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Impact of El Nino-Induced Drought on the Academic Performance of Visually Impaired Rural Learners: Insights from Bikita, Zimbabwe

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Abstract

This qualitative study examined the consequences of El Niño-induced drought on the academic performance of learners with visual impairments attending rural secondary schools in Zimbabwe. Rural secondary schools in Zimbabwe face numerous challenges including shortage of qualified teachers resulting in low pass rate in final examinations. However, there is a dearth of comprehensive research on specific effects of El Niño-induced drought on the academic performance of rural learners with visual impairments. To address this gap, this study purposively selected twenty-two participants, taking into account gender, experience, and community roles. Data was collected through two focus groups, one involving adult participants and other comprising learners, to ensure balanced power dynamic. The data was then thematically analysed using six stages of Braun and Clarke's (2006) procedures, namely familiarisation with data, generating initial codes, searching for themes, reviewing themes, defining and naming themes and writing up. Ethical considerations were given utmost importance, with participants providing informed consent. The findings of the study revealed that El Niño-induced drought has had significant negative impact on the academic performance of rural learners with visual impairments in Zimbabwe. Consequently, it is recommended that various stakeholders in Zimbabwe, including government, non-governmental organisations, parents, and business communities, collaborate to provide extensive support to rural learners with visual impairments affected by El Niño-induced drought. This support should encompass provisions such as food, academic materials, and access to medication, with the ultimate goal of improving their academic performance.

Keywords: academic performance, El Niño-induced drought, visual impairment, vulnerable rural learners, Zimbabwe

Introduction

The academic performance of learners is a crucial indicator of the overall quality and efficacy of an education system (Darmawan & Keeves, 2018). However, in the context of developing nations, numerous factors can adversely impact the academic achievement of learners, particularly those from vulnerable populations. One such pressing concern is the influence of climate-related disasters, such as droughts, on the educational outcomes of marginalised groups (Hime et al., 2020). In Zimbabwe, the effects of the El Niño weather phenomenon have led to severe droughts in recent years, with dire consequences for rural communities (Manatsa et al., 2024). Learners with visual impairments attending rural secondary schools in these drought-affected areas face compounded challenges as they also contend with educational barriers associated with their disability and the broader socioeconomic upheaval caused by the drought (Mavundla et al., 2018).

Despite the clear need for targeted interventions, there remains a dearth of comprehensive research examining the specific impacts of El Niño-induced drought on the academic performance of this vulnerable population. To address this critical research gap, the present qualitative study examined the consequences of El Niño-induced drought on the academic achievement of rural secondary school learners with visual impairments in Zimbabwe. Drawing on in-depth interviews and focus group discussions with a diverse range of stakeholders, including educators, learners, parents, policymakers, and community leaders, the study provides a multifaceted understanding of the challenges faced by this marginalised group and the potential avenues for support. The findings of this study hold significant implications for educational policy and practice in Zimbabwe and other developing nations grappling with the intersecting issues of disability, rural poverty, academic failure and climate-related disasters. By amplifying the voices and experiences of vulnerable rural learners with visual impairments, the study underscores the urgent need for holistic and context-specific interventions that address the unique barriers to academic success faced by this population. Moreover, the research contributes to the broader scholarly discourse on the complex relationship between environmental stressors, educational outcomes, and social equity, offering valuable insights for researchers, policymakers, and practitioners working to promote inclusive and sustainable educational systems.

Background of the study

The impact of climate change and extreme weather events on the education of vulnerable populations have become an increasingly critical area of research (Chinhara, 2020). One particularly pressing issue is the effect of El Niño-induced drought on the academic performance of rural learners with visual impairments in developing countries like Zimbabwe (Chipfakacha, 2021). Learners with visual impairments in rural Zimbabwe already face significant barriers to education, including lack of access to assistive technologies, inadequate teacher training, and social stigma (Majoko, 2020). The added strain of drought, which can lead to food insecurity, water scarcity, and disruption of school operations, further exacerbates these challenges and affect their academic performance (Mweemba et al., 2021; Okori & Okware, 2019). Research has shown that drought can negatively impact school attendance, concentration, and learning outcomes for all learners, with the impact being more severe for those from socioeconomically disadvantaged backgrounds (Chipfakacha, 2021; Mutasa, 2017).

For learners with visual impairments, the effects may be even more pronounced, as they often rely on specialised materials and individualised support that may be disrupted during times of crisis (Dakwa, 2017). Furthermore, the limited availability of resources and infrastructure in rural areas can hinder the ability of schools to effectively support learners with visual impairments during drought conditions (Chipfakacha, 2021; Mutasa, 2017). This can lead to increased absenteeism, reduced academic achievement, and higher dropout rates among this vulnerable population (Chireshe, 2018; Mweemba et al., 2021). Despite the critical importance of this issue, there is a paucity of research on the specific impact of El Niño-induced drought on the educational outcomes of rural learners with visual impairments in Zimbabwe (Okori & Okware, 2019). This paper aims to address this gap by examining the academic performance of this population in the context of drought, as well as the strategies and interventions that can be implemented to mitigate its negative effects (Chipfakacha, 2021; Mweemba et al., 2021). The findings of this research have important implications for policy, practice, and the development of more inclusive and resilient education systems in the face of climate change (Chireshe, 2013; Mutasa, 2017).

Research objectives

i) To examine the specific challenges faced by visually impaired learners during periods of drought caused by El Niño.

ii) To explore potential interventions to mitigate the impact of drought on the academic performance of visually impaired learners in Zimbabwean rural communities.

Research questions

1) What are the unique challenges faced by vulnerable visually impaired learners during periods of drought in Zimbabwe?
2) What interventions can be implemented to support and enhance the academic performance of visually impaired learners impacted by El Niño-induced drought in the rural areas of Zimbabwe?

Significance of the study

The examination of the impact of El Niño-induced drought on the academic performance of vulnerable rural learners with visual impairments in Zimbabwe holds profound implications that extend far beyond the confines of this specific research endeavour. This study represents a ground-breaking exploration into the complex interplay between environmental adversity, socioeconomic disadvantage, and educational equity, revealing insights that have the potential to reshape the scholarly discourse and inform far-reaching policy decisions. At the heart of this study lies a profound recognition of the intersectional nature of vulnerability. Through delving into the unique challenges faced by a population that sits at the intersection of multiple marginalised identities (rural residents, the visual impaired, and those faced by socioeconomic deprivations), the research sheds light on the compounded barriers to educational attainment encountered by those who find themselves on the periphery of societal privilege. This holistic understanding of intersectional vulnerability is a critical contribution to the field, as it challenges the prevailing narratives that often simplify or overlook the multifaceted nature of disadvantage. The insights gleaned from this study hold immense potential for informing targeted interventions and the development of evidence-based educational policies. The comprehensive analysis of the specific obstacles faced by visually impaired learners in rural Zimbabwe during periods of drought, such as disruptions to educational infrastructure, limited access to specialized resources, and socioeconomic vulnerabilities, provides a roadmap for the design of tailored support mechanisms and the allocation of resources to address these issues with precision. By grounding proposed strategies for mitigation and support in empirical evidence, this research offers a blueprint for policymakers and educational practitioners to cultivate inclusive, adaptive, and equitable approaches to ensuring the academic success of marginalised learners, even in the face of environmental crises. Furthermore, this study's contribution extends beyond the confines of the Zimbabwean context, as it significantly informs the broader discourse on the intersections between climate change, environmental disasters, and educational equity. By examining the disproportionate impact of El Niño-induced drought on the educational outcomes of visually impaired learners in rural areas, the research sheds light on how climate-related crises can exacerbate existing inequities, posing a direct challenge to the pursuit of inclusive and sustainable education. These findings have the potential to shape the development of more holistic and equitable approaches to addressing the consequences of climate change, ensuring that the educational needs of the most vulnerable learners are not overlooked or further marginalised by environmental adversity.

