Community Perceptions of Non-Communicable Diseases, Mental Health, Gender-Based Violence and Substance Abuse in Rural Zimbabwe- the case of Binga District

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ABSTRACT

Non-communicable diseases (NCDs) are a leading cause of death globally, and in Zimbabwe they co-exist with mental health conditions that share their risk factors. Help-seeking is often pluralistic, and the largely asymptomatic early course of many NCDs delays diagnosis, yet little is known about how rural, marginalized communities understand these conditions and related social problems. This study explored community perceptions of NCDs, mental health conditions, gender-based violence (GBV) and substance abuse in Binga District, Zimbabwe, to inform contextualized and integrated primary health care. A qualitative design was used, comprising three community dialogues in Siabuwa, Siansundu and Simatelele, which represent the district's communal farming, trading and fishing communities. Participants (208; 137 women) included traditional and religious leaders, community health workers, youth and other community members. Dialogues were facilitated in Tonga, audio-recorded, transcribed verbatim, translated into English and analyzed thematically. Participants recognized hypertension, diabetes, asthma and cancer in their communities but had limited knowledge of their causes. Traditional remedies such as moringa, baobab and tamarind were widely used, which participants linked to long distances, staff shortages, non-functional diagnostic equipment and erratic medicine supplies at primary health care (PHC) level. Alcohol and cannabis use was reported in all three dialogues and attributed mainly to economic hardship and stress, with youth described as most affected. Household financial strain and substance use were perceived as drivers of GBV, with women and children most affected. Human–wildlife conflict and drowning emerged as additional concerns in fishing and farming areas. These findings reflect perceptions rather than prevalence, but they point to gaps in health literacy and PHC capacity. Priorities include male-focused community engagement in the local language, integrated screening at PHC, reliable supplies of NCD medicines and diagnostic equipment, and functional GBV referral pathways.

Keywords: Non-communicable diseases, mental health, gender-based violence, substance abuse, primary health care

INTRODUCTION

Noncommunicable diseases are a major and persistent source of premature mortality. The World Health Organization estimated that at least 43 million people died from NCDs in 2021, representing 75% of global deaths unrelated to the COVID-19 pandemic (World Health Organization, 2025). NCDs are rising rapidly across sub-Saharan Africa alongside HIV, nutritional disorders and other communicable diseases, producing multimorbidity and underscoring the need for health systems that address chronic disease while sustaining efforts against communicable disease (Bulamba et al., 2024; Karbasi et al., 2025; Nyabani, 2021). Zimbabwe faces a similar dual burden, with NCD prevalence rising against a background of persistent communicable disease (Nyabani, 2021). Regional health bodies have recommended expanding community-based prevention, especially for young people, to address NCD risk factors early (Masiye et al., 2026). The co-occurrence of NCDs and mental health conditions, and their overlapping risk factors, are well

documented, and integrating them within public health interventions has been proposed as an effective and efficient approach to prevention and control (Stein et al., 2019).

In rural sub-Saharan Africa, mental health conditions are often attributed to witchcraft, curses, misfortune or God's will rather than to biomedical causes, and similar explanatory models may shape how communities understand other chronic conditions and substance abuse (Bila & Carbonatto, 2022; Daniel et al., 2018). Help-seeking is commonly pluralistic: care may be sought first from traditional and religious healers, with health facilities used as a last resort (Bila & Carbonatto, 2022; Daniel et al., 2018). Such practices are shaped by beliefs, stigma, cost, distance and previous experiences of care. In addition, the largely asymptomatic early course of many NCDs contributes to low-risk perception, delayed help-seeking and late diagnosis, increasing the risk of complications. Together, community perceptions, plural help-seeking and structural barriers contribute to large treatment gaps. The World Health Organization's Package of Essential Non-communicable Disease Interventions for Primary Health Care (WHO PEN) emphasizes investment in NCD prevention and management at primary care level (World Health Organization, 2020).

Although evidence on the prevalence of NCDs and mental health conditions in Zimbabwe is growing, few studies have examined how rural, marginalized communities understand these conditions together with related social problems such as gender-based violence (GBV) and substance abuse. This limits the evidence available for designing culturally appropriate health promotion interventions. Binga District, a remote and marginalized district in Matabeleland North Province, is an important setting in which to address this gap. This study therefore aimed to (i) explore community perceptions of NCDs, mental health conditions, GBV and substance abuse in Binga District; (ii) document traditional knowledge systems and practices used to manage these conditions; and (iii) identify perceived barriers to care, in order to inform contextualized, culturally grounded and integrated primary health care.

