; Stuart, 2016; Chiwaridzo, 2024).

Zimbabwe has made notable strides in formulating mental health policies, though their adequacy remains a subject of debate. For instance, the 2007 Mental Health Strategy advocated for increased investment in mental health in both urban and rural areas (Mangezi & Chibanda,

2010). Additionally, the National Mental Health Strategic Plan of 2019 to 2023 promoted the improvement of mental health awareness and empowering of communities as well as the promotion of research and development of locally relevant, innovative solutions to challenges in Zimbabwe's mental health system (Ministry of Health and Child Care, 2019). However, the reality on the ground is that service delivery remains heavily skewed toward urban centres, leaving rural communities underserved (Mabrouk et al., 2022).

Research in Sub-Saharan Africa consistently identifies low uptake of formal psychological interventions, especially in rural areas. Cultural narratives framing formal services as 'foreign medicine' or 'ineffective' further deter help-seeking, reinforcing preferences for traditional systems (Mabrouk et al., 2022). Commonly cited contributing factors include a shortage of trained professionals, limited financial resources and inadequate transportation networks (Onah & Onah, 2012; Mudege & Zulu, 2011).

Stigma and cultural beliefs further prevent seeking for professional help. Across rural Zimbabwe, psychological disorders are frequently attributed to supernatural or spiritual causes, prompting reliance on traditional healers or faith-based solutions before or instead of, formal services (Stuart, 2016; Jorm, 2012). Such beliefs are reinforced by a lack of community awareness about the nature and efficacy of psychological interventions (Mangezi & Chibanda, 2010). Chibanda et al. (2016) demonstrated that even when accessible, psychological interventions require active community engagement to overcome deep-rooted misconceptions. Similarly, Jenkins et al. (2010) emphasised that mental health literacy or the community's knowledge and beliefs about mental disorders plays a pivotal role in shaping attitudes toward seeking professional help. In many low and middle-income countries, low literacy is associated with high perceived barriers and low perceived benefits of formal care (Patel & Prince, 2011). However, recent work by Mutanga (2025) emphasises the need for multidimensional approaches that acknowledge and respect cultural and spiritual dimensions alongside Western-based medical interventions, particularly in addressing the limitations of solely relying on Western mental health conceptualisations.

Work by Mudege & Zulu, (2011) in Zimbabwean rural districts found that local leaders can serve as effective champions normalising help-seeking and reducing stigma. However, few studies systematically integrate community perceptions with quantitative measures of service uptake. This gap is pronounced in growth points. Maphosa and Maphosa (2021) observed that residents of growth points experience intensified access challenges such as scarce infrastructure and limited professional staffing which contribute to a persistent treatment gap. Growth points are semi-urban centres that were established by the Zimbabwean government to stimulate rural development (Manyanhaire et al. 2011). The growth points are unique in that their infrastructural and cultural setup do not align to either urban or deep-rural models. As a result, there remains limited evidence on how psychological interventions might be tailored to the unique social fabric of growth points.

Understanding how adult community members in growth points perceive psychological services is critical for developing interventions that are both culturally sensitive and logistically feasible. This study, therefore, aims to fulfil this research gap by investigating adult residents' perceptions of susceptibility, severity, benefits and barriers regarding psychological services at Neshuro growth point in Mwenezi District, Masvingo. It aims to uncover how these perceptions influence service utilisation and in so doing inform culturally appropriate outreach and intervention strategies for enhancing social integration through applied psychology in rural growth points. This study was guided by the following objectives: to assess the level of

knowledge and awareness of psychological services among adult residents of Neshuro growth point, to identify the socio-cultural barriers that hinder the uptake of psychological services in the community and to explore how societal narratives and stigma influence attitudes towards formal psychological care. As practical and theoretical contribution, the study introduces the Culturally Adaptive Community-Integrated Mental Health (CACIM) framework, a three-pillar model to enhance uptake of psychological services in growth points.