Ultimately, the significance of this study transcends the boundaries of academic inquiry, as its implications have the power to inform and influence global initiatives aimed at promoting inclusive and sustainable education. The insights gained from this research can contribute to the advancement of the United Nations Sustainable Development Goal 4, which calls for the provision of "inclusive and equitable quality education and lifelong learning opportunities for all". Therefore, by highlighting the unique challenges faced by visually impaired learners in rural Zimbabwe during periods of drought, this study can inform the development of more comprehensive and context-specific strategies to achieve the targets outlined in this global framework, ultimately empowering marginalised communities and ensuring that no one is left behind in the pursuit of educational equity.

Literature review

The extant scholarly literature has long grappled with the multifaceted challenges faced by marginalised learners in the pursuit of equitable educational opportunities (Chidarikire & Nyokanhete, 2024). Within this expansive body of research, the unique experiences of visually impaired learners, particularly those residing in rural and socioeconomically disadvantaged communities, have garnered increasing attention (Chidarikire & Magomana, 2024). However, the specific impacts of climate-related crises on the academic performance of this vulnerable population remain underexplored. Recent studies conducted in the United States have shed light on the disproportionate burden that environmental disasters can place on learners with disabilities. For instance, Stein et al. (2020) documented the disruptions to specialised educational services and the exacerbation of learning challenges faced by visually impaired learners in the aftermath of Hurricane Harvey, underscoring the need for more robust emergency preparedness and response measures. Similarly, research in the United Kingdom by Greenwood et al. (2021) highlighted the heightened vulnerability of visually impaired learners to the effects of climate change, with disruptions to transportation and learning resources emerging as key barriers to educational continuity. Expanding the geographic scope, studies from China have examined the intersections of disability, poverty, and environmental degradation, revealing the compounded challenges confronting visually impaired learners in rural areas. Zhao and Meng (2018) documented the limited access to specialised educational resources and the disproportionate impact of natural disasters on the academic performance of this population, calling for targeted interventions and policy reforms to address these disparities.

ln the African context, a growing body of literature has shed light on the unique challenges faced by visually impaired learners in various countries. In Nigeria, Adebiyi and Adetoro (2019) explored the barriers to inclusive education. Their research emphasised the need for enhanced teacher training and the provision of assistive technologies to support the learning experiences of visually impaired learners. Similarly, research in Botswana by Monyatsi and Mukhopadhyay (2020) highlighted the importance of community-based support networks in enabling visually impaired learners to navigate educational, social, and environmental challenges. Closer to the focus of the present study, the Zimbabwean educational landscape has been the subject of extensive scholarly inquiry. Studies by Mpofu et al. (2019) documented the persistent challenges faced by visually impaired learners in accessing educational resources and infrastructure, presenting a concerning backdrop for the potential impact of climate-related crises. Furthermore, research by Shumba and Mawere (2022) explored the socioeconomic vulnerabilities that compound the educational experiences of marginalised learners in rural Zimbabwean communities, underscoring the critical need for holistic and context-specific interventions. Despite the growing body of research on the intersections of disability, socioeconomic status, and educational equity, the specific impact of El Niño-induced droughts on the academic performance of visually impaired learners in rural Zimbabwean communities remains a significant gap in literature. This study sought to address this void, providing a comprehensive examination of the challenges faced by this population and proposing evidence-based interventions to mitigate the detrimental effects of environmental crises on their educational attainment. By drawing on the insights from previous studies conducted in various geographical contexts, this research contributes to a more nuanced understanding of the complex interplay between climate change, disability, and educational inequality, ultimately informing the development of inclusive, adaptive, and sustainable educational policies and practices.

Research methodology

This study employed a qualitative research approach to investigate the impact of El Niño-induced drought on the academic performance of rural secondary learners with visual impairments in Zimbabwe. The qualitative research approach was deemed suitable as it allowed for an in-depth exploration of the complex phenomenon, capturing the perspectives and experiences of the participants (Creswell & Poth, 2018). The research design was a case study, which enabled a comprehensive and contextual understanding of the issue within the specific setting of rural Zimbabwe (Yin, 2018). Purposive sampling was used to select twenty-two participants, including secondary school teachers, learners with visual impairments, parents, a Ministry of Primary and Secondary Education official, a non-governmental organisation (NGO) official, and a local village head. The selection criteria were based on the participant's gender, disability, experience, and community roles, ensuring a diverse and information-rich sample (Patton, 2015). Data was collected through two focus group discussions, one with learners and another with adult participants. The focus group approach allowed for the exploration of shared experiences, perceptions, and insights among the participants (Krueger & Casey, 2020).

The research instruments used were a focus group guide and observations, which provided a comprehensive understanding of the phenomenon (Morgan, 2019). The data collection process lasted for 3 hours, with each participating group having one and a half hours. This duration ensured that the participants had ample time to share their perspectives and experiences comprehensively (Onwuegbuzie et al., 2019). The generated data was analysed using thematic analysis, following Braun and Clarke's (2006) six-phase process. This method allowed for the identification, analysis, and reporting of patterns (themes) within the data, providing a rich and nuanced understanding of the impact of El Niño-induced drought on the academic performance of vulnerable rural learners with visual impairments (Mahanya, 2020).

Ethical considerations were paramount in this study. Confidentiality was maintained through the use of pseudonyms, and participants were required to sign informed consent forms before taking part in the research. Participants were also informed of their right to withdraw from the study at any time, and the purpose of the study was clearly explained to the participants (Bhura, 2020). These ethical safeguards ensured the protection of the participants' rights and the integrity of the research process.

Theoretical framework: Critical disability theory

Critical disability theory (CDT) provides a robust theoretical framework for examining the impact of El Niño-induced drought on the academic performance of vulnerable rural learners with visual impairments in Zimbabwe. This theory, which has gained increasing prominence in the field of disability studies, challenges the traditional medical model of disability and; instead, views disability as a complex, socially constructed phenomenon that is inextricably linked to issues of power, oppression, and marginalisation (Meekosha & Shuttleworth, 2019; Goodley, 2017). At the core of CDT is the understanding that disability is not solely a result of individual impairment, but rather a product of the physical, social, and attitudinal barriers that society erects, which serve to exclude and disempower individuals with disabilities (Berne, 2017; Hosking, 2008). In the context of this study, the El Niño-induced drought can be viewed as an environmental barrier that exacerbates the challenges faced by visually impaired learners in rural Zimbabwe, further entrenching their marginalisation and exclusion from educational opportunities. According to CDT, the academic performance of visually impaired learners is not solely a function of their capacities and adaptations, but is also shaped by how the educational system and the broader social and environmental context respond to their needs and accommodate their differences (Fitzgerald, 2019; Meekosha & Shuttleworth, 2019). In drought-affected rural areas of Zimbabwe, the disruption of educational infrastructure, the lack of specialised resources and assistive technologies, and the breakdown of community support networks can all serve to create additional barriers that hinder the academic progress of the visually impaired learners (Mutambara et al., 2021; Grable et al., 2019). Moreover, CDT emphasises the importance of centring the lived experiences and perspectives of individuals with disabilities, recognising them as experts in their own lives and empowering them to be active agents in shaping the policies and practices that affect them (Goodley, 2017). In the context of this study, this would involve amplifying the voices of visually impaired learners in rural Zimbabwe, understanding their unique challenges and coping strategies, and incorporating their insights into the development of interventions and support systems that address their specific needs (Berne, 2017; Fitzgerald, 2019). When applying the lens of critical disability theory to this research topic, scholars can gain a deeper understanding of the systemic and structural barriers that contribute to the academic underperformance of visually impaired learners in drought-affected rural areas of Zimbabwe.

