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Strengthening the Mental Health System in Zimbabwe: A Scoping Review of Policy and Health System Barriers to Achieving SDG 3

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ABSTRACT

Mental health is crucial for achieving Sustainable Development Goal 3 (SDG 3), yet it remains overlooked in many low- and middle-income countries. In Zimbabwe, the burden of mental disorders is increasing despite the existence of a national health strategy, raising concerns about the readiness of the health system to deliver equitable and effective mental health care. This scoping review synthesises evidence on the policy and health-system barriers influencing progress toward SDG 3 mental health targets in Zimbabwe. Guided by the Health Policy and Systems Analysis (HPSA) framework and reported in line with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews (PRISMA-ScR) guidelines, 12 peer-reviewed studies published between 2014 and 2025 were reviewed. Data were charted and analysed across key HPSA themes, including governance, financing, workforce, service delivery, and health information systems. The review identified several persistent system-level challenges. Although mental health policy frameworks exist, their implementation is limited by weak accountability mechanisms, insufficient decentralisation, and fragmented leadership. Chronic underfunding, combined with reliance on donor support, undermines the sustainability of services. Shortages and uneven distribution

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of skilled mental health professionals restrict access to care, particularly in rural areas. Task-sharing initiatives have improved access but remain inadequately supported and are not fully integrated into the health system. In addition, weak mental health information systems limit the use of data for planning and monitoring. Broader challenges, including stigma, urban–rural inequalities, and poor intersectoral coordination, further constrain progress. Progress toward SDG 3 mental health targets in Zimbabwe requires stronger governance and accountability, increased domestic financing, investment in community-based mental health workforces, and better integration of mental health indicators into routine health information systems. Zimbabwe's experience offers useful lessons for other resource-constrained settings.
Keywords: Mental Health System, Sustainable Development Goal 3, Zimbabwe

INTRODUCTION

Although Sustainable Development Goal 3 (SDG 3) aims to ensure healthy lives and promote well-being for all, the continued neglect of mental health remains a major obstacle to achieving this ambition (United Nations, 2025). Despite global commitments, mental disorders continue to rise. Between 1990 and 2021, the age-standardised incidence of mental disorders increased by 15.23%, while disability-adjusted life years rose by 17.28% (Fan et al., 2025). Beyond their impact on morbidity and mortality, poor mental health also imposes a substantial economic burden; productivity losses associated with depression and anxiety alone are estimated at nearly US$1 trillion annually (World Health Organization, 2025). Despite this burden, more than half of individuals in low and middle-income countries (LMICs) receive no mental health treatment, with treatment gaps reaching up to 90% in the poorest settings (Freeman, 2022).

Zimbabwe is not spared from the global mental health crisis. Though, the country is facing a growing burden of numerous cases of mental disorders, which are already high, mental health remains one of the least prioritised areas within its public health agenda. According to the World Health Organization (WHO) Special Initiative for Mental Health Situation Analysis conducted in 2020, Zimbabwe faces a substantial burden of mental disorders, coupled with limited access to treatment across all conditions and population groups (World Health Organization [WHO] & University of Washington, 2020). Estimated prevalence rates include schizophrenia (0.1%), bipolar disorder (0.5%), major depressive disorder (approximately 1.4% overall, rising to 5.5% among older

adults), epilepsy (0.3%), and alcohol use disorder (1.3%) (WHO & University of Washington, 2020). These figures highlight a significant mental health load further compounded by economic instability, prolonged humanitarian crises, and weak public health systems.

The Government of Zimbabwe has acknowledged these challenges in its National Health Strategy 2021–2025, which outlines key policy priorities aimed at strengthening service delivery and improving access to care (Zimbabwe Ministry of Health and Child Care, 2021). However, it remains unclear whether these policy frameworks have translated into meaningful improvements in service availability, financing, or accountability. This implementation gap is common across many LMICs, where mental health policies often exist but are constrained by limited resources, weak infrastructure, and workforce shortages. These persistent gaps between policy intent and system performance raise concerns about Zimbabwe's ability to meet its mental health targets. Understanding how structural and contextual factors interact is therefore critical to informing reforms that can support a more equitable, responsive, and sustainable mental health system.

Several studies have examined aspects of mental health in Zimbabwe, focusing on areas such as community-based programmes, workforce training, and service accessibility. However, there is limited synthesis of this evidence to provide a system-level understanding of the mental health landscape. In particular, existing research has not sufficiently explored how policy frameworks and health system structures interact to influence mental health outcomes.

This study aims to conduct a scoping review to synthesise and map existing evidence on the policy and health system barriers hindering Zimbabwe's progress towards achieving its mental health goals. Scoping reviews are well suited to under-researched areas as they enable a systematic mapping of available evidence, identification of knowledge gaps, and clarification of key conceptual relationships. The analysis was guided by the Health Policy and Systems Analysis (HPSA) framework (Gilson, 2012), which highlights the interrelated roles of governance, financing, health workforce, service delivery, and health information systems. This framework provides a structured approach to examining how systemic constraints shape progress toward equitable, effective, and sustainable mental health care.

METHODOLOGY

Study Design

This scoping review was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews (PRISMA-ScR) guidelines (Tricco et al., 2018). The review aimed to systematically map and synthesise evidence on health system and policy barriers hindering Zimbabwe's progress toward achieving its mental health goals. The analysis was guided by the HPSA framework, which provided a structured approach to examining key health system domains.

Objectives of the Review

The review aims to identify and map the available evidence on health-system and policy barriers affecting the achievement of SDG 3 mental-health targets in Zimbabwe. It further seeks to categorise these barriers across the five domains of the Health Policy and Systems Analysis framework, namely governance, financing, health workforce, service delivery, and health information systems. In addition, the review aims to identify evidence gaps and highlight opportunities for system strengthening and policy reform.