Theoretical Framework

This study is informed by the Health Belief Model (HBM). The HBM is a social-cognitive framework originally developed to explain preventive health behaviours according to Rosenstock (1974). The HBM posits that an individual's likelihood of engaging in a health-related behaviour such as seeking psychological services is influenced by their perceived susceptibility to a condition, its perceived severity, the perceived benefits of acting and perceived barriers to doing so (Green et al., 2020). The model's core strength lies in its focused structure, which provides a clear, testable framework for predicting health behaviours based on individual cognitions. Its predictive utility has been empirically validated across various health domains, including mental health service utilisation in low and middle-income countries (LMICs), where research demonstrates a positive correlation between higher perceived benefits, lower perceived barriers and increased help-seeking intentions (Jenkins et al., 2010; Patel & Prince, 2011).

However, the HBM exhibits significant limitations, particularly relevant when applied to diverse cultural setups. Its primary focus on individual-level cognitive processes often overlooks the profound influence of socio-cultural, economic and structural factors (Otto et al., 2021) This individualistic bias renders it less attuned to the dynamics of collectivist societies where community norms, familial expectations and social support networks critically shape health decisions (Adiyoso et al., 2023). Furthermore, the model's origins in Western health paradigms mean its core constructs may not adequately capture or translate the complexities of health beliefs and illness explanations prevalent in non-Western countries (Mutanga, 2025).

The present study significantly enhances the theoretical significance and applicability of the HBM by directly addressing these limitations within the specific context of rural African communities, rigorously testing its validity within environments characterised by distinct infrastructural challenges and socio-cultural frameworks. It also integrates the influence of indigenous spiritual systems, as posited by Mutanga (2025), who advocate for integrating cultural and spiritual dimensions with Western therapeutic approaches, thereby moving the study beyond merely applying the HBM.

Materials and Methods

This investigation employed a mixed methods design to assess adult residents' knowledge and uptake of psychological services at Neshuro growth point. Quantitative and qualitative data were collected concurrently between April to May 2025 to capture complementary perspectives within the same temporal setting, thereby minimising contextual shifts and enabling triangulation during analysis (Giri et al., 2021).

The study targeted adult residents aged 18 years and above of Neshuro growth point. For the quantitative component, 80 participants were selected using stratified random sampling based on gender (50% men, 50% women) to ensure equal representation. Eligibility criteria required participants to have resided in Neshuro for at least six months, to possess the cognitive capacity to complete the questionnaire and to provide informed consent. The qualitative component

involved 10 purposively selected key informants representing diverse community perspectives: three community health workers, three local schoolteachers, two religious leaders one from a mainline church and another from an apostolic sect and two social service professionals. Informants were chosen for their roles as authority figures and for their potential insights into the barriers and facilitators of psychological service uptake.

A structured questionnaire based on the Health Belief Model was developed, containing sections on demographic information, knowledge and awareness of psychological services, perceived benefits and perceived barriers. Internal consistency was satisfactory. Cronbach's alpha for all items ranged from 0.78-0.83. Demographic information covered age, gender, education, occupation and household income. Qualitative data were collected using a semi-structured interview guide that explored community narratives of mental disorders, barriers to accessing psychological services, perceived roles of traditional versus formal providers and suggestions for outreach. Questions were open-ended with room for follow ups to increase depth.

Two research assistants (RAs), fluent in both Shona and English, underwent two days of training on questionnaire administration, interview techniques and informed consent procedures. The instruments were piloted in the nearby Rutenga growth point to refine item wording, clarity, interview flow and to ensure cultural appropriateness. For the main study, the RAs administered print questionnaires to participants, with each session lasting approximately 20 minutes. Filled in forms were checked daily for completeness. Semi-structured interviews, lasting between 30 and 45 minutes, were conducted by the lead researcher in private locations chosen by the informants.

Quantitative data were analysed using R software. Descriptive statistics were generated for demographic and HBM variables. Chi-square tests examined associations between demographic variables and knowledge of psychological services with statistical significance set at $p < .05$.

Qualitative data were analysed using thematic analysis, complemented by discourse analysis. Interview transcripts were coded, and themes were developed. Thematic analysis followed Braun and Clarke's (2006) six-phase framework: familiarisation with the data, generation of initial codes, searching for themes, reviewing themes, defining and naming themes and producing the report. In addition, discourse analysis was conducted to examine how local narratives and language choices constructed mistrust or acceptance of formal psychological services. Data integration involved comparing quantitative and qualitative results to identify convergence and divergence, using qualitative findings to explain quantitative results. Trustworthiness was enhanced through instrument validation and methodological triangulation.