METHODOLOGY

Study Design

We conducted a qualitative study using community dialogues, nested within an implementation research project funded by the UK-Zim Health Partnership Pilot. Community dialogues are facilitated, participatory group discussions in which community members share and debate collective views on locally relevant health issues. The study is reported in line with the Consolidated Criteria for Reporting Qualitative Research (COREQ) (Tong et al., 2007).

Study Setting

The study was conducted in Binga District, Matabeleland North Province, a rural district on the southern shore of Lake Kariba where Tonga is the predominant language. The 2022 Population and Housing Census recorded 159,982 residents in the district (Zimbabwe National Statistics Agency, 2022). The district is manned by twenty-four health facilities comprising of a district hospital, a rural hospital, a mission hospital, two uniformed forces clinics and sixteen rural health centers. The district is approximately 436 kilometers from Mpilo hospital (referral hospital) in Bulawayo. Three communities were purposively selected to represent the district's main livelihood groups: Siabuwa (communal farming), Siansundu (trading) and Simatelele (fishing).

Participants and Recruitment

Participants were purposively recruited to capture a range of community perspectives. The Nurse-in-Charge for each health facility visited invited the participants through community health workers and mobile phone messaging. Participant invitation was done three days prior to the dialogues. Eligible participants were adults aged 18 years and above living in the selected communities. Each dialogue included at most 70 participants drawn from traditional leaders, religious leaders, community health workers, representatives of community groups, youth and the general population, with both women and men represented. None of the invited participants refused to participate and no drop-outs were experienced. The composition of each dialogue is summarized in Table 1.

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Table 1: Characteristics of the three community dialogues

Characteristic	Siabuwa	Siansundu	Simatelele	Total
Main livelihood	Communal farming	Trading	Fishing	–
Date of dialogue	17/02/2026	19/02/2026	18/02/2026	–
Duration (minutes)	60	55	45	–
Total participants, n	74	68	66	208
Women, n (%)	50 (68)	45(66)	44 (67)	139 (67)
Men, n (%)	24(32)	23 (34)	22 (33)	69 (33)
Youth (aged 15–35 years), n	18	22	24	64
Traditional leaders, n	6	4	5	15
Religious leaders, n	3	3	2	8
Community health workers, n	7	8	6	21
Community group representatives, n	3	1	3	7
Other community members, n	37	30	26	93
Breakout groups used (yes/no)	No	No	No	–

Data Collection

A semi-structured community dialogue guide was developed by the research team in consultation with the District Health Executive and pretested at Binga hospital, revised then utilized. The guide covered (i) the perceived existence and causes of NCDs, mental health conditions, GBV and substance abuse; (ii) traditional knowledge systems and practices used to prevent or manage these conditions; (iii) experiences of accessing health services; and (iv) community-proposed solutions.

Dialogues were facilitated mainly in Tonga by three facilitators, two females and a male. The lead facilitator was a female who holds a Masters' in Public Health majoring in Health Promotion, has over 8 years of experience practicing health promotion including conducting community dialogues. She is fluent in Tonga language. The second, was also female, attained a Bachelor of Science degree in Health Education and Promotion with 3 years of experience in conducting community dialogues. The third was a male Professor, having over 20 years of experience in practicing community medicine. The three developed the community dialogue guide and conducted a virtual meeting to agree on its components and structure before pretesting it as a team. They also reoriented themselves on participatory facilitation, handling of sensitive disclosures and GBV referral procedures. Each dialogue lasted approximately 50 minutes and was held at health facilities in February 2026. Three note-takers per dialogue captured proceedings through audio recordings and written field notes.

Transcription and translation

Audio recordings were transcribed verbatim and translated from Tonga into English by the bilingual researcher. Back-translation of a sample of transcripts was done to validate translation. Comparison of back translation to the original source document was done to identify discrepancies. Transcripts were checked against the field notes and audio recordings for completeness, and identifying information was removed before analysis.