Conceptual Framework

The HPSA framework informed the conceptual approach of this review (Gilson, 2012). The framework emphasises the interconnected roles of governance, policy, financing, health workforce, service delivery, and health information systems in shaping health system performance. It was selected for its ability to capture the complex and interrelated factors influencing mental health outcomes in resource-constrained settings such as Zimbabwe. In addition, the HPSA framework incorporates critical dimensions such as policy processes, power dynamics, and institutional contexts. The five domains of the HPSA framework were used to guide data analysis and to directly correspond to the analytical objectives of the review (Table 1).

Table 1: The conceptual framework

HPSA Domain	Analytical Focus	Link to SDG 3 Mental Health Targets
Governance and Leadership	Examines policies, legislation, coordination, and accountability mechanisms	Identifies institutional barriers to effective mental health governance
Health Workforce	Reviews training, staffing, and integration of mental health professionals	Identifies human resource constraints limiting service coverage
Health Information Systems (HIS)	Assesses data availability and utilization for mental health planning	Highlights evidence gaps and weak monitoring systems
Service Delivery	Evaluates accessibility, quality, and continuity of care	Maps operational and structural service barriers
Financing	Analyses funding levels, mechanisms, and sustainability	Identifies fiscal inequities constraining mental health services

Studies and documents were deemed eligible for inclusion if they met the following criteria:

- Focused on Zimbabwe's mental health system or the broader health system with explicit reference to mental health.,
- Addressed at least one of the five HPSA framework (governance, workforce, financing, service delivery, or health information systems),
- Included peer-reviewed articles, as well as government and NGO reports, policy briefs, and strategic documents,
- Published in English language or had an available English language translation,
- No restriction was placed on publication year.

Studies and documents were excluded if they met any of the following criteria:

- Studies focusing solely on clinical interventions or prevalence without system-level analysis,
- Commentaries or opinion pieces lacking empirical or policy relevance,
- Non-English language publications without an available translation.

Search Strategy

Two independent reviewers conducted a literature search using PubMed and Google Scholar between January and March 2025. These sources were selected to capture both peer-reviewed studies and relevant grey literature on mental health systems in Zimbabwe. PubMed was included as a core biomedical database to ensure coverage of peer-reviewed health and clinical research. Google Scholar was used to complement this by providing broader

interdisciplinary coverage and facilitating the identification of additional studies, including those from regional journals and grey literature that may not be indexed in traditional subscription-based databases.

The search combined controlled vocabulary Medical Subject Headings (MeSH terms) and free-text words. Terms were organized around three main concepts: (1) mental health and mental disorders (e.g., "mental health", "depression", "psychological distress"); (2) health systems and policy (e.g., "governance", "health workforce", "financing", "service delivery", "health information systems"); and (3) geographic context ("Zimbabwe").

Boolean operators (AND, OR) have been used to combine and refine the search terms. The full search strategy for each database is provided in Table 2.

Table 2: Comprehensive search strategy for all the databases

Database	Search Terms / Strategy
PubMed	("mental health"[MeSH] OR "mental disorders"[MeSH] OR "depression" OR "psychological distress") AND ("health systems" OR "health policy" OR "governance" OR "financing" OR "service delivery" OR "health workforce" OR "information systems") AND ("Zimbabwe")
Google Scholar	"mental health" AND ("health system" OR "policy" OR "governance" OR "financing" OR "workforce" OR "service delivery") AND "Zimbabwe"

Grey Literature

Grey literature was identified through Google Scholar and targeted searches of institutional websites. These included the Zimbabwe Ministry of Health and Child Care, WHO, the United Nations Development Programme, the World Bank, and non-governmental organizations (NGOs) such as the Friendship Bench. Documents were included if they were published by recognised institutions and provided relevant information or evaluations of Zimbabwe's mental health system.

Selection Process

All identified records were imported into EndNote and Microsoft Excel for management and screening. Duplicate records were removed prior to screening. Study selection was conducted in two stages. First, titles and abstracts were screened to exclude clearly irrelevant sources. Second, full-text articles were assessed against the inclusion criteria. Screening was conducted independently by two reviewers, with disagreements resolved through discussion and consensus. The selection process was summarised in Figure 1.

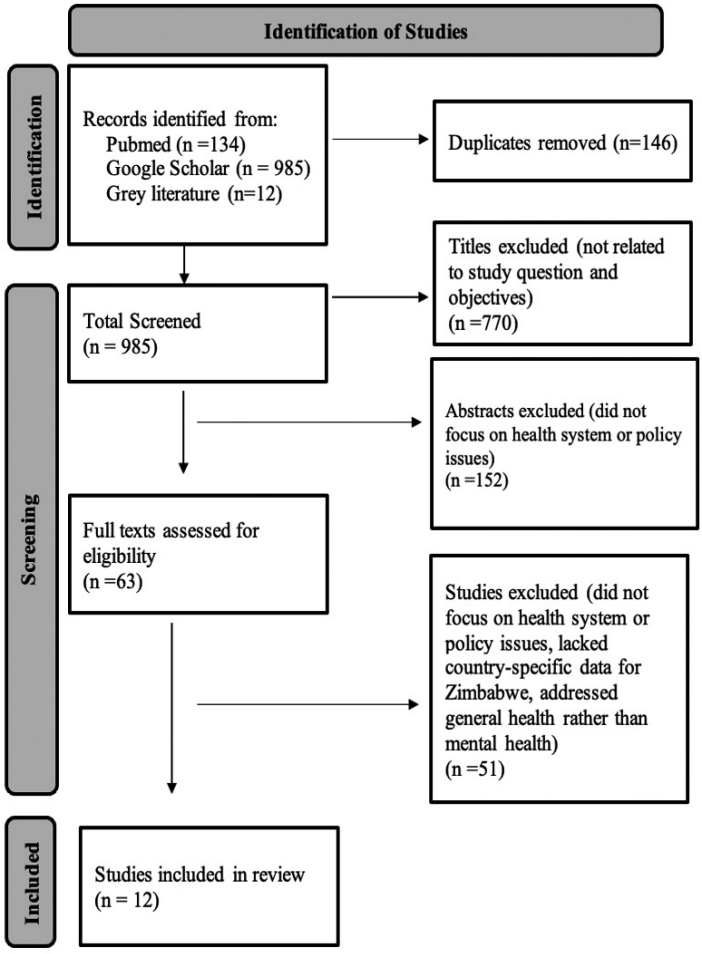

Figure 1. PRISMA flowchart diagram

Quality Assessment

Consistent with established methodological guidance for scoping reviews, a formal critical appraisal of included studies was not undertaken. As outlined by the Joanna Briggs Institute, the primary objective of scoping reviews was to systematically map the breadth, range, and nature of existing evidence, rather than to evaluate the methodological quality of individual studies (Khalil et al., 2025; Peters et al., 2015). In line with this approach, the present review prioritised a comprehensive identification and synthesis of evidence on health system and policy barriers, enabling a broad and inclusive understanding of the field. This approach is particularly appropriate given the heterogeneity of study designs and evidence types included in the review.