This theoretical framework also highlights the importance of adopting an intersectional approach that recognises how disability intersects with other forms of marginalisation, such as poverty, rurality, and gender, to further compound the challenges faced by these vulnerable learners (Meekosha & Shuttleworth, 2009; Goodley, 2017). Finally, critical disability theory offers a powerful theoretical foundation for driving transformative change in the educational system and the broader social environment, ensuring that visually impaired learners in drought-affected rural areas of Zimbabwe are not only provided with the necessary resources and support, but are also empowered to actively shape the policies and practices that affect their lives (Berne, 2017; Fitzgerald, 2019).

Findings and discussion

Theme 1: Challenges faced by rural visually impaired learners during drought

The following verbal responses of the participants reflect numerous challenges faced by visually impaired learners in rural Zimbabwe due to El-Nino-induced drought. These challenges affect their academic performance negatively.

Female Learner narrated that:

> "During droughts, it gets tough for us. The lack of water means fewer people come to school because they have to walk long distances to fetch water. I often feel left behind, especially when our teachers struggle to provide the resources we need."

Furthermore, the Female Teacher argued that:

> "The challenges are immense. Many of our visually impaired learners rely on tactile materials and audio resources, which are not always accessible. During droughts, some families prioritise basic survival over education, and that impacts attendance significantly."

On the other hand, the Male Ministry of Primary and Secondary Education Official expounded that:

> "We recognise that droughts exacerbate existing vulnerabilities. Visually impaired learners face unique challenges, such as reduced access to educational materials and support services, which are crucial during these times. We are working on policies to address these disparities."

Additionally, Female Non-Governmental Organisation Officials commented that:

> "Our organisation is on the ground, witnessing these challenges first-hand. The drought not only affects water availability but also creates food insecurity, which can lead to a decline in health and concentration among visually impaired learners. We need to focus on holistic support."

Furthermore, Male Village Head said:

> "In our village, when drought hits, many families are overwhelmed by the need to find food and water. Education becomes secondary. It's heart-breaking to see the visually impaired children struggle even more, as they often need extra help that becomes harder to provide in such times."

From the above narrations by participants, the challenges faced by rural vulnerable visually impaired learners during droughts are multifaceted and deeply intertwined with broader socio-economic issues. As highlighted by the female learner, drought conditions significantly hinder attendance, as families prioritise immediate survival needs over education (Chidarikire & Nyokanhete, 2024). This sentiment is echoed in recent literature, which emphasises how environmental stressors, such as drought, disproportionately affect marginalised communities, leading to increased dropout rates and educational disruption (Herald, 2024; Oxfam, 2022). The physical barriers created by long distances to water sources exacerbate these issues, particularly for visually impaired learners who require additional support and resources (Chidarikire & Mangomana, 2024).

The perspective of the female teacher underscores the scarcity of tactile and auditory educational materials during drought periods (Tarisayi, 2024). This scarcity is critical as visually impaired learners often rely on such resources for effective learning (Jim et al., 2024). Research by Al-Azawei et al. (2019) indicates that the absence of accessible materials can severely limit educational outcomes for learners with disabilities, highlighting a systemic failure in providing inclusive education. The teacher's observation that families may prioritise basic survival over education further illustrates a tragic cycle where educational access becomes a secondary concern in the face of existential threats (Majoko, 2024).

The insights from the male Ministry of Primary and Secondary Education official shed light on the recognition of these disparities at a policy level. However, the effectiveness of such policies remains to be seen (Dube, 2020). Recent studies suggest that, while awareness is growing, the implementation of inclusive educational frameworks often lacks the necessary resources and training for teachers to adequately support visually impaired learners, particularly in crises (UNESCO, 2023). This gap highlights the need for targeted interventions that not only address immediate educational needs, but also consider the holistic well-being of these learners.

The observations of the female NGO official further emphasise the interconnectedness of food insecurity and educational attainment. Drought-induced food scarcity can lead to health declines among learners, which, in turn, affects their ability to concentrate and learn effectively (World Food Programme, 2023). This holistic view of support is essential, as it acknowledges that educational challenges cannot be separated from the broader context of physical and emotional well-being (Nyahunda et al., 2024).

Finally, the comments from the male village head reflect a community-level understanding of the impact of drought on education. His statement about the overwhelming burden faced by families during these times highlights the emotional toll on both parents and children. Research indicates that community support systems play a crucial role in the educational journey of visually impaired learners, especially in rural settings where institutional support may be lacking (Murray et al., 2021). Therefore, fostering community resilience and support networks is vital for ensuring that visually impaired learners do not fall further behind during droughts.

Resultantly, the findings reveal a complex interplay of educational, social, and health-related challenges faced by visually impaired learners during droughts. Addressing these challenges requires an integrated approach that combines policy intervention, resource allocation, and community engagement to create a supportive environment where all learners can thrive, regardless of their circumstances.

Theme 2: Potential interventions to mitigate the impact of drought

The participants were of the view that many interventions could be applied by different stakeholders to mitigate challenges faced by learners with visual impairments from Zimbabwe rural secondary schools encountered during drought periods especially El Niño-induced drought. These interventions help rural visually impaired learners to excel in their academic studies despite drought.

Male Learner was of the view that:

> "I think we need more materials that are easy to access, like braille books and audio recordings. If the school can help us get these resources, it would make a big difference, especially when we miss classes due to drought."

On the other hand, Male Teacher explained that:

> "Interventions should include training for teachers on how to better support visually impaired learners, especially during crises. Additionally, we need partnerships with NGOs to provide supplementary resources and ensure that learning continues, even when attendance drops."

On the same issue, Male Ministry of Primary and Secondary Education Official recommended that:

> "Our ministry is committed to developing emergency response plans that focus on inclusive education. This includes ensuring that visually impaired learners receive the necessary materials and that schools are equipped to handle such crises effectively."

Moreover, Male Non-Governmental Organisation Official suggested that:

> "We believe in community engagement as a key intervention. By involving local leaders and parents, we can create support networks that would help visually impaired learners access resources and stay motivated to continue their education during tough times."

Finally, the Female Village Head believed that:

> "As a community, we need to prioritise education even during droughts. We should organise community learning sessions where visually impaired learners can come together and study, ensuring no one falls behind. Collaboration between families, teachers, and NGOs can make a real impact."

From the above discourse participants, the potential interventions identified by participants to mitigate the impact of drought on visually impaired learners in rural Zimbabwean secondary schools underscore a collaborative and multi-faceted approach. These interventions are crucial, particularly during periods of extreme weather such as El Niño-induced droughts, which exacerbate existing vulnerabilities. The male learner's emphasis on the need for accessible materials, including braille books and audio recordings, points to a significant gap in educational resources for visually impaired learners. Recent research indicates that access to appropriate learning materials is essential for fostering an inclusive educational environment (Al-Azawei et al., 2020). For instance, initiatives that provide braille resources and audiobooks have been shown to improve academic performance and engagement among visually impaired learners (Murray et al., 2021). By prioritising the acquisition and distribution of such materials, schools can enhance educational continuity even when physical attendance is compromised due to drought.

The male teacher's perspective highlights the necessity for teacher training focused on supporting visually impaired learners, particularly during crises. Studies have shown that effective teacher training can significantly impact the quality of education for learners with disabilities (UNESCO, 2023). For example, professional development programs that equip teachers with adaptive strategies and resources may lead to better educational outcomes for visually impaired learners. Furthermore, partnerships with NGOs to supplement resources can bridge the gap in educational provision during droughts, ensuring that teachers are not left to navigate these challenges in isolation (World Food Programme, 2023).