Approval to conduct the research was obtained from the local traditional leadership. Informed consent was secured from all participants, emphasising voluntary participation, confidentiality and the right to withdraw. To maintain confidentiality, participants' identifiers were replaced with the codes P01 to P80.

Results

Demographic Profile

Table 1, shows that the study sample consisted of 80 participants aged between 18 and 65 years ($M = 34.2$, $SD = 12.8$). The gender distribution was relatively balanced, with 52.5% being

female and 47.5% male. Educational attainment varied significantly, with 15% of participants reporting no formal education, 37.5% having completed primary education, 35% secondary education and 12.5% tertiary education. Most participants (80%) were engaged in subsistence farming or informal trading, while 15% identified as small-scale traders and 5% as unemployed. Monthly household income largely fell below US\$56 for 78.8% of participants, highlighting a significant economic vulnerability in the community.

Table 1: Demographic profile of participants (Source: Makaruke fieldwork, 2025)

Variable	Category	n	%
Age (years)	Mean	34.2	
	SD	12.8	
	Range	18–65	
Gender	Female	42	52.5
	Male	38	47.5
Educational Attainment	No formal education	12	15.0
	Primary education	30	37.5
	Secondary education	28	35.0
	Tertiary education	10	12.5
Main Livelihood*	Subsistence farming	25	31.2
	Informal trading	39	48.8
	Small-scale traders	12	15.0
Monthly Household Income	< ZAR1000 (approx. US\$56)	63	78.8
	≥ ZAR1000	17	21.2

*4 participants (5%) were unemployed

Knowledge of Psychological Services

Key knowledge gaps were identified. Only 40% of the participants correctly identified psychological services as addressing stress and emotional problems, while 43.8% incorrectly believed that these services were exclusively for individuals with severe mental disorders. The remaining 16.2% were unsure. A significant 71.3% of the respondents were unaware that trained mental health practitioners were available at Neshuro hospital while the remaining 28.7% demonstrated some level of awareness. There were significant differences in knowledge of psychological services ($\chi^2 = 12.47$, $df = 3$, $p = 0.006$) between participants of varying education levels. Tertiary-educated individuals demonstrated the highest levels of knowledge, while those with no formal education exhibited the lowest levels.

Utilisation of Psychological Services

Utilisation rates of psychological services were low, with only 16.3% of participants reporting ever having accessed such services. Among this subset, the preferred sources of psychological support were faith-based counsellors (46.2%), traditional leaders (30.8%), government hospital health workers (15.4%) and NGO (7.7%). Service usage was predominantly one-time (61.5%), with occasional usage (2–5 sessions) reported by 30.8% and regular monthly utilisation by only 7.7% of participants.

Health Belief Model Perceptions

Participants' perceptions of the benefits and barriers to psychological services were assessed on a 5-point scale. Participants recognised the benefits of psychological services, such as

learning stress management skills, finding practical solutions and improving relationships. Among the barriers to accessing mental health services, financial constraints emerged as the most significant, with 62 out of 80 participants (77.5%) identifying cost as a primary obstacle. In addition, fear of gossip and stigma was reported by 48 participants (60%), underscoring the persistent influence of social perceptions on help-seeking behaviour. 36 participants (45%) expressed a preference for traditional methods, reflecting the persistent role of cultural practices in shaping mental health responses.

Societal Narratives

Cultural Misconceptions and Stigmatisation

Mental health was predominantly understood through terms such as ‘*chirwere chepfungwa*’ (mental illness) and ‘*kupenga*’ (madness). Additionally, it was also primarily associated with witchcraft, ‘*ngozi*’ (avenging spirits) or spirit possession. This cultural discourse perpetuated stigma, as seeking psychological help was often equated with disclosing “madness” or mental disorders. Participants also attributed mental health challenges to social stressors, such as poverty and unemployment (80%) or spiritual causes, such as witchcraft and avenging spirits (60%), while biological explanations were only mentioned by a few (10%).