Data Charting

Data from the included sources were charted using a standardised Excel form developed by the authors. Extracted information included author, year of publication, source type, study focus, methodology, reported barriers or enabling factors, and the corresponding HPSA domain. The charting form was piloted on five studies to ensure consistency and allow for refinement. Two reviewers independently extracted the data and cross-checked the entries to ensure accuracy.

Synthesis

Data were synthesised using a thematic approach, guided by the HPSA framework. A deductive analytical approach was applied, whereby findings were organized into five pre-defined HPSA domains: governance, health workforce, health information systems, service delivery, and financing. Within each domain, data were coded and summarised to identify recurring patterns, cross-cutting challenges, and interactions between system components. For example, the analysis examined how financing constraints influenced workforce capacity and the functioning of health information systems. The synthesis drew on examples from individual studies to illustrate key themes. Overall, the analysis focused on understanding system interconnections and underlying structural factors, rather than providing a purely descriptive summary.

RESULTS

A total of 12 publications were included in the final synthesis. The studies were published between 2014 and 2025, with most (11 of 12; 91.7%) appearing after 2015, reflecting growing, though still limited research attention to mental health systems in Zimbabwe over the past decade. Most studies were conducted in urban or peri-urban settings such as Harare, Masvingo, Mutare, and Gweru, while a few included national-level analyses or multi-country comparisons involving Zimbabwe.

Across the studies, sample sizes and participant characteristics varied widely, ranging from small qualitative studies with 6–30 participants to larger quantitative or mixed-methods studies with several hundred respondents. The predominant study designs were qualitative (n=7), followed by mixed methods (n=2), quantitative (n=2), and documentary reviews (n=1).

Collectively, the included studies drew on perspectives from health professionals, policymakers, educators, and service users, providing a multi-level view of governance, workforce, financing, service delivery, and health information systems shaping mental health in Zimbabwe.

Governance and Leadership

The reviewed studies highlight governance challenges that extend beyond policy gaps to reflect deeper structural constraints within the health system. Although Zimbabwe has policy frameworks aligned with global mental health priorities, their implementation remains limited due to restricted decentralised decision-making and insufficient implementation capacity (Chihambakwe & Mlambo, 2024; Kidia et al., 2017). Even where policies and strategic documents exist, follow-through is often weak, with limited monitoring and accountability mechanisms (Abas et al., 2014; Kidia et al., 2017). This gap between policy and practice suggests that while strategic direction is present, it is undermined by operational challenges and weak coordination across sectors.

Centralisation further shapes these governance challenges by concentrating decision-making authority at higher levels of the system. As a result, frontline providers have limited autonomy, which can constrain responsiveness to local needs and reduce opportunities for adaptive learning. These governance dynamics are therefore not only administrative but also reflect broader system relationships including limited trust, slow responsiveness, and weak participatory planning. Together, these factors constrain progress toward SDG 3 by limiting system responsiveness, slowing innovation, and reinforcing inequalities in access and quality of care.

Financing

Across the reviewed studies, underinvestment in mental health reflects broader political and institutional prioritisation rather than simply a budgetary shortfall. Mental health consistently received a disproportionately small share of national health funding, highlighting its low priority relative to other health areas (Abas et al., 2014; Chibanda et al., 2016b; Mayavo, 2024). This chronic underfunding created structural constraints, including recurrent medication stockouts, deteriorating infrastructure, and limited capacity to recruit, train, and retain skilled personnel. These challenges, in turn, affected both the quality and the continuity of care.

Limited domestic investment was not fully offset by donor-supported programmes. While NGOs and community-based initiatives expanded access to psychosocial support in some settings, these efforts were often fragmented and time-limited. This highlights the risks of relying on externally funded programmes, which may not be sustained beyond the duration of specific projects. As a result, service delivery may fluctuate, with periods of expansion followed by gaps when funding ends.

These financing patterns therefore extend beyond resource constraints. They also signal the marginal position of mental health within a broader health system. Low investment contributes to weak system performance, which can in turn reinforce continued deprioritization. Without more predictable and sustained domestic financing, Zimbabwe remains vulnerable to funding instability, limiting the system's ability to deliver consistent and equitable mental health care and to progress toward SDG 3 targets.

Health Information Systems

Gaps in mental health information systems extended beyond technical data limitations to reflect broader weaknesses in institutional learning and accountability. Across the reviewed studies, inconsistencies in recording mental health consultations and poor integration into national reporting systems resulted in fragmented and unreliable data (Abas et al., 2014; Chihambakwe & Mlambo, 2024; Khombo et al., 2023; Zirima, 2022). These challenges were further compounded by limited disaggregation of data by age, geography or diagnosis which hampers the ability of planners to identify priority groups, tailor interventions, and monitor equity.

Data-related challenges also reflected the limited prioritisation of mental health within national health information systems. Inadequate training in mental health data management, together with the absence of standardised indicators, limited the ability of health workers to effectively record, interpret, and use data. This in return, contributed to a cycle in which limited data availability reduced visibility and weakened attention to mental health in planning and resource allocation.