Data analysis

Data were analyzed thematically following Braun and Clarke's six phases: familiarization with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report (Braun & Clarke, 2006). A combined deductive and inductive approach was used. An initial coding framework was derived from the topics in the dialogue guide, and new codes were added as they arose from the data; the theme on human–wildlife conflict was developed inductively in this way. Manual data coding was done by four coders. Transcripts were independently coded and then compared. To resolve disagreements, coders reverted to original records together and went through the areas together and agreed on way forward. Codes were grouped into candidate themes, which were reviewed against the coded extracts and full transcripts and refined through team discussion. The final themes and sub-themes are shown in Table 2.

Because community dialogues generate group-level data, we distinguished shared views from individual opinions during analysis. A view was treated as a shared community perspective when it was raised in more than one dialogue or was explicitly endorsed by other participants in the same dialogue, as recorded in field notes. Views voiced by a single participant, or contested by others, are reported as individual or divergent views. In the results, "participants" refers to views that were widely shared, and we state explicitly when a view was expressed by one participant or in only one dialogue. The number of dialogues was set by the project design (one dialogue per livelihood community) rather than by data saturation.

Trustworthiness

To strengthen credibility, audio recordings were triangulated with written field notes, and the research team held debriefing sessions after each dialogue. Facilitators and analysts reflected on how their positions as health workers or researchers might influence discussion and interpretation. Illustrative quotations are presented with participant descriptors to support transparency.

Ethical Considerations

The study was approved by the Midlands State University Ethical Review Board. Permission was obtained from the Provincial Medical Directorate of Matabeleland North Province and the Binga District Health Executive, and community entry was negotiated with local traditional leaders. Verbal informed consent was obtained from participants before each dialogue. Participants were informed in Tonga of the study purpose, that participation was voluntary, that they could decline to answer any question or leave at any time without consequence, and that the discussion would be audio-recorded. Participants were provided with refreshments which comprised of biscuits, juice and water.

Participants were asked to respect the confidentiality of what others said and were reminded that confidentiality cannot be fully guaranteed in a group setting. No names were recorded in transcripts, and quotations are attributed only by broad descriptors. Audio files and transcripts were stored on password-protected devices accessible only to the research team and will be destroyed in line with institutional policy.

Because GBV and substance use are sensitive topics, facilitators asked participants to discuss community-level experiences rather than disclose personal experiences in the group. The research team outlined the country's referral pathway: The Zimbabwe Republic Police Victim Friendly Unit, The Rural District Council Social Services department, The Department of Social Development, community case management,

community health workers, safe spaces and local health facilities. However, no participant was referred and none of them sought private follow-up after the dialogue.

RESULTS

A total of 208 participants took part in the three dialogues (Table 1). Five themes were developed (Table 2): (1) perceived existence and understanding of NCDs, mental health conditions and substance abuse; (2) traditional management of NCDs and barriers to formal care; (3) perceived drivers and consequences of GBV; (4) local perspectives on drug and substance abuse; and (5) human–wildlife conflict and drowning. The findings represent participants' perceptions and experiences and do not indicate the clinical prevalence of these conditions.

Table 2: Themes and sub-themes

Theme	Sub-themes	Derivation
1. Perceived existence and understanding of NCDs, mental health and substance abuse	Recognized NCDs (hypertension, diabetes, asthma, cancer); substance abuse and mental disorders as emerging threats; limited knowledge of causes; absence of IEC materials; co-morbidity and diagnostic challenges	Deductive
2. Traditional management of NCDs and barriers to formal care	Herbal remedies (moringa, baobab, tamarind, tree bark); perceived symptom relief but not cure; distance, understaffing, non-functional equipment and medicine stock-outs	Deductive
3. Perceived drivers and consequences of GBV	Household financial strain; substance use; women and children as main victims; role of fathers; male-targeted engagement	Deductive
4. Local perspectives on drug and substance abuse	Alcohol (local and cross-border) and cannabis; stress and economic hardship; family conflict and neglect; perceived mental health effects; parental engagement	Deductive
5. Human–wildlife conflict and drowning	Crocodile and hippopotamus attacks; divergent views on life jackets; local avoidance strategies; fatalism; elephant incursions	Inductive

Theme 1: Perceived existence and understanding of NCDs, mental health conditions and substance abuse