Economic Barriers

Cost was a critical barrier to accessing psychological services. Hospital consultation fees and transport costs were reported as prohibitive for most households. Many participants highlighted that the need to prioritise daily subsistence over mental health concerns further limited-service utilisation.

Trust in Traditional and Faith-Based Systems

Traditional healers (*n’anga*) and faith-based counsellors were the preferred sources of psychological support due to their cultural alignment, accessibility and flexible payment terms. Participants emphasised that traditional healers provided culturally relevant explanations and solutions without requiring to be paid upfront and accepted livestock as payment. Formal services were perceived as ‘*zvevarungu*’ (Western) and less practical.

Limited Awareness and Information Gaps

Awareness of available psychological services was minimal, with most participants relying on informal word-of-mouth communication, typically through family, friends or community members who had prior experience with mental health services. More effective communication channels, such as radio and community meetings, were underutilised. Health workers noted that existing information materials were often inaccessible due to language barriers and low literacy levels.

Narrative from Discourse Analysis

Three dominant narratives emerged from discourse analysis. The first was the “Foreign medicine narrative” where formal psychological services were viewed as incompatible with local values and spirituality. Secondly, the “Weakness” narrative wherein help-seeking was viewed as an admission of personal or familial failure, contradicting local values of resilience. Thirdly, the “Ineffectiveness” narrative where formal services were often perceived as overly theoretical and less practical than traditional methods.

Discussion

The findings of this study align with existing literature on the challenges of psychological services utilisation in rural sub-Saharan Africa. The low levels of knowledge and uptake of

psychological services in Neshuro Growth Point can be attributed to a combination of socio-cultural, economic and structural factors that are consistent with previously documented barriers in similar backgrounds (Komu et al., 2025). This section discusses these findings.

Knowledge and Awareness of Psychological Services

The study revealed that only a few of participants had adequate knowledge of psychological services. This finding supports Jenkins et al. (2010) and Patel and Prince (2011), who highlight the critical role of mental health literacy in shaping attitudes toward professional help-seeking. Low levels of knowledge were pronounced among participants with no formal education, suggesting that education-specific interventions may bridge this gap. Similarly, the limited awareness of available services at Neshuro Hospital mirrors the findings of Chibanda et al. (2016), who noted a lack of community engagement in disseminating information about psychological interventions in rural Zimbabwe.

The misconceptions identified in this study align with Jorm's (2012) observation that mental health literacy in poor backgrounds is hindered by narrow and inaccurate understandings of mental disorders. These misconceptions reinforce stigma and prevent individuals from recognising the value of psychological services for common mental health challenges, such as stress and emotional problems.

Barriers to Utilisation

Stigma emerged as one of the most prevalent barriers in this study, with participants frequently associating mental health issues with "*kupenga*" (madness) or spiritual causes, such as witchcraft and avenging spirits. This supports similar findings from Stuart (2016) and Jorm (2012), who note that stigma stemming from cultural misconceptions often deters help-seeking in rural communities. It also aligns with regional evidence that stigma perpetuates low service uptake, particularly where mental distress is attributed to spiritual causes rather than biopsychosocial factors (Mabrouk et al., 2022).

The discourse analysis conducted in this study identified dominant narratives, such as the "Weakness" narrative which views help-seeking as an admission of personal and extended family failure. This aligns with Jenkins et al. (2010), who emphasise that cultural values such as resilience can discourage individuals from accessing formal care. The preference for traditional healers and faith-based counsellors, is consistent with prior research (Mangezi & Chibanda, 2010; Mudege & Zulu, 2011). Participants trusted these community-based providers due to their cultural alignment, accessibility and flexible payment terms.

The findings also indicate that economic barriers significantly hinder access to psychological services. Several participants reported that hospital consultation fees were prohibitive for the majority to access formal mental health services. These barriers echo the observations of Komu et al. (2025) and Mangezi and Chibanda (2010), who highlight the critical role of infrastructure and economic factors in limiting access to mental health care in rural areas. The high perceived barriers related to cost align with Onah and Onah (2012), who argue that rural dwellers prioritise subsistence-related activities over health-seeking behaviours when faced with financial constraints.