As a result, mental health remained underrepresented in routine health planning and performance monitoring processes, constraining evidence-based decision-making and policy implementation. Without reliable data on service needs, utilisation, and outcomes, decision-makers lacked the information required to guide resource allocation and system improvements. These information system gaps therefore both reflect and reinforce broader system weaknesses, limiting targeted investment and slowing progress toward SDG 3 Mental Health Targets.

Health Workforce

Persistent workforce shortages and uneven distribution of skills emerged as key structural barriers across the reviewed studies. Mental health specialists, including psychiatrists and psychologists, were largely concentrated in urban

tertiary facilities, creating significant service gaps at primary and district levels, where care is often delivered by general nurses with limited mental health training (Abas et al., 2014; Chihambakwe & Mlambo, 2024; Mayavo, 2024). This imbalance reflects longstanding challenges in training capacity, weak incentives for rural deployment, and limited integration of mental health into pre-service and in-service training.

Task-sharing initiatives, including the use of lay counsellors and non-specialist health workers, have shown potential to expand access to basic psychosocial care (Chibanda et al., 2016b; Kemp et al., 2022). However, their sustainability has been constrained by limited supervision, irregular refresher training, and the lack of formal pathways for accreditation and career progression. As a result, many of these programmes remain small-scale or donor-supported, limiting their continuity and scalability.

Overall, these workforce challenges point to a system that struggles to develop, deploy, and retain mental health personnel in line with the service needs. This contributes to persistent inequities in access, particularly for rural and underserved populations, and limits the system's capacity to respond to increasing demand. In return, these constraints slow down the progress toward the mental health targets of SDG 3.

Service Delivery

Service delivery gaps were consistently characterised by limited geographic coverage, fragmented care pathways, and variable quality across facilities. Evidence showed that mental health services remain concentrated in urban tertiary centres, resulting in reduced access for rural and peri-urban populations who face barriers to counselling, diagnostic services, and essential psychotropic medicines (Chibanda et al., 2016a; Chihambakwe & Mlambo, 2024; Mayavo, 2024). This reflects the historical centralisation of specialist services and the limited integration of mental health into primary care.

Community-based and task-shared interventions demonstrated strong acceptability and the potential to extend psychosocial support into underserved settings. However, their sustainability was constrained by reliance on donor funding, limited integration into national systems, and weak supervisory structures. As a result, many promising initiatives struggled to move beyond pilot phases into routine scalable service models.

Service gaps were particularly pronounced for young people, with shortages of youth-friendly services and limited access to appropriate mental health information among adolescents (Doyle et al., 2023; Khombo et al., 2023).

Overall, the uneven distribution of services and disruptions in continuity of care contribute to inequitable access and limit the delivery of comprehensive, integrated mental health services. These challenges reduce the health system's ability to respond to increasing demand and slow progress toward the mental health targets of SDG 3.

Table 3: Summary of the eligible studies

Author & Year	Study Type	Study Setting	Study Participants	Key Findings
(Abas et al., 2014)	Qualitative (In-depth Interviews)	Broader Zimbabwe	6 Doctors	**Health Workforce** • Lack of learning resources • Small number of mental health trainers • Lack of specialist training opportunities • No training in ethics or professionalism • No training in management and public health advocacy • Poor integration with other medical specialties • Stigma of psychiatry among health professionals • Low salaries • Lack of training in research for psychiatry students **Health Financing** • Lack of resources for patient care **Health Information System** • Lack of exposure to up-to-date evidence/ research
(Chibanda et al., 2016a)	Qualitative Participatory Study (Focus Group Discussions)	Harare, Zimbabwe	149 Multiple Stakeholders That Included Policy Makers From the Ministry of Health, University Lecturers, Research Officers, Psychiatrists, Psychologists	**Service Delivery** • Nurses lack the time to provide structured counselling at City Health clinics
(Chibanda et al., 2016b)	Mixed-Methods Study (Focus Group Discussions, Workshops, Skills Assessment, In-Depth Interviews)	Broader Zimbabwe	48 Nurses, 12 District Health Promoters, 300 Lay Health Workers, 6 Key Stakeholders	**Health Workforce** • Lack of training **Service Delivery** • Shortage of psychiatric drugs • Nurses lack the time for counselling • Poor and unreliable referral system for people suffering from depression

(Chihambakwe & Mlambo, 2024)	Mixed-Methods Study (Qualitative Descriptive Durvey, In-Loco Observation, Interviews, FGDs, Document Analysis)	Broader Zimbabwe	5 Mental Health Nurses, 2 Social Workers, 4 General Hands, 1 Psychiatrist	**Governance and Leadership** • Institutional practices guided by medical models with limited recognition of counselling as a core component • The Mental Health Act (1996) does not clearly provide for the inclusion of professional counsellors within the health team **Health Workforce** • Shortage of qualified counselling professionals within mental-health teams • Multidisciplinary collaboration limited to nurses, social workers, and psychiatrists, absence of professional counsellors • Some staff members unaware of the importance of counselling for patient recovery and relapse prevention **Service Delivery** • Lack of psychosocial follow-up
(Doyle et al., 2023)	Quantitative Study (Population-Based Cross Sectional Study)	Five Urban and Peri-Urban Communities in Harare and Mashonaland East	634 Young People Aged 13–24 Living in Households in the Study Areas	**Service Delivery** • Lack of youth friendly mental health services
(Kemp et al., 2022)	Qualitative (Case Study)	Bangladesh, Jordan, Paraguay, the Phillipines, Ukraine and Zimbabwe	Multiple Stakeholders	**Service Delivery** • No psychiatric care for inmates • Lack of specialized facilities for child/ adolescence **Health Workforce** • Severe shortage of mental health professionals [18 psychiatrists, 917 psychiatric nurses (6.5 per 100,000) and 6 psychologists (0.04 per 100,000)] • Maldistribution of mental-health professionals in (17 of psychiatrists in Harare)
(Khombo et al., 2023)	Qualitative Study (Semi-structured interview)	3 Different Secondary Schools, Gweru	15 Students	**Health Information System** • Adolescents lack correct mental health information
(Kidia et al., 2017)	Qualitative Needs Assessment (Interviews)	Broader Zimbabwe	30 Participants Including Policy Makers, Administrators, Providers, and Researchers	**Governance and Leadership** • Lack of implementation of mental health policy • Little consultation with key stakeholders in policy formulation • Outdated mental health policy and law