Participants acknowledged that NCDs such as hypertension, asthma, diabetes and cancer occurred in their communities. Substance abuse and mental health conditions were mentioned less readily, but on probing, participants described them as an emerging threat to community wellbeing and to the future generation. Alcohol and substance abuse were described as widespread in all three dialogues. Most participants described limited knowledge of NCDs and their causes; the few causes mentioned included poor diet, genetics, witchcraft, vehicle emissions and smoke. Participants linked this limited knowledge in part to the absence of NCD information, education and communication (IEC) materials. They also described how co-existing conditions, together with shortages of medicines and sundries, made the diagnosis and management of NCDs difficult. Participant 1, CD 1 had this to say: "The causes of these diseases is not even clear, but there should be some act of witchcraft. Some say they run with lineage and also sometimes what we eat but how they (the diseases) select whom to attack is what is not clear, that is why we really think there is some witchcraft." Participant 4, CD 1 bemoaned smoke emissions saying, "We have a big challenge here, because

of rampant waste burning done at our business center here. A lot of smoke is released into our air, polluting it and exposing us to many of these diseases."

Theme 2: Traditional management of NCDs and barriers to formal care

Participants described a range of traditional remedies used to manage diabetes, cancers, hypertension and other conditions, including moringa, baobab seed "coffee", baobab fruit pulp, tamarind and the bark of other indigenous trees. Moringa was described as a multi-purpose herb for diabetes, hypertension, asthma and cancer; tamarind and baobab pulp were believed to lower blood pressure and blood glucose; and a drink made from boiled tree bark was taken for the same purposes. These are participants' beliefs about the remedies; their effects were not assessed in this study. Participants themselves noted that the remedies relieved symptoms but did not cure the diseases. Participant 2, CD 3 explained, "In our community, we have a variety of plant products that we use to stop the pain and manage some of the symptoms of these diseases, the likes of moringa, baobab seed coffee and tamarind. However, they only work for a short while and the symptoms come back, so at the end, one has to go the clinic for help."

Participants explained their reliance on traditional remedies with reference to barriers in the formal health system: long distances to health facilities, understaffing, limited diagnostic services, malfunctioning equipment at primary care level (such as blood pressure machines and glucometers) and the intermittent unavailability of NCD medicines. In their account, these barriers left many people with chronic conditions with little option but to manage them with traditional methods. Participant 5, CD 2 commented on health systems challenges saying, "The major challenge is that at our clinic sometimes the nurses say that the equipment for testing these diseases are not working and even the medicines may not be there, so we are left with no option hence we continue on our local remedies while the disease itself continues to grow."

Theme 3: Perceived Drivers and Consequences of GBV

Participants identified household financial strain and substance use as the main perceived drivers of GBV and described women as the victims in most cases. They explained that economic hardship and inadequate household income led to quarrels that could escalate into physical violence. Participant 8, CD 2 echoed, "Lack of money is the major cause of fights in households because the wife will be expecting money to buy household items but life is difficult out here and money is very hard to come by. You get back home with nothing and the woman asks you to provide something for the meals. Exchange of words begin and the discussion gets hot, and because of anger, people end up fighting." Substance use was described as impairing judgement, and spending on alcohol or drugs as depleting scarce household resources, heightening tensions that could end in violence. Participants emphasized fathers' early engagement with boys, to foster responsible behavior and a caring character, as important in shaping responsible future husbands. Participant 6, CD 2 highlighted the negative effects of drugs saying, "Our youthful generation here is being destroyed by these cheap drugs like kanjengu, some illegally imported from our neighboring country through the Zambezi waters while some is now locally brewed. Once they drink it, they get extremely drunk for days and cannot do anything. They cannot even look for money but will need more money to buy more, so they even steal small livestock or household goods for resale, just to quench their thirst for drugs." The community participants strongly recommended community engagement and awareness activities specifically targeting men. Discussions focused on community-level patterns, and participants did not disclose personal experiences of violence.

Theme 4: Local Perspectives on Drug and Substance Abuse

Participants openly acknowledged substance use and abuse in their communities, identifying alcohol and cannabis as the main substances. Both locally brewed alcohol and imported beverages, often from neighboring Zambia and locally termed kanjengu, were reportedly misused, and participants indicated that cannabis was grown and sold locally. Participants most commonly attributed substance use to stress and economic hardship. Participant 5, CD 2 also indicated: "People grow and sell cannabis as a recreational substance, but it's also widely abused by both youths and adults. The biggest problem is now with our

children, the youth. They have no jobs; they cannot start projects for themselves because they do not have money. They are stressed by this life. They have resorted to these drugs to free themselves from stress."