Societal Narratives

The discourse analysis revealed three dominant societal narratives namely "Foreign Medicine," "Weakness" and "Ineffectiveness". These narratives perpetuate mistrust in formal psychological services. The narratives align closely with findings by Mangezi and Chibanda

(2010) and Maphosa and Maphosa (2021), who noted that rural communities often view formal mental health services as incompatible with local values and spirituality. Such perceptions are worsened by the belief that formal providers lack practical solutions compared to traditional healers, who offer culturally relevant explanations and treatments. Addressing these narratives requires culturally sensitive approaches that integrate traditional health systems into formal psychological service delivery.

Health Belief Model Integration

The study's findings align with the Health Belief Model (HBM), which posits that perceived susceptibility, severity, benefits and barriers influence health-seeking behaviours (Rosenstock, 1974). While participants recognised the benefits of psychological services, such as stress management and relationship improvement, high perceived barriers were the primary deterrents. This supports Patel and Prince's (2011) assertion that low perceived benefits and high perceived barriers are significant predictors of low utilisation rates of psychological services in low-income countries.

Implications for Scholarship, Policy and Practice

The findings of this study carry significant implications for policymakers, mental health practitioners and community leaders striving to enhance psychological service utilisation in growth points such as Neshuro.

First, the critically low levels of mental health literacy underscore the urgent need for targeted, culturally appropriate public health campaigns. Policymakers should invest in initiatives that disseminate accurate information about common mental health challenges and available services. In addition, the initiatives should also actively challenge deep-seated misconceptions that equate mental distress with "madness" or spiritual conditions. These campaigns should make use of trusted community figures such as village heads, traditional and faith-based healers as key communicators, as they are already integral to the community's support systems (Mabrouk et al., 2022). Repackaging mental health information in familiar vernacular descriptions and utilising accessible communication channels such as local radio and community gatherings can be crucial for effective outreach, particularly for individuals with lower educational levels.

Second, the prevalent stigma and cultural barriers demand an approach that acknowledges and respects existing cultural beliefs. Instead of solely promoting Western models of care, policymakers and practitioners should explore avenues for integrating formal psychological services with traditional and faith-based healing systems. Such integration aligns with evidence that collaborative, multi-level interventions that blend economic support, family strengthening and psychological care yield the highest impact in resource-limited settings (Mabrouk et al., 2022). This could involve collaborative training for traditional healers and faith healers on basic mental health first aid and referral pathways, while formal providers simultaneously receive cultural competency training to better understand local healing practices. Such integration can foster trust, reduce the perception of formal services as "foreign medicine" and ultimately encourage individuals to seek help within a culturally coherent framework. The Dandemutande approach proposed by Mutanga (2025) provides a theoretical foundation for such integration, emphasising reparation and healing initiatives that honour indigenous spiritual frameworks while maintaining clinical effectiveness.

Third, the identified economic barriers necessitate practical, accessible solutions. Policymakers should prioritise funding and resources for decentralised mental health services, such as mobile

clinics and community-based workshops. This direct service delivery model can significantly reduce the prohibitive costs of transport and time off work, which are major deterrents for the predominantly low-income population. Furthermore, exploring flexible payment models or subsidised services within public health facilities could alleviate financial strain and encourage help-seeking behaviour.

The study's alignment with the Health Belief Model highlights the importance of reframing the perceived benefits of psychological services while actively mitigating perceived barriers. Practitioners should emphasise the practical utility of these services such as stress management skills and improved relationships rather than focusing solely on severe mental illness. Simultaneously, efforts that demonstrate the tangible effectiveness of formal interventions, through local testimonials from individuals who have benefited, can help counter narratives of "ineffectiveness" and "weakness."

The interdependency of the barriers and narratives in previous sections necessitates a framework with integrated components that simultaneously tackle these interconnected challenges such as the Dandemutande approach (Mutanga, 2025). To this end, the author proposes a CACIM framework. The Culturally Adaptive Community-Integrated Mental Health (CACIM) framework was designed to respond directly to the challenges identified in the study. The framework is composed of three interconnected pillars, namely Cultural Adaptation, Enhanced Accessibility and Community Integration as shown in Figure 1.