(Masara & Zirima, 2024)	Quantitative Study (Survey)	Great Zimbabwe University, Masvingo	400 Undergraduate Students	**Health Information System** • Only 50.51% of participants were mental health literate
(Mayavo, 2024)	Documentary (Review)	Broader Zimbabwe	Discussed Documents and Reports Relating to Sustainable Development Goal 3 Implementation	**Health Workforce** • Severe shortage of trained mental health personnel, including trainers and specialist • Few opportunities for professional development, ethics or management training, and almost no exposure to research • Poor integration of psychiatry with other health disciplines, low remuneration, and stigma toward mental health professionals further weaken the workforce • The lack of training in research and limited specialist pathways exacerbate skill gaps and retention challenges within the mental health system **Health Information System** • Limited access to current research and up-to-date learning materials undermines evidence-based practice **Health Financing** • Inadequate resources for patient care indicate chronic underfunding in the mental health sector **Service Delivery** • Nurses at City Health clinics lack sufficient time to offer structured counselling, reflecting systemic understaffing and heavy workloads
(Sibanda et al., 2022)	Qualitative Study (Semi-Structured Interviews)	Odzi High School, Mutare	12 Teachers	**Health Information System** • Participants lack training and development on dealing with mental health among students
(Zirima, 2022)	Qualitative Study (In-depth Interviews)	Broader Zimbabwe	11 Practitioners, 5 Psychologists, 4 Counsellors, 2 Clinical Social Workers	**Health Workforce** • Inadequate mental health specialists • Lack of professionalism among mental health staff **Service Delivery** • Lack of psychiatric drugs in hospital • Little coordination between professionals in the mental health sector **Health Financing** • Lack of government funding for non-pharmacological mental health practitioners

Cross-Cutting Themes

Several cross-cutting system weaknesses have been identified across all domains, highlighting structural challenges that undermine sustained mental health system strengthening. The stigma has emerged not only as a social attitude but also as a barrier within the health system, shapes managerial priorities, influences provider's behaviour, and reduces demand for services. Its presence in both communities and the health sector has limited the service uptake and reduced the political prioritisation of mental health.

Rural inequities were also evident, with persistent disparities in financing, workforce distribution, and service availability disproportionately affecting non-urban populations. These inequities reflect longstanding centralisation of resources and point to the need for more equity-focused planning approaches to reach underserved communities.

Financing patterns further contributes to the system fragility. Reliance on fragmented, donor-driven funding leads to inconsistence for programme continuity and limited domestic ownership, constraining the scale-up of effective interventions and weakening long-term sustainability.

Together, these intersecting barriers show how stigma, geographic inequities, and financial dependency reinforce one another. Rather than acting in isolation, they shape broader system conditions that limit the effectiveness of reforms, slow integration, and constrain progress toward achieving the mental health targets of SDG 3.

DISCUSSION

This review highlights how interrelated weaknesses across governance, financing, health information systems, workforce, and service delivery continue to constrain the mental health system in Zimbabwe. These challenges operate as a connected system, where limitations in one domain reinforce weaknesses in others. For example, underinvestment restricts the workforce capacity and service availability, while weak governance and information systems limit effective implementation and planning. Together, these constraints contribute to persistent inequities in access to care, particularly for rural populations and young people, and slow down the progress toward achieving the mental health targets of SDG 3.

Governance and Leadership

Consistent with the findings of this review, weak governance structures particularly limit the decentralised decision-making, poor implementation of policy frameworks, and inadequate monitoring and accountability emerged as

key barriers to strengthening mental health care in Zimbabwe. Similar patterns have been reported in other LMICs. A multi-country study across Africa and Asia has found that weak governance, characterised by poor coordination, limited district-level management capacity, and insufficient accountability and transparency, have significantly constrained the delivery and scale-up of mental health services (Petersen et al., 2017). These similarities suggest that strengthening decentralised governance and improving accountability mechanisms may be critical for translating mental health policies into effective practice in Zimbabwe.

Financing

Underfunding emerged as a major constraint to the process of strengthening mental health system in Zimbabwe. Limited financial allocation restricts the implementation of policies, the expansion of services, and the availability of essential resources, ultimately affecting the quality and continuity of care. This pattern reflects broader trends that have been observed across Africa, according to the WHO reports, that governments in the region allocate on average less than US$0.50 per capita to mental health which is well below the recommended US$2 per capita for low-income countries (World Health Organization [WHO], 2022). Other studies similarly highlight the persistent low prioritisation and underfunding of mental health services across African settings (Kauye et al., 2014; Mostert et al., 2024). Together, these findings indicate that insufficient and inconsistent financing not only limits service delivery but also undermines the effective implementation of mental health policies, reinforcing gaps in access and quality of care.

Health Information Systems

Challenges in mental health information systems including inconsistencies in data recording and insufficient integration into national reporting platforms were identified as key barriers to effective policy implementation in Zimbabwe. Weak data systems limit the ability to monitor service coverage, track outcomes, and support evidence-based planning. Similar challenges have been reported in other LMICs. A multi-country study across Africa and Asia found that limited infrastructure, a shortage of health management information system specialists, and inadequate technical support constrained the collection and use of mental health data (Upadhaya et al., 2016). In addition, a commentary in the Lancet Psychiatry notes that mental health information systems in many LMICs remain either unavailable or too underdeveloped to effectively monitor

key indicators such as service coverage (Ryan et al., 2015). Collectively, these findings suggest that weak information systems not only hinder the monitoring of mental health policies but also limit informed decision-making and resource allocation. Strengthening data systems, including improving data quality, integration, and use will therefore be essential for supporting effective mental health system planning and accountability.