The commitment expressed by the male Ministry of Primary and Secondary Education official to develop emergency response plans that incorporate inclusive education is a promising step forward. Research indicates that comprehensive disaster response plans that consider the needs of marginalised groups are essential for reducing educational disruption (Oxfam, 2022). By integrating policies that ensure visually impaired learners receive the necessary materials and support, the ministry can foster resilience within the education system. For instance, establishing stockpiles of accessible educational resources for use during emergencies can help maintain educational continuity.

The male NGO official's call for community engagement as a key intervention is also significant. Community involvement can enhance support networks for visually impaired learners, facilitating access to resources and motivation to continue their education during challenging times (Murray et al., 2021). Successful examples include community-led initiatives that provide tutoring and peer support, which have proven effective in maintaining educational engagement among vulnerable populations (UNICEF, 2022). By fostering collaboration among local leaders, parents, and NGOs, communities can create a supportive environment that encourages visually impaired learners to persevere in their studies.

Finally, the female village head's advocacy for prioritising education during droughts through organised community learning sessions exemplifies a proactive approach to ensuring that no student falls behind. Research shows that community-based learning initiatives can serve as effective alternatives during times of crisis, providing safe spaces for learners to gather and learn (World Bank, 2023). By facilitating collaboration between families, teachers, and NGOs, these sessions can reinforce the importance of education and provide much-needed support for visually impaired learners.

The findings illustrate that a combination of accessible resources, targeted teacher training, inclusive policy development, community engagement, and organised support networks is essential to mitigating the impact of drought on visually impaired learners. Implementing these interventions could help create a more resilient educational framework that recognises and addresses the unique challenges faced by these learners, ensuring they have the opportunity to succeed even in the most adverse conditions.

Conclusion

The study sought to investigate the challenges faced by rural visually impaired learners during drought periods caused by El Niño, as well as to explore interventions to mitigate the impact of such droughts on their academic performance. The findings indicate that these learners encounter unique obstacles, including limited access to resources, inadequate support systems, and disrupted educational environments. Consequently, these challenges significantly hinder their academic progress and overall well-being. Potential interventions identified in the study range from enhancing resource availability to fostering community engagement, suggesting that a multifaceted approach is essential to effectively support these vulnerable learners.

Recommendation

To address these challenges, a series of recommendations has been proposed. For visually impaired learners, establishing peer support networks could help facilitate academic and social support among learners. Additionally, engaging in skills training workshops focused on alternative learning methods and self-advocacy could empower these learners. The Ministry of Primary and Secondary Education should formulate and implement inclusive educational policies that specifically cater to the needs of visually impaired learners during drought conditions, while also ensuring the provision of appropriate educational materials and assistive technologies. Non-governmental organisations (NGOs) could play a crucial role by conducting awareness campaigns to highlight the challenges faced by visually impaired learners, thereby mobilising community support and facilitating resource partnerships.

The Government of Zimbabwe is encouraged to integrate disability considerations into national disaster preparedness and response strategies, ensuring that visually impaired learners receive appropriate support during droughts. Increasing funding for programs targeting the educational needs of vulnerable populations is also essential, especially during climate-related crises. Village heads and local community members should work to foster an inclusive environment by educating others about the needs and rights of visually impaired learners and promoting community-led initiatives that provide support systems such as tutoring and resource sharing.

Teachers and school heads ought to engage in professional development to equip themselves with the skills necessary to effectively teach and support visually impaired learners, particularly in challenging circumstances. Furthermore, adapting the curriculum to include accessible materials and teaching methods is vital. Lastly, parents are encouraged to actively participate in their children’s education by advocating for their needs and collaborating with schools, while also providing a supportive home environment that emphasises the importance of education and resilience during difficult times. One recommendation for future researchers studying the impact of El Niño-induced drought on the academic performance of visually impaired rural learners in Bikita, Zimbabwe, is to conduct longitudinal studies that track academic performance over multiple years. This approach would allow researchers to better understand the long-term effects of environmental stressors on educational outcomes. By implementing these recommendations, stakeholders can work collaboratively to enhance the educational experiences and outcomes for visually impaired learners in rural Zimbabwean communities, particularly during challenging periods of drought.

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Enhancing a Sense of Achievement for Improved Treatment Outcomes among Youths Receiving Tuberculosis Treatment at a Hospital in Harare, Zimbabwe

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Abstract

This study explores the importance of fostering a sense of achievement to improve treatment outcomes for chronically ill tuberculosis (TB) youths in Zimbabwe. Conducted at a local hospital in Harare, Zimbabwe, the research employed mixed methods to collect data from 30 youths undergoing TB treatment. Both probability and non-probability sampling techniques were utilised to select participants from a target population of 500 youths receiving care at the hospital. Quantitative data was gathered through surveys using lists of a questionnaire, while qualitative data was collected via focus group discussions, in-depth interviews, and key informant interviews. Descriptive statistics were used to analyse the quantitative data, and thematic content analysis was applied to the qualitative data. The burden of treatment theory was used to explain the phenomenon observed in the study. The findings indicate that recognising patients' efforts in managing their daily activities enhances their sense of achievement. Additionally, rewarding individuals for regaining tangible functions, such as weight gain and improved decision-making skills, further boosts their sense of achievement and leads to positive treatment outcomes. The study concludes that collaborative efforts among healthcare providers, patients, and their relatives or caregivers are essential to enhance a sense of achievement and achieve favourable treatment results. It is recommended that healthcare workers accept TB patients as they are and acknowledge their progress in improving health. A multi-faceted approach to enhancing the sense of achievement among TB patients should be integrated into the treatment process.

Keywords: achievement, outcome, sense, tuberculosis, treatment, Zimbabwe

Introduction

Tuberculosis (TB) is a social disease that can affect anyone, regardless of individual differences. It is considered deadly worldwide as it can attack any part of the body. The disease is characterised by generalised muscle wasting, loss of energy, and cognitive impairment. Those affected often lose their jobs due to the prolonged illness and treatment period, leading to various adverse effects (Chikwaiwa, 2019). Individuals diagnosed with tuberculosis may experience a significant loss of their overall human function, particularly their sense of achievement. Many chronically ill TB patients become completely dependent on others for basic daily activities, such as brushing their teeth, using the bathroom, walking, and sometimes even feeding themselves. Although it is in their best interest to perform these tasks independently, their illness may hinder their ability to do so. Fostering a sense of achievement among TB patients remains largely unexplored despite its potential to improve treatment outcomes. This paper therefore examines how medical health practitioners, patients, and caregivers can work together to promote the development of a sense of achievement in TB patients, ultimately leading to better treatment outcomes.

Background to the study

The treatment of tuberculosis (TB) often causes anxiety in patients, as reported by Bahuguma (2017). Typically, the TB treatment process takes an instructional approach, which can make patients feel marginalised and reduced to mere recipients of orders from healthcare professionals (Kumwenda et al., 2016). Research conducted by Peddireddy (2016) in India and Subbaraman et al. (2016) revealed that TB patients experience high levels of stress, a sense of loss, and low morale when starting treatment. The physical suffering of TB patients is further exacerbated by the expectations placed on them to follow directives from hospital and clinic staff, as well as to wait, obtain treatment, and complete all necessary paperwork before beginning to actively participate in their own treatment process.

Baughman (2017) noted that tuberculosis (TB) patients often lose their sense of achievement when required to attend multiple follow-up appointments, and they sometimes receive contradictory advice from healthcare providers. This situation creates a significant burden on patients who cannot attend these reviews due to personal commitments. When patients are unable to complete treatment tasks, they may feel a loss of accomplishment, especially when faced with circumstances beyond their control (Kumwenda et al., 2016; Subbaraman et al., 2016). In this study, the sense of achievement is defined by patients' ability to perform basic tasks, such as getting out of bed without assistance, walking a few steps unaided, using the bathroom independently, remembering to take medication, recognising people in their environment, sitting alone for a short period, and experiencing sexual energy.