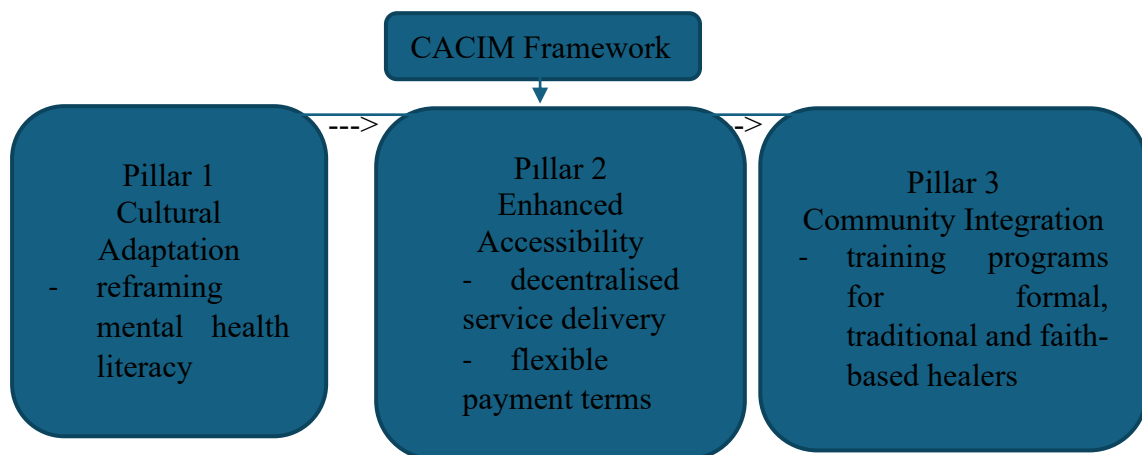


Figure 1: Proposed CACIM framework
 (Source: Makaruke, 2025)

The first pillar which is Cultural Adaptation addresses this problem of low mental health literacy and stigma by reframing mental health within the community's existing cultural and social context. It moves beyond merely disseminating information to a more practical approach that makes use of established community structures and communication styles.

The second pillar directly addresses the identified economic and structural factors that prevent most of the low-income population from seeking care. The framework proposes two key strategies to overcome these barriers. First, prioritising funding for decentralised mental health services, such as mobile clinics and community-based workshops, bringing services directly to the people. Secondly, exploring and piloting flexible payment models or subsidised services within public health facilities to alleviate financial strain. This approach not only makes care

more affordable but also adopts a practice that is already culturally resonant and effective within the community.

Pillar 3, on Community Integration aims at bridging formal and informal health systems. It addresses the deep-seated mistrust in formal services and the "Foreign Medicine" narrative. The framework embeds formal services within the community's pre-existing, trusted support networks. The pillar can be implemented through training programs for traditional and faith-based healers on basic mental health first aid, symptom recognition and referral pathways. Equally, formal health practitioners can also receive training to better understand and respect local healing practices and cultural explanations for mental distress.

Conclusion

Psychological services in Zimbabwean growth points such as Neshuro remain significantly underutilised, with only 16.3% of the population accessing formal mental health care. This low uptake is primarily attributed to limited awareness, widespread stigma, economic constraints and a mistrust in Western psychological models. 77% of respondents reported that they preferred traditional or faith-based providers.

The study employed a mixed-methods approach to uncover these findings, revealing that education and cultural storytelling play a critical role in shaping attitudes toward mental health services. In response to these findings, the CACIM framework was developed to offer an integrative solution that addresses cultural, economic and systemic barriers. The framework proposes a holistic model for improving mental health service uptake in growth points.

The study contributes to academia by introducing the CACIM framework as a promising model for further empirical testing in similar contexts. From a policy perspective, the government is commended of the urgent need for funding decentralisation, advocating for mobile clinics and the inclusion of growth points in national mental health equity initiatives. The findings urge practitioners to make use of culturally adapted outreach strategies, such as radio campaigns in local languages and the establishment of collaborative networks between traditional healers and mental health professionals to rebuild community trust and foster inclusive care pathways.

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