Health Workforce

Workforce shortages identified in this review reflect a broader challenge observed across many LMICs. For example, South Africa has also been reported experiencing significant shortages of mental health care providers, limiting service availability and access (Wolvaardt et al., 2024). Similarly, a study using WHO Assessment Instrument for Mental Health Systems data in 58 LMICs found that all the LMICs and 59% of these had far fewer mental health professionals than required to deliver a core set of interventions (Bruckner et al., 2011). In addition, consistent with the findings of this review, the limited number of available specialists in these settings are often concentrated in urban areas, further widening disparities in access between urban and rural populations (Wolvaardt et al., 2024). Overall, these findings suggest that addressing workforce shortages and improving the distribution of mental health personnel particularly through training, task-sharing, and incentives for rural deployment will be critical to improving access and advancing progress toward mental health targets.

Service Delivery

Service delivery gaps identified in this review were characterised by unequal access, with services largely concentrated in urban areas and limited availability in rural and informal settlements. These disparities disproportionately affect vulnerable groups, particularly young people, and constrain the effective implementation of mental health policies. Similar challenges have been reported in other settings. For example, in South Africa, psychiatric services are primarily available at regional and tertiary levels, with fewer resources at primary and community levels and limited attention to specialised areas such as child and adolescent mental health (Sorsdahl et al., 2023). More broadly, a review of LMICs found that mental health resources are unevenly distributed, with most specialists based in urban centres, making access difficult for rural populations due to distance and transport barriers (Rathod et al., 2017). These findings suggest that improving mental health service delivery will require

greater integration of services into primary care, expansion of community-based models, and targeted efforts to address geographic and population-level inequities in access.

Global and Regional Context

The challenges identified in Zimbabwe reflect broader patterns observed across LMICs, where persistent gaps in governance, financing, workforce capacity, poor service delivery, and information systems continue to limit the scale-up of mental health services (Semrau et al., 2019; World Health Organization, 2019). These findings suggest that Zimbabwe's experience is part of a wider pattern of underinvestment and limited prioritisation of mental health within health systems.

Across sub-Saharan Africa, similar constraints are evident. For example, in Ghana, the implementation of mental health policy has been slowed by funding and workforce limitations, although the establishment of a Mental Health Authority demonstrates the potential of stronger governance structures (Walker & Osei, 2017). In Kenya and Malawi, efforts to integrate mental health into community-based and primary care platforms including task-sharing approaches have shown potential to improve access despite resource constraints (Kauye et al., 2014; Kiima & Jenkins, 2010). Taken together, these experiences highlight that while system-level constraints are widespread, targeted reforms particularly in decentralised governance, sustainable financing, and community-based service delivery can strengthen mental health systems. Applying these lessons within the Zimbabwean context will be critical to improving access and advancing progress toward the mental health targets of Sustainable Development Goal 3.

Study Limitations

This review is not without limitations. First, the number of included studies was relatively small (n=12), and most were qualitative in nature and conducted in urban areas. This reflects the limited availability of research specifically focused on mental health systems and policy in Zimbabwe, where much of the existing literature has concentrated on clinical outcomes or prevalence rather than system-level analysis. Second, the review has included a limited number of databases. However, the use of Google Scholar alongside PubMed has allowed for broader coverage, as Google Scholar indexes a wide range of academic sources including studies from multiple databases as well as grey literature. This approach increased the likelihood of capturing relevant studies,

although it is still possible that some publications may not be identified. Finally, as this is a scoping review, no formal quality appraisal of included studies has been conducted. While this approach is consistent with scoping review methodology, it limits the ability to assess the methodological rigour of the included evidence.

Implications of the Study

Despite the study limitations, this review provides important insights into the structure and functioning of Zimbabwe's mental health system. It highlights key system-level challenges across governance, financing, workforce, service delivery, and information systems, offering a foundation for future research and policy development. Given the limited evidence base, there is a clear need for more comprehensive and methodologically diverse studies on mental health systems and policy in Zimbabwe. Future research should move beyond descriptive and prevalence-focused studies to include evaluations of system performance, implementation processes, and the effectiveness of policy interventions. These findings also underscore the importance of adopting a systems approach to mental health reform. Strengthening coordination across health system domains, investing in sustainable financing, and expanding community-based models of care will be critical to improving access and advancing progress toward mental health targets.

CONCLUSION

The challenges that Zimbabwe's mental health system faces are both locally specific and consistent with patterns observed across many LMICs. While shaped by economic constraints, they are rooted in structural weaknesses including underfunding, workforce shortages, and gaps in governance and implementation. Addressing these challenges will require coordinated, system-level reforms supported by sustained political commitment to prioritising mental health within national health agendas. Strengthening governance, increasing domestic financing, expanding the mental health workforce, and improving data systems will be critical to improving access and quality of care. Integrating mental health into primary care and broader universal health coverage frameworks will be essential to achieving more equitable and sustainable service delivery. These efforts will be key to advancing progress toward the mental health targets of SDG 3 in Zimbabwe.

Based on the key findings of this review, the following recommendations are proposed to strengthen Zimbabwe's mental health system:

Strengthen Mental Health Governance and Accountability: Weak implementation, limited decentralisation, and poor coordination that have been identified in this review highlight the need for stronger governance structures. Establishing a dedicated mental health directorate within the Ministry of Health and Child Care could improve coordination, accountability, and oversight of policy implementation. Strengthening the decentralised decision-making may also enhance responsiveness to local needs.

Increase and Stabilise Domestic Financing: Chronic underfunding and reliance on donor-supported programmes have been the key constraints identified in this review. Increasing domestic investment in mental health, including earmarked funding within primary health care budgets will be critical to improving sustainability and reducing fragmentation. More predictable financing mechanisms can support continuity of services and long-term system strengthening.

Expand and Support the Mental Health Workforce: Workforce shortages and uneven distribution of skilled personnel, particularly in rural areas were major obstacles to accessing services. Expanding task-sharing approaches and strengthening training for non-specialist health workers may improve coverage. These efforts should be supported by regular supervision, clear career pathways, and incentives for rural deployment.