According to Sahile et al. (2018), tuberculosis (TB) treatment impacts patients' mental well-being and overall treatment outcomes. Patient experiences, as reported by Boland et al. (2016), are intricately narrated by those who have gone through the treatment. These narratives illuminate the genuine challenges patients face, emphasising the nature and sources of treatment burden (Boland, 2016). TB patients deserve to live fulfilling lives characterised by happiness, hope, and high self-esteem, just like anyone else. However, when the quality of life is significantly diminished, leading to a loss of achievement, energy, initiative, motivation, and sleep due to the treatment process, TB treatment becomes a heavy burden (Sahile et al., 2018; May et al., 2014).

Tuberculosis (TB) patients often describe their treatment burden as stemming from several factors, including their interactions with the healthcare system, medication-related challenges, lifestyle changes, financial difficulties, the learning process about their treatment, and various social circumstances in their environment (Rosbach & Andersen, 2017). According to estimates from the World Health Organisation (2015) and Peddireddy (2016), approximately 40% to 70% of TB patients experience anxiety disorders related to their experiences during treatment. Below, we discuss how these factors contribute to the overall well-being of TB patients in detail.

Patients with tuberculosis (TB), like all patients, have an ethical obligation to take charge of their health. This empowerment is essential for them to meet their basic human rights, such as freedom, respect, and autonomy, which can often be diminished during treatment (Firfirey & Hess-April, 2014; Kumwenda et al., 2016). Similarly, TB patients should be equipped to respond to and manage their symptoms, despite the significant challenges present within health delivery systems (Chikovore et al., 2014; Kumwenda et al., 2016; Nliwasa et al., 2016).

TB treatment involves patients as active participants who weigh the costs and benefits of available options. The patients negotiate and navigate their past experiences, current realities, and potential future outcomes to achieve positive treatment results (Kumwenda et al., 2016).

Explanatory variables

There are variables which constitute achievement in the context of TB treatment among youths, and these are discussed in turn.

Remembering to take medication

Researchers have conducted a study to gauge the impact of treatment burdens on young patients' mental well-being and sense of accomplishment. Chikwaiwa et al. (2018) observed that remembering to take medication is key to achieving positive outcomes from TB treatment. This study posits that young patients who successfully adhere to their medication schedules can experience a greater sense of accomplishment, which can lead to better overall treatment outcomes.

Performing activities of daily living

Tuberculosis can significantly drain a patient's energy, leading to serious consequences for their physical abilities. According to Bravell, Zarit and Johansson (2011), the disease can negatively affect even basic activities of daily living such as bathing, maintaining continence, dressing, mobility, and eating (excluding meal preparation). As a result, patients may need to relearn these skills to perform these activities successfully. The impact of tuberculosis can be devastating; many patients lose the ability to bathe themselves, maintain hair and nail hygiene, or control their bowels and bladder. They may also struggle to choose appropriate clothes and dress independently. Additionally, some patients may find walking or moving from one location to another difficult, such as getting in and out of bed or a chair, moving food from their plate to their mouth, or chewing and swallowing (Milmac & Feng, 2016). They may also be unable to get on and off the toilet and clean themselves without assistance.

The inability to perform essential activities of daily living (ADLs) can result in unsafe conditions and a reduced quality of life. The healthcare team must assess patients' ADL capabilities to identify those who need assistance. Successfully managing these daily personal tasks independently, without support from significant others, would be a significant achievement for patients.

Having libidinal energy

Calababro et al. (2019) define libido as the biological need for sexual activity (the sex drive) and frequently is expressed as sex-seeking behaviour. Sigmund Freud originated this concept to signify the instinctual physiological or psychic energy associated with sexual urges and, in his later writings, with all constructive human activity (Stoléru, 2014).

Most TB patients lose libidinal energy as a result of adverse effects of TB. Sexual desire, arousal, and orgasm are mediated by complex, yet still not fully understood interactions of the somatic and autonomic nervous systems operating at the central and peripheral levels (Stoléru, 2014). Disruption of endocrine, neural, or vascular response caused by ageing, medical illness, neurological diseases, surgery, or drugs can lead to sexual dysfunctions, thus significantly affecting TB patients' quality of life. This narrative review aims to characterise the involvement of the central nervous system in human sexual behaviour.

Passing flatus

Most patients who take tuberculosis medication experience constipation, which can lead to gas accumulation during digestion. This trapped gas can cause discomfort and pain in the abdomen (Migala, 2023). Passing gas or farting throughout the day and night is actually beneficial because it releases this trapped gas and prevents uncomfortable bloating. If gas build-up is not relieved, it can cause cramping pain and discomfort in the colon (Weaver et al., 2018). Pain may also occur in the upper right or left part of the colon, which can feel similar to gallbladder or heart pain (Lacey et al., 2020). Therefore, farting can provide relief from gas and the associated pain or pressure caused by TB medication. However, some patients may find it difficult to pass gas, even though it is beneficial to do so. While farting can be healthy, excessive gas may cause discomfort. When a patient feels pressure building in their stomach, releasing gas can be incredibly satisfying (Migala, 2023).

Ability to sit without support

When individuals contract TB and become bedridden, they often experience paralysis in their lower limbs and trunk, which can make sitting unsupported quite challenging (Harvey et al., 2011). To improve their ability to sit, TB patients may require the services of a physiotherapist, which can be costly for those who are responsible for payment. Sitting unaided is an essential skill for individuals with TB as it can enhance their breathing ability and enable them to carry out daily activities while seated (Sahile et al., 2018). For TB patients who may have struggled with this skill due to their illness, being able to sit unsupported can be an enormous accomplishment. The recovery of TB patients can be assessed based on their ability to perform activities they may have lost due to their illness (Harvey et al., 2011).

Study objective

This study sought to explore the importance of fostering a sense of achievement to improve treatment outcomes for chronically ill tuberculosis (TB) youths in Zimbabwe.

Methodology

This study utilised a cross-sectional design and mixed research methods to explore youths' lived experiences undergoing tuberculosis treatment. The target population consisted of thirty youths diagnosed with tuberculosis at a Local Authority Infectious Diseases Hospital. Participants were selected using probability and non-probability sampling techniques from a larger population of 500 youths receiving treatment at the hospital in Harare.

Participants

The study involved 30 youths undergoing tuberculosis treatment who volunteered to participate. Additionally, key informants included the doctor-in-charge of the TB clinic, the matron, the sister-in-charge, four caregivers, and three nurse aides. Key informants were selected for participation in the study based on their knowledge, expertise, and experience working with TB patients.

Sampling

For the quantitative aspect of the study, a probability sampling technique was employed to randomly select 30 respondents. Simple random sampling was used to ensure that each respondent had an equal chance of being chosen for the research. A random number generator was utilised to select every fifth patient for an interview while they waited to enter the doctor's examination room.

For the qualitative aspect of the study, a non-probability sampling technique was utilised to purposively select eight participants. Youths undergoing tuberculosis treatment and willing to participate in the study were chosen for the research.

Data collection

Quantitative data were collected using surveys, with the questionnaire designed to gather information from respondents. In contrast, qualitative data were obtained through focus group discussions, in-depth interviews, and key informant interviews. Specific guides were utilised for each method to ensure comprehensive data collection from the study participants. Additionally, focus group discussions were conducted with the participants until saturation, the point at which no new information emerged, was reached.

The collected data were analysed using descriptive statistics and thematic content analysis for the quantitative and qualitative aspects of the study, respectively.