Participants described substance abuse as a cause of disputes, family disharmony and neglect, with women and children bearing much of the burden. They also associated it with "brain damage", irresponsibility, violence, mental health problems and lost productive time; these are community perceptions and were not clinically assessed. Parents spending time with their children to understand their social lives was proposed as a way to identify difficulties early and to offer guidance that might prevent substance use among youth. Participant 10, CD 2 was quoted, "Long ago, men used to provide life coaching and survival skills training to their sons through taking them for hunting, fishing and making crafts. Nowadays, that practice stopped and this is killing the young generation. We need to sit down with our children, teach them about life and also talk to them to understand what they are going through so that we can also help them socially before they are drowned into substance abuse."

Theme 5: Human–Wildlife Conflict and Drowning

Road traffic injuries, a major cause of morbidity and disability in Zimbabwe, were not raised by participants as a major local concern. Instead, both community members and the District Health Executive reported an increase in human–wildlife conflict, resulting in injuries and deaths. A District Health Executive member stated:

"We are deeply concerned with the rise in cases of crocodile and hippo attacks along the Zambezi River, with life being lost." (District Health Executive member, female)

She described these incidents as reflecting a genuine conflict over the river: people depend on it for their livelihoods, while the animals regard it as their habitat and hunting ground. One community member attributed drownings to fishermen not using life jackets:

"Our major challenge is that the fishermen do not want to use the life jackets to prevent drowning. They ignore the simple life-saving concept and perish in the water." (Female participant, Siansundu)

Another participant disagreed, giving a local rationale for avoiding life jackets:

"Life jackets are a death trap when under hippo attack because you keep floating and the hippo will come after you easily and kill you. We would rather swim, hiding along the way." (Male participant, Siansundu)

In one dialogue, participants explained that hippopotamus paths were known and that the safest strategy was to avoid them when setting nets or travelling on the water. Regarding crocodile attacks, participants expressed a sense of having little control, suggesting that a person would die when their time came. One participant compared these risks with those of other livelihoods: urban residents and frequent road users were seen as prone to road traffic deaths and gold panners to mining accidents, and fishermen were likewise seen as exposed to drowning and animal attacks. Participants from farming communities also reported occasional elephant incursions that destroyed crops and, at times, caused loss of life.

DISCUSSION

This study explored how residents of three rural communities in Binga District perceive NCDs, mental health conditions, substance abuse and GBV. Participants recognized common NCDs but had limited knowledge of their causes, widely reported using traditional remedies, and described substantial barriers to diagnosis and treatment at primary care level. Substance use was perceived as an emerging and growing problem, linked by participants to economic hardship, and both substance use and financial strain were perceived as drivers of GBV. Human–wildlife conflict emerged as an additional, locally specific health concern. Because these findings are based on perceptions, they show how communities understand and experience these problems rather than how common they are.

Participants' reports of unavailable NCD diagnostic tools, medicines and sundries at primary care level mirror barriers described by primary health care nurses working in urban clinics in Harare- Zimbabwe's capital city (Kamvura et al., 2022). Our findings suggest that similar gaps are experienced in a remote rural district, where the main alternative, private providers concentrated in urban areas, is costly and distant. These reports should be verified through facility assessments, but they indicate that ensuring a reliable supply of NCD diagnostic tools, medicines and sundries at all levels of care is essential if Zimbabwe is to progress towards Sustainable Development Goal 3.

The limited NCD awareness reported by participants is concerning because the asymptomatic early course of many NCDs makes community awareness central to early detection. Kamvura et al. (2022) similarly identified limited community knowledge of NCDs as a barrier to care. Although the Ministry of Health and Child Care and partners implement NCD awareness activities nationally, participants' accounts and the reported absence of IEC materials suggest that these activities may not be reaching remote communities such as those in Binga. Greater investment in context-appropriate awareness raising is needed to promote prevention and healthy lifestyles and to encourage early diagnosis and treatment.

Participants' perception that substance abuse is an emerging threat is consistent with national concern. Zimbabwe's Multisectoral Drug and Substance Abuse Plan (2024–2030) recognizes drug and substance abuse as a significant public health, development and national security challenge that disproportionately affects women, youth, vulnerable children, informal-sector workers including artisanal miners, and adult male employees across socio-economic groups (Government of Zimbabwe, 2024). Other authors identify youth as the most affected group because of socio-economic challenges and structural disadvantage (Banda, 2023). Consistent with participants' attribution of substance use to economic hardship, a 2025 Afrobarometer survey reported that Zimbabweans perceive drug and substance abuse as widespread and associate it mainly with the country's prolonged economic difficulties, and identified citizen education on the dangers of drugs as one solution (Masunungure et al., 2025). Because this study did not measure substance use, it cannot establish whether prevalence in Binga is increasing; it does show that communities perceive it as a growing threat. Addressing it will require a multisectoral response combining prevention, community engagement, treatment, rehabilitation and social reintegration with appropriate law enforcement.