Strengthen Mental Health Information Systems: Weak data systems and poor integration into national reporting platforms have limited the evidence-based planning and accountability. Integrating mental health indicators into routine health information systems, such as District Health Information Software and improving data quality and use will be essential for monitoring progress and guiding resource allocation.

Improve Equitable and Integrated Service Delivery: Service delivery gaps, particularly in rural areas and among young people highlight the need to expand community-based and primary care mental health services. Strengthening the integration into primary health care and scaling up community-based interventions can improve access and continuity of care.

Ethical Approval: Not applicable. This study is a review of published literature and does not involve human participants or primary data collection.

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REFERENCES

Abas, M. A., Nhiwatiwa, S. M., Mangezi, W., Jack, H., Piette, A., Cowan, F. M., Barley, E., Chingono, A., Iversen, A., & Chibanda, D. (2014). Building mental health workforce capacity through training and retention of psychiatrists in Zimbabwe. International Review of Psychiatry, 26(4), 453–459. https://doi.org/10.3109/09540261.2014.924487

Bruckner, T. A., Scheffler, R. M., Shen, G., Yoon, J., Chisholm, D., Morris, J., Fulton, B. D., Dal Poz, M. R., & Saxena, S. (2011). The mental health workforce gap in low- and middle-income countries: A needs-based approach. Bulletin of the World Health Organization, 89(3), 184–194. https://doi.org/10.2471/BLT.10.082784

Chibanda, D., Verhey, R., Munetsi, E., Cowan, F. M., & Lund, C. (2016a). Using a theory driven approach to develop and evaluate a complex mental health intervention: The Friendship Bench Project in Zimbabwe. International Journal of Mental Health Systems, 10(1), 16. https://doi.org/10.1186/s13033-016-0050-1

Chibanda, D., Verhey, R., Munetsi, E., Rusakaniko, S., Cowan, F., & Lund, C. (2016b). Scaling up interventions for depression in sub-Saharan Africa: Lessons from Zimbabwe. Global Mental Health, 3, e13. https://doi.org/10.1017/gmh.2016.8

Chihambakwe, W., & Mlambo, N. (2024). Role of professional counselling in mental health services provision: A case of Zimbabwe. Scholars Journal of Arts, Humanities and Social Sciences, 12(10), 312–314. https://doi.org/10.36347/sjahss.2024.v12i10.004

Doyle, A. M., Bandason, T., Dauya, E., McHugh, G., Grundy, C., Simms, V., Chibanda, D., & Ferrand, R. (2023). Common mental health and emotional and behavioural disorders among adolescents and young adults in Harare and Mashonaland East, Zimbabwe: A population-based prevalence study. BMJ Open, 13(3), e065276. https://doi.org/10.1136/bmjopen-2022-065276

Fan, Y., Fan, A., Yang, Z., & Fan, D. (2025). Global burden of mental disorders in 204 countries and territories, 1990–2021: Results from the global burden of disease study 2021. BMC Psychiatry, 25(1), 486. https://doi.org/10.1186/s12888-025-06932-y

Freeman, M. (2022). Investing for population mental health in low and middle income countries—where and why? International Journal of Mental Health Systems, 16(1), 38. https://doi.org/10.1186/s13033-022-00547-6

Gilson, L. (2012). Health policy and systems research: A methodology reader. World Health Organization. https://iris.who.int/server/api/core/bitstreams/32fc3903-1361-4690-aaa3-c08ced2f1400/content

Kauye, F., Jenkins, R., & Rahman, A. (2014). Training primary health care workers in mental health and its impact on diagnoses of common mental disorders in primary care of a developing country, Malawi: A cluster-randomized controlled trial. Psychological Medicine, 44(3), 657–666. https://doi.org/10.1017/S0033291713001141

Kemp, C. G., Concepcion, T., Ahmed, H. U., Anwar, N., Baingana, F., Bennett, I. M., Bruni, A., Chisholm, D., Dawani, H., Erazo, M., Hossain, S. W., January, J., Ladyk-Bryzghalova, A., Momotaz, H., Munongo, E., Oliveira e Souza, R., Sala, G., Schafer, A., Sukhovii, O., ... Collins, P. Y. (2022). Baseline situational analysis in Bangladesh, Jordan, Paraguay, the Philippines, Ukraine, and Zimbabwe for the WHO special initiative for mental health: Universal health coverage for mental health. PLOS ONE, 17(3), e0265570. https://doi.org/10.1371/journal.pone.0265570

Khalil, H., Jia, R., Moraes, E. B., Munn, Z., Alexander, L., Peters, M. D. J., Asran, A., Godfrey, C. M., Tricco, A. C., Pollock, D., & Evans, C. (2025). Scoping reviews and their role in identifying research priorities. Journal of Clinical Epidemiology, 181, 111712. https://doi.org/10.1016/j.jclinepi.2025.111712

Khombo, S., Khombo, K., Stoddart, R. S., Sifelani, I., & Sibanda, T. (2023). Knowledge, attitudes, and uptake of mental health services by secondary school students in Gweru, Zimbabwe. Frontiers in Psychology, 14, 1002948. https://doi.org/10.3389/fpsyg.2023.1002948

Kidia, K., Machando, D., Mangezi, W., Hendler, R., Crooks, M., Abas, M., Chibanda, D., Thornicroft, G., Semrau, M., & Jack, H. (2017). Mental health in Zimbabwe: A health systems analysis. The Lancet Psychiatry, 4(11), 876–886. https://doi.org/10.1016/S2215-0366(17)30128-1

Kiima, D., & Jenkins, R. (2010). Mental health policy in Kenya -an integrated approach to scaling up equitable care for poor populations. International Journal of Mental Health Systems, 4(1), 19. https://doi.org/10.1186/1752-4458-4-19

Masara, T., & Zirima, M. H. (2024). Levels of mental health literacy amongst university students: Findings from a university in Masvingo province, Zimbabwe. International Journal of Research and Innovation in Social Science, 8(6), 826–837.