Ethical considerations

This paper honoured ethical standards set by generic research ethics. Study respondents and the participants were informed about the purpose of the study and all the steps to be undertaken under the study. Thus, informed consent was sought from the participants before the study was conducted. The participants were informed that the study was voluntary and that they were not forced to participate. The key ethical issues addressed to promote the protection and human rights of the participants, who were largely TB patients, were confidentiality, anonymity, least harm, and voluntarism. To ensure the confidentiality of TB patients` information, the researchers assured the patients of such and proceeded to record and keep records in lockable drawers and passworded folders. The information would be available at the patient's request or for continuous treatment. Anonymity was upheld as the researcher used pseudonyms and codes to hide the identity of participants. Given that TB is a social disease that carries a lot of stigma, participants were encouraged not to respond to questions they regarded sensitive; hence, the participants were protected from the least harm. Voluntarism to participate in the study was facilitated through non-coercion in selecting the participants.

Feasibility

The Harare City Health Department granted approval to conduct the study at the hospital after meeting the requirements of the Institutional Research Board.

Study results

Results from the study showed that positive tuberculosis treatment outcomes are a function of a patient`s attainment of a sense of achievement. Youths on treatment attained a sense of achievement as they displayed an ability to remember to take medication, perform activities of daily living (bathing, using the toilet, brushing teeth unaided), ability to realise the presence of libidinal energy (through experiencing an erection), passing flatus and ability to sit alone for a while without support. Results on the proportion of youths` sense of achievement while on treatment are presented next.

Components of achievement amongst TB patients

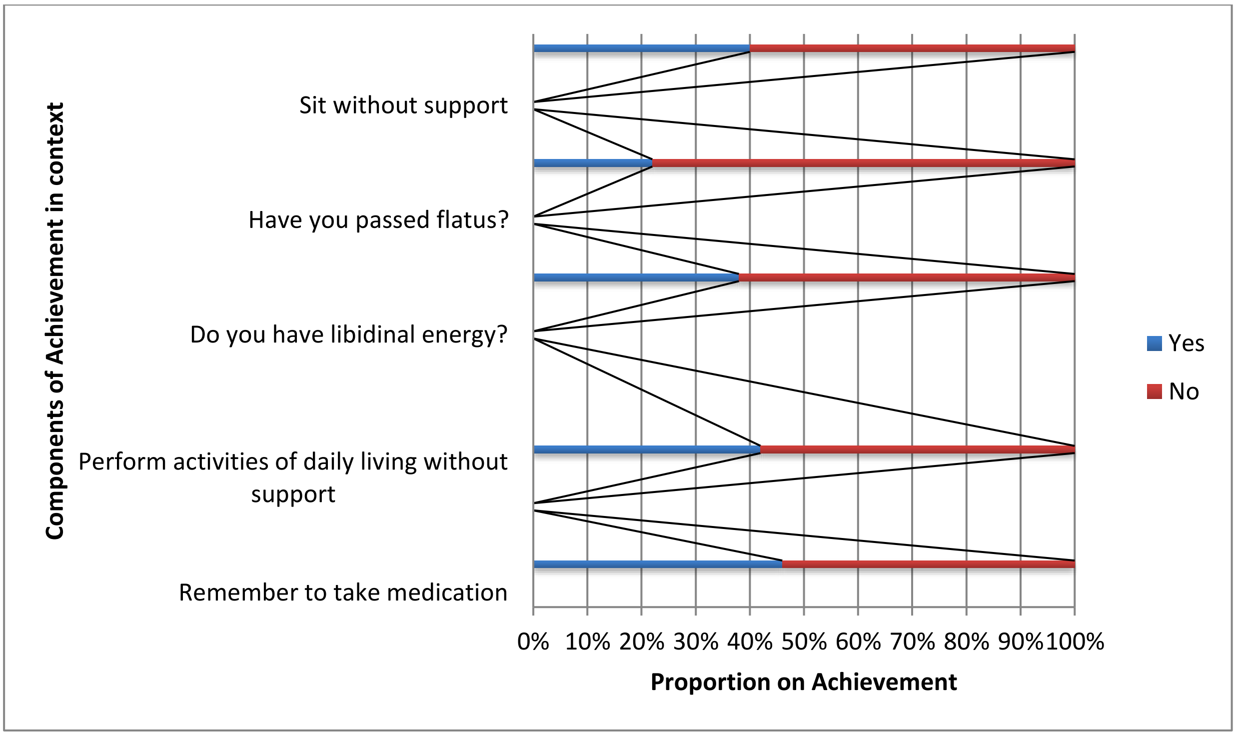

Figure 1: Showing the proportion of the sense of achievement among youths on TB treatment

Study findings showed that 48% of youths on TB treatment remembered to take their medication, 42% were able to perform activities of daily living, 38% had libidinal energy, 22% could pass flatus, and 40% could sit without support.

The above study findings are presented jointly through descriptive statistics and in themes next.

Remember to take medication

Results from the study illustrated that 48% of the youths on TB treatment made significant achievements through remembering to take medication without being reminded by caregivers to do so.

Evidence from the focus group discussions (FDGs) showed that it takes an effort for patients on TB treatment to remember to take medication. This finding was supported by a participant who made the following remarks:

> TB drugs weaken the body's muscles, and they have sedative effects. During the first days of treatment, I was totally dependent on the nurses for my medication; hence I could not do anything for myself. As time elapsed, I was regaining my independence and would sometimes remember to take medication without being reminded to do so. This was a great achievement for me, and I knew that I was going to recover soon.

Able to perform activities of daily living

Study results revealed that 42% of the respondents were able to perform activities of daily living as a milestone towards selfcare.

Qualitative results from the study showed that being able to perform activities of daily living without external help was a great achievement amongst most TB patients. A study participant echoed this finding during in-depth interviews, and he gave the following narration:

> “Chirwere cheTB hachina kumira mushe hama dzangu. Chikakubata zvakanaka unotadza kuita chero chinhu zvokuti unenge wongoitirwa zvese kunge chitunha. Ukaona wave kukwanisa kuzviitira zvishoma woziva kuti wararama”.

Translated into simple English language, the study participant meant to say that:

> TB is a devastating disease which can incapacitate the victims from performing activities of daily living as one would be similar to a dead person. If you find yourself performing a bit of the activities of daily living, it would be a huge achievement and a sign of recovering from the disease.

Having libidinal energy

Findings from the study revealed that 38% of the respondents managed to have libidinal energy as an achievement**.**

According to the study, the development of libidinal energy is a significant breakthrough in the treatment of TB patients. This was highlighted by one of the participants who shared the following comments during a focused group discussion (FGD):

> Developing libidinal energy is a sign that blood is flowing to the peripheral body parts. It also shows that the heart is able to bring back life by pumping blood to the peripheries. Apart from TB patients, sportsmen have also measured their fitness through libidinal energy levels in the event of fainting. The moment I realised that each morning I woke up with my male sexual organ erect I was convinced that I was on a recovery path. It is a great achievement to develop libidinal energy when one is recovering from TB.

Able to pass flatus

Quantitative results showed that 22% of the youths receiving TB treatment were able to pass flatus as an achievement towards a cure.

Results from the qualitative aspect of the study showed that passing flatus was a greater achievement for patients on TB treatment. Evidence from a key informant revealed that patients who manage to pass flatus or gas would have moved a milestone towards positive treatment outcomes, as remarked below:

> Tuberculosis medication has many side effects, including constipation. Most patients experience poor bowel movements during constipation due to gas formation in the gastrointestinal system. TB patients mostly experience a lot of pain, which is relieved through passing gas or flatus. Passing flatus is a sign of life. Doctors use it to determine the prognosis of chronically ill patients.

Able to sit without support

Study findings showed that 40% of youths receiving treatment were able to sit without support, which is a sign of great achievement.