Participants perceived that household economic strain and substance use drive GBV, and that women and children are most affected. National evidence places GBV within a broader policy concern: the 2023–24 Zimbabwe Demographic and Health Survey documented violence experienced by women, while the national drug and substance abuse plan addresses prevention, care and rehabilitation (Zimbabwe National Statistics Agency, 2025; Government of Zimbabwe, 2024).

However, this study cannot establish causal relationships between economic hardship, substance use and GBV; these are associations described by participants. The strong call for male-targeted engagement suggests that gender-transformative approaches involving men and boys may be acceptable in these communities.

The widespread use of traditional remedies is consistent with the pluralistic help-seeking documented elsewhere in the region (Bila & Carbonatto, 2022; Daniel et al., 2018). Notably, participants framed traditional remedies partly as a response to the unavailability of formal services rather than solely as a cultural preference, and acknowledged that they did not cure disease. The effectiveness and safety of the remedies described, and their potential interactions with conventional medicines, were not assessed; this underscores the value of engaging traditional healers and community leaders on referral and chronic disease management.

Human–wildlife conflict and drowning emerged as health risks specific to fishing and farming livelihoods in Binga. The divergent views on life jackets show that safety messages which do not address locally perceived risks, here the belief that floating makes a person more vulnerable to hippopotamus attack, may be rejected. Prevention efforts are therefore more likely to succeed if they are co-designed with fishing communities. The fatalism expressed about crocodile attacks also suggests a need for messaging that strengthens perceived control over preventable risks.

STRENGTHS AND LIMITATIONS

This study generated contextual insights into the intersection of NCDs, mental health conditions, substance abuse and GBV in a marginalized rural district, an under-researched setting. Conducting dialogues in Tonga and including traditional and religious leaders, community health workers and youth supported culturally appropriate engagement and captured a range of community perspectives.

Several limitations should be considered. First, the findings reflect community perceptions and do not establish the prevalence of NCDs, mental health conditions, substance abuse or GBV, nor causal relationships between the factors participants described. Second, the large size of the dialogues (at least 70 participants each) may have limited the depth of individual contributions, allowed influential voices such as those of leaders to dominate, and discouraged disclosure on sensitive topics such as GBV and substance use, introducing social desirability bias. Third, only three dialogues were conducted in one district, and their number was not determined by data saturation; the findings may therefore not transfer to other settings, although they may resonate with similar rural, marginalized communities. Future studies should use mixed methods, including population-based surveys with objective measurement (for example, blood pressure and blood glucose screening and validated mental health and substance use instruments) to estimate prevalence and risk patterns, and in-depth interviews or smaller focus groups to explore sensitive experiences.

Implications for Practice

Participants' accounts point to structural weaknesses in rural primary health care that may limit the prevention and management of NCDs and co-occurring mental health conditions. Reported shortages of diagnostic equipment and medicines, and limited capacity at PHC level, could undermine early detection, continuity of care and chronic disease control. Operationalizing integrated chronic disease management at PHC level, including task-sharing, standardized screening protocols aligned with WHO PEN (World Health Organization, 2020), and routine assessment of multimorbidity, could reduce fragmentation of care.

Limited community knowledge of NCDs and mental health conditions suggests gaps in health literacy and risk perception. Community engagement should move beyond information dissemination towards participatory social and behavior change communication delivered in Tonga and grounded in local beliefs. Community dialogues proved a feasible platform for respectfully exploring traditional belief systems and could be used to co-create prevention strategies. Given men's role as household decision-makers and their reported involvement in substance use and GBV, gender-transformative approaches that engage men and boys are warranted, alongside household economic strengthening and survivor-centered GBV services with psychosocial support and functional referral systems. Youth-focused substance use prevention, community-based rehabilitation and economic empowerment should be prioritized through multisectoral collaboration that includes schools and faith-based organizations. District health plans in wildlife-affected areas should also address human–wildlife conflict as an environmental determinant of health.