Mayavo, C. (2024). Obstacles to achieving SDG3 in sub-Saharan countries: Perspectives from Zimbabwe. Journal of Environmental Education and Sustainable Development, 12(4), 21–36. https://doi.org/10.30473/ee.2024.70919.2723

Mostert, C. M., Nesic, O., Udeh-Momoh, C., Khan, M., Thesen, T., Bosire, E., Trepel, D., Blackmon, K., Kumar, M., & Merali, Z. (2024). Who should pay the bill for the mental health crisis in Africa? Public Health in Practice, 7, 100458. https://doi.org/10.1016/j.puhip.2023.100458

Peters, M. D. J., Godfrey, C. M., Khalil, H., McInerney, P., Parker, D., & Soares, C. B. (2015). Guidance for conducting systematic scoping reviews. JBI Evidence Implementation, 13(3), 141–146. https://doi.org/10.1097/XEB.0000000000000050

Petersen, I., Marais, D., Abdulmalik, J., Ahuja, S., Alem, A., Chisholm, D., Egbe, C., Gureje, O., Hanlon, C., Lund, C., Shidhaye, R., Jordans, M., Kigozi, F., Mugisha, J., Upadhaya, N., & Thornicroft, G. (2017). Strengthening mental health system governance in six low- and middle-income countries in Africa and South Asia: Challenges, needs and potential strategies. Health Policy and Planning, 32(5), 699–709. https://doi.org/10.1093/heapol/czx014

Rathod, S., Pinninti, N., Irfan, M., Gorczynski, P., Rathod, P., Gega, L., & Naeem, F. (2017). Mental health service provision in low- and middle-income countries. Health Services Insights, 10, 1–7. https://doi.org/10.1177/1178632917694350

Ryan, G., De Silva M., Terver, J. S., Ochi, O. P., & Eaton, J. (2015). Information systems for global mental health. The Lancet Psychiatry, 2(5), 372–373. https://doi.org/10.1016/S2215-0366(15)00097-8

Semrau, M., Alem, A., Ayuso-Mateos, J. L., Chisholm, D., Gureje, O., Hanlon, C., Jordans, M., Kigozi, F., Lund, C., Petersen, I., Shidhaye, R., & Thornicroft, G. (2019). Strengthening mental health systems in low- and middle-income countries: Recommendations from the Emerald programme. BJPsych Open, 5(5), e73. https://doi.org/10.1192/bjo.2018.90

Sibanda, T., Sifelani, I., Kwembeya, M., Matsikure, M., & Songo, S. (2022). Attitudes and perceptions of teachers toward mental health literacy: A case of Odzi High School, Mutare District, Zimbabwe. Frontiers in Psychology, 13, 1003115. https://doi.org/10.3389/fpsyg.2022.1003115

Sorsdahl, K., Petersen, I., Myers, B., Zingela, Z., Lund, C., & van der Westhuizen, C. (2023). A reflection of the current status of the mental healthcare system in South Africa. SSM-Mental Health, 4, 100247. https://doi.org/10.1016/j.ssmmh.2023.100247

Tricco, A. C., Lillie, E., Zarin, W., O'Brien, K. K., Colquhoun, H., Levac, D., Moher, D., Peters, M. D. J., Horsley, T., Weeks, L., Hempel, S., Akl, E. A., Chang, C., McGowan, J., Stewart, L., Hartling, L., Aldcroft, A., Wilson, M. G., Garritty, C., … Straus, S. E. (2018). PRISMA extension for scoping reviews (PRISMA-ScR): Checklist and explanation. Annals of Internal Medicine, 169(7), 467–473. https://doi.org/10.7326/M18-0850

United Nations (UN). (2025). The sustainable development goals report 2025. https://unstats.un.org/sdgs/report/2025/The-Sustainable-Development-Goals-Report-2025.pdf

Upadhaya, N., Jordans, M. J. D., Abdulmalik, J., Ahuja, S., Alem, A., Hanlon, C., Kigozi, F., Kizza, D., Lund, C., Semrau, M., Shidhaye, R., Thornicroft, G., Komproe, I. H., & Gureje, O. (2016). Information systems for mental health in six low and middle income countries: Cross country situation analysis. International Journal of Mental Health Systems, 10(1), 60. https://doi.org/10.1186/s13033-016-0094-2

Walker, G. H., & Osei, A. (2017). Mental health law in Ghana. BJPsych International, 14(2), 38–39. https://doi.org/10.1192/s2056474000001768

Wolvaardt, G. G., Stein, D. J., & Mumbauer, A. E. (2024). South Africa's mental health human resources dilemma: From shortage to solution. South African Health Review, 27, 68–77. https://doi.org/10.61473/001c.142351

World Health Organization (WHO). (2019). The WHO special initiative for mental health (2019-2023): Universal health coverage for mental health. https://iris.who.int/handle/10665/310981

World Health Organization (WHO). (2022). Barriers to mental health care in Africa. https://www.afro.who.int/news/barriers-mental-health-care-africa

World Health Organization (WHO). (2025). Over a billion people living with mental health conditions – services require urgent scale-up. https://www.who.int/news/item/02-09-2025-over-a-billion-people-living-with-mental-health-conditions-services-require-urgent-scale-up

World Health Organization (WHO) & University of Washington. (2020). Zimbabwe WHO special initiative for mental health situational assessment. https://www.who.int/docs/default-source/mental-health/special-initiative/who-special-initiative-country-report---zimbabwe---2020.pdf?sfvrsn=2bb0ac14_4

Zimbabwe Ministry of Health and Child Care. (2021). National Health Strategy 2021–2025 https://extranet.who.int/countryplanningcycles/sites/default/files/public_file_rep/ZWE_Zimbabwe_National-Health-Strategy-for-Zimbabwe_2021-2025.pdf

Zirima, H. (2022). Sustainable mental health provision options in Zimbabwe: Insights from non-pharmacological practitioners. Sustainable Communities Review, Sustainable Communities Review, 15(1), 1–11.