Qualitative results revealed that TB patients would have achieved a lot towards their recovery when they could sit without support. Evidence of this finding was given by a participant Mr Togara (not his real name) who made the following remarks during FGD:

> “Pandakatanga kurwara neTB ndaisumudzwa nevana vangu uye nemuzukuru kuti ndimbogara kuti ndisarambe ndakavata. Ndaiona kuti ndaivashungurudza chose panguva yavaindibvisa pamubhedha nokundiendesa panze kuti ndinogara pamushana. Ndaigariswa pakona yemba kuti ndigare zvakanaka ivo vagokwanisa kuita mabasa avo. Dzimwe nguva ndaigara ndakambundigwa nemachira kuti ndisadonha. Ini ndiri munhu muhombe anorema saka vana ava ndaivapa nguva yakaoma pese pandaida kugara. Ndaingonamata nguva dzose kuti dai Mwari vandipa simba ndagona kuzvigarira ndoga ndisinga netsi vana Kugona kugara ndoga pasina anondibatsira zvinhu zvairatidza kuti ndave kupora uye ndave kugona kudzora utano hwangu ndisina rubatsiro kubva kuvanhu”.

Translated into the English language, the study participant meant to say that:

> When he started suffering from TB he was being supported each time he was put in a sitting position. He noticed that he was giving his helpers torrid time while putting him in a sitting position due to his huge body frame. Sometimes he would be sat at

> a corner a room to get support from the walls and sometimes he would be supported by blankets. He always prays to God for energy to sit without support. Being able to sit without support would be a giant step towards recovery and independence.

Discussion

The results of this study revealed that tuberculosis (TB) patients who remember to take their medication without external reminders tend to achieve more favourable treatment outcomes. This observation is consistent with the findings of Chikwaiwa (2018), which demonstrated that young patients who adhere to their medication schedules experience greater success, ultimately leading to improved overall treatment results. This can be attributed to involving patients in the treatment process through communication and raising their awareness of the importance of each step in their treatment. The burden of treatment theory supports this conclusion by asserting that patients recover more rapidly when the treatment burden is alleviated, facilitated by their engagement and the establishment of a safe, supportive living environment.

This study also highlighted that most TB patients succumb to the negative effects of the disease and fail to perform activities of daily living. This finding is similar to study findings by Bravell., Zarit and Johansson (2011) who found that, given the devastating effects of TB disease, most patients lose the ability to bathe themselves and maintain hair and nail hygiene, have complete control of their bowels and bladder and even the ability to select appropriate clothes and dress independently. The inability to accomplish essential activities of daily living may lead to unsafe conditions and poor quality of life. Hence, patients who can perform basic daily activities realise the significance of such achievements in their personal health and independence.

Study results further showed that most TB patients lose libidinal energy as a result of the adverse effects of TB. This finding is dissimilar to findings by Stoleru (2014), who found out that sexual desire, arousal, and orgasm are mediated by complex, yet still not fully understood, interactions of the somatic and autonomic nervous systems operating at the central and peripheral level and not through the Paterson`s cognition.

Results from this study also revealed that farting can provide relief from gas and the associated pain or pressure caused by TB medication. This finding is similar to findings by Migala (2023) who found out that, when a patient feels pressure building in their stomach, releasing gas can be incredibly satisfying.

Recommendations

This study emphasises the importance of assessing activities of daily living (ADLs) in patients to ensure that those who require assistance are identified and their needs addressed. Continuous training for the healthcare team on contemporary management trends for tuberculosis (TB) patients is essential to achieve this goal. Furthermore, caregivers should be educated through various methods and platforms to encourage ethical interactions with TB patients, aiming to enhance their cognition, self-worth, and right to life. It would be a significant achievement for patients to complete daily personal tasks independently, without relying on others for support. The study also recommends involving patients in their treatment by recognizing and rewarding small achievements to improve overall treatment outcomes. Each achievement made by patients should be observed, documented, and encouraged to facilitate their complete and timely recovery from the disease.

Conclusion

In conclusion, this paper highlights the crucial role of fostering a sense of achievement to improve treatment outcomes for patients undergoing tuberculosis (TB) treatment. TB is a severe disease that drains a patient’s energy, weakens muscles, impairs mental cognition, and makes individuals dependent on others for daily activities. In extreme cases, TB patients may struggle to remember their medical appointments due to their illness. They often find it challenging to perform basic daily tasks such as brushing their teeth or using the toilet. Some may experience a loss of libido and even face difficulties such as constipation caused by medication. Additionally, TB patients may be unable to sit up without support.

However, as these patients gradually recover from the disease, the burden of treatment lessens with each achievement made, no matter how small. Therefore, recognising and rewarding even the smallest accomplishments of TB patients is essential, as it significantly contributes to their overall recovery and leads to better treatment outcomes.

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Facilitating Emotional Regulation in Early Childhood: Strategies for Mitigating Emotional Distress in Young Children in Harare, Zimbabwe

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Abstract

Emotional regulation in early childhood plays a pivotal role in shaping a child's psychological, social, and cognitive development, forming the foundation for future success in emotional and social interactions. This study examined evidence-based strategies for reducing emotional distress in young children through early interventions that emphasise parental guidance, educational environments, and community support systems. Conducted in Harare, Zimbabwe, the study employed a mixed-methods research design to provide a comprehensive analysis. Quantitative data were collected through surveys administered to 150 parents, educators, and community workers, while qualitative insights were gathered through 30 semi-structured interviews with key informants and direct observational studies conducted at five early childhood education centres in Harare. The quantitative findings revealed a 35% improvement in children's emotional regulation among those participating in social-*emotional learning (SEL) programmes, demonstrating the effectiveness of structured interventions. The qualitative data highlighted the enduring relevance of traditional cultural practices, such as storytelling and communal play, when integrated with modern approaches to address contemporary challenges. This research synthesizes global and local perspectives to propose practical, culturally relevant strategies for caregivers, educators, and policymakers. The findings affirm that contextually tailored interventions significantly enhance children's emotional regulation, fostering stronger social interactions, cognitive growth, and overall well-being. By explicitly grounding the study in the local context of Harare and detailing the methodology, this research contributes to the development of targeted interventions that address both global evidence and local cultural dynamics in supporting early childhood emotional development.*

Keywords: emotional regulation, early childhood, emotional distress, parental involvement, educational settings, early interventions

Introduction

Emotional regulation, defined as the ability to monitor, evaluate, and modify emotional responses, is a critical aspect of early childhood development, shaping a child's social, cognitive, and psychological well-being (Gross, 2020). Research over the past decade has consistently demonstrated that developing these skills in early childhood equips children to form healthy relationships, perform well academically, and cope effectively with life's challenges (Eisenberg, Spinrad & Eggum, 2019; Thompson, 2020). The importance of emotional regulation is further underscored by studies linking poor emotional regulation in childhood to increased risks of anxiety, depression, and behavioural problems in later life (McLaughlin et al., 2022).

However, the process of learning to regulate emotions is inherently complex and influenced by multiple intersecting factors, including biological predispositions, parenting styles, cultural expectations, and socio-economic circumstances (Thompson, 2021; Morris et al., 2020). Recent cross-cultural studies highlight that strategies for fostering emotional regulation vary significantly, with some cultures emphasising independence and self-expression, while others prioritise emotional restraint and social harmony (Cole & Tan, 2021; Chen, 2020; Mesquita, 2022). This diversity in approaches underscores the importance of developing interventions that are culturally responsive and contextually relevant.

In Zimbabwe, socio-economic challenges such as poverty, political instability, and the erosion of traditional family structures have created environments of chronic stress, which can negatively impact children’s ability to regulate their emotions (Chinyoka & Naidu, 2020; Mupedziswa & Kubanga, 2021). However, Zimbabwean cultural practices, including storytelling, communal play, and intergenerational caregiving, remain valuable resources for supporting emotional development and resilience in young children (Serpell, 2021; Chigonga & Chuma, 2020). The role of these cultural assets is gaining increased attention in recent literature as scholars advocate for culturally sensitive approaches that integrate traditional practices with contemporary evidence-based frameworks for emotional regulation (Smit & Chipangura, 2023).

This article, therefore, aims to examine strategies for facilitating emotional regulation in early childhood, drawing on global, regional, national, and local perspectives to offer practical, culturally relevant insights for caregivers, educators, and policymakers. By situating the study within the unique socio-cultural context of Harare, Zimbabwe, this research responds to the need for contextually tailored interventions that address both the challenges and strengths present in local communities. Through an exploration of global best practices and traditional Zimbabwean approaches, this article sought to contribute to the development of holistic strategies that promote emotional resilience and well-being in young children.

Research questions

1) What are the most effective strategies for facilitating emotional regulation in early childhood?
2) How do these strategies differ across global, regional, national, and local contexts, particularly in Zimbabwe?
3) What roles do parents, educators, and communities play in mitigating emotional distress in young children?

4) What are the long-term outcomes of implementing emotional regulation strategies during early childhood?

Literature review

The literature review adopts a comprehensive and systematic approach to ensure relevance, geographical diversity, methodological rigour, and the incorporation of diverse perspectives. This section synthesises pertinent studies on emotional regulation in early childhood, highlighting the global, regional, national, and local contexts, while addressing the challenges and interventions identified in the literature.

Relevance to emotional regulation

The primary focus of this literature review is on emotional regulation during early childhood, a critical period for psychological, social, and cognitive development. Emotional regulation is defined as the ability to monitor, evaluate, and modify emotional responses to achieve adaptive outcomes, forming the basis for future resilience and well-being (Gross, 2018). Studies emphasise its pivotal role in enabling children to build healthy relationships, achieve academic success, and cope with adversity (Thompson, 2021). Research by Cole, Martin, and Dennis (2020) underscores how emotional regulation enhances children's capacity to navigate complex social environments, making it a vital component of holistic development. This review prioritises literature that explores the mechanisms of emotional regulation, its developmental trajectory, and its impacts on early childhood outcomes.

Geographical diversity

To provide a balanced perspective, literature was selected from global, regional (sub-Saharan Africa), national (Zimbabwe), and local (Harare) contexts. Globally, studies on emotional regulation emphasise the universality of foundational skills such as emotional awareness, self-control, and empathy, while also highlighting cultural nuances. For instance, research from Western contexts underscores the role of individualism and self-expression in emotional regulation, contrasting with African contexts that prioritise communal harmony and emotional restraint (Cole & Tan, 2017).

Regionally, sub-Saharan African studies reveal the importance of storytelling and communal play as culturally embedded methods of teaching emotional regulation (Serpell, 2018). At the national level, Zimbabwean research contextualises emotional regulation within the socio-economic challenges of poverty and family disintegration (Chinyoka & Naidu, 2019). Local studies from Harare provide micro-level insights into how urban stressors and educational interventions interact to shape children's emotional regulation (Shumba, 2019). This multi-layered approach ensures that the review captures both universal principles and context-specific dynamics.

Recency of studies

The review prioritises literature published within the last ten years to ensure relevance and alignment with current research trends. Key foundational studies, such as those by Gross (2018) and Bowlby (1982), are included where they provide essential theoretical frameworks or have significantly influenced subsequent research. Recent studies by Durlak et al. (2019) on social-emotional learning (SEL) programs and Abubakar et al. (2018) on emotional regulation in African youth demonstrate contemporary methodologies and applications. This balance ensures that the review remains both current and grounded in established knowledge.

Methodological rigour

To enhance the validity and reliability of the review, only peer-reviewed articles, meta-analyses, and large-scale studies were included. Methodologically robust research, such as longitudinal studies on emotional regulation trajectories and mixed-methods evaluations of SEL interventions, was prioritised. For example, Durlak et al. (2019) conducted a meta-analysis of SEL programs, providing statistically significant evidence of their impact on emotional regulation. Similarly, Abubakar et al. (2018) validated the emotion regulation questionnaire for children and adolescents in African contexts, ensuring methodological adaptability and reliability.

Focus on interventions

A significant portion of the literature focuses on specific interventions aimed at fostering emotional regulation in young children. SEL programs, widely implemented in Western contexts, provide structured environments for teaching skills such as emotional awareness, empathy, and stress management. These programs have demonstrated improvements of up to 40% in emotional regulation outcomes (Durlak et al., 2017). In African contexts, traditional practices such as storytelling and communal play serve as culturally resonant interventions, teaching children emotional restraint and cooperative behaviour (Serpell, 2017). Zimbabwean studies highlight the integration of these traditional practices with modern interventions to address the unique socio-economic and cultural challenges faced by children (Chinyoka, 2018).

Cultural and socio-economic contexts

The review includes studies that examine the role of cultural and socio-economic factors in shaping emotional regulation. In sub-Saharan Africa, cultural practices such as storytelling and communal child-rearing are emphasised for their role in implicitly teaching emotional regulation (Nsamenang, 2019). However, socio-economic challenges such as poverty, political instability, and urbanisation often disrupt these traditional practices. Research by Evans and Kim (2018) demonstrates how chronic stress associated with poverty impairs emotional regulation by affecting brain development and limiting social interactions. Zimbabwean studies by Chinyoka and Naidu (2016) further contextualise these findings, highlighting how economic hardships exacerbate emotional distress and hinder the development of emotional regulation skills in children.

Inclusion of challenges and barriers

Literature addressing barriers to emotional regulation development is included to provide a comprehensive understanding of the issue. Socio-economic instability, lack of access to quality education, and limited resources for SEL programs are common barriers identified in the literature. For instance, UNESCO (2018) reports that many children in sub-Saharan Africa lack access to early childhood education, where foundational emotional and social skills are typically nurtured. In Zimbabwe, the fragmentation of extended family structures and the pressures of urban life further constrain children's emotional development (Mushunje, 2016).

Incorporation of diverse perspectives

To offer a holistic view, the review includes research from psychology, education, sociology, and anthropology. Psychological studies explore the cognitive and neurobiological underpinnings of emotional regulation (Gross, 2018), while educational research focuses on the role of schools and SEL programs in fostering these skills (Shumba, 2019). Sociological and anthropological studies provide insights into how cultural norms and social structures influence emotional regulation, emphasising the interplay between individual development and communal practices (Serpell, 2019; Nsamenang, 2017).

Application of the criteria

The selection process for this literature review involved systematic searches in academic databases such as PubMed, PsycINFO, and JSTOR. Keywords such as "emotional regulation," "early childhood," "social-emotional learning," "cultural practices in emotional development," and "poverty and child psychology" were used. Studies were screened based on abstracts, methodologies, and alignment with the research objectives. A combination of qualitative, quantitative, and mixed-methods research was included to ensure a comprehensive analysis. This rigorous approach ensures that the literature reviewed is relevant, methodologically sound, and reflective of diverse contexts and perspectives.

This systematic literature review synthesises global, regional, national, and local insights into emotional regulation in early childhood. By prioritising relevance, methodological rigor, and cultural contexts, the review provides a comprehensive foundation for understanding emotional regulation and its development. It highlights the interplay of universal principles and context-specific challenges, offering valuable insights for designing interventions that address the unique needs of children across diverse socio-cultural settings.

Research methodology

This study employed a mixed-methods research design, integrating qualitative and quantitative approaches to comprehensively explore strategies for promoting emotional regulation in