Recommendations

Table 3 presents prioritized recommendations, with suggested lead actors and indicators that could be used to monitor progress.

Table 3: Prioritized recommendations, lead actors and example indicators

Priority area	Recommendation	Suggested lead actors	Example indicators
1. NCD diagnostics and medicines at PHC	Include tracer NCD medicines and diagnostic consumables in routine PHC supply; establish preventive maintenance and replacement of blood pressure machines and	Ministry of Health and Child Care (MoHCC); District Health Executive (DHE); NatPharm	Proportion of PHC facilities with a functioning BP machine and glucometer; stock-out days per quarter for

	glucometers		tracer NCD medicines
2. Integrated screening at PHC	Introduce routine screening for raised blood pressure, raised blood glucose, common mental health conditions and harmful substance use using WHO PEN and validated brief tools; train nurses and community health workers (task-sharing)	MoHCC; DHE	Proportion of adult PHC attendees screened for raised blood pressure; number of nurses and community health workers trained
3. Outreach for remote wards	Schedule regular outreach visits for NCD screening, follow-up and medicine refills in wards far from facilities	DHE; implementing partners	Outreach visits per ward per quarter; proportion of registered NCD patients reviewed in the past three months
4. Male-focused community engagement in Tonga	Hold regular community dialogues and men's forums on NCDs, substance use and GBV; develop and distribute Tonga-language IEC materials	DHE health promotion; traditional and religious leaders; NGOs	Dialogues or men's forums held per ward per year and number of men reached; availability of Tonga-language NCD IEC materials at each PHC facility
5. GBV referral and survivor support	Map and publicize a ward-level referral pathway linking community health workers, the police Victim Friendly Unit, social services and health facilities	DHE; Zimbabwe Republic Police; social services; women's affairs ministry	Documented referral pathway available in each ward; number of survivors referred and followed up
6. Youth substance use prevention	Implement school- and faith-based prevention and parenting sessions, with linkage to treatment and rehabilitation, aligned with the national plan	Ministry of Primary and Secondary Education; DHE; faith leaders; youth organizations	Number of schools implementing prevention sessions; number of young people referred for treatment or rehabilitation
7. Engagement with traditional healers	Orient traditional healers on NCD danger signs and on referring people with suspected NCDs to health facilities	DHE; Zimbabwe National Traditional Healers Association	Number of healers oriented; referrals from healers recorded at PHC facilities
8. Human–wildlife conflict and drowning	Co-design water-safety and wildlife-risk measures with fishing communities; record wildlife-related injuries in district health information	DHE; Rural District Council; Zimbabwe Parks and Wildlife Management Authority; fishing cooperatives	Wildlife-related injuries and deaths recorded; number of fishing camps with a community safety plan

CONCLUSION

Communities in Binga District recognized common NCDs but reported limited knowledge of their causes, widespread use of traditional remedies, and barriers to care that included unavailable diagnostics and medicines, staff shortages and long distances to health facilities. Substance use, GBV and human–wildlife conflict were perceived as important and interlinked community health concerns. While these findings reflect perceptions rather than measured prevalence, they identify feasible priorities for rural primary health care: reliable supplies of NCD medicines and functional diagnostic equipment, integrated screening, male-focused community engagement in the local language, functional GBV referral pathways and locally co-designed injury prevention. Population-based studies are needed to quantify the burden of these conditions in the district.

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Ethical Approval

This study involved human participants and was approved by the Midlands State University Ethical Review Board. Permission was obtained from the Provincial Medical Directorate of Matabeleland North Province and the Binga District Health Executive, and verbal informed consent was obtained from all participants before data collection.

Conflict of Interest

The authors declare no conflict of interest.

Data Availability

The data are not publicly available because the transcripts contain information that could identify participants in small rural communities. De-identified excerpts are available from the corresponding author on reasonable request, subject to ethics approval.

Authors' Contributions

Constance Mandengenda, Professor D. Munodawafa and Vannessa Masukusa contributed to the conception of the study, its design and data generation. Constance analyzed the data and developed the manuscript's first draft.. Bartholomeo Gambiza, Praise Gwenzi and Tarisai Karima provided notes and recordings for the community dialogues. Vannessa Masukusa, Professor D. Munodawafa, Dr. Reason Chivaka and Lloyd Goronga revised the manuscript. Constance Mandengenda then finalized the manuscript and submitted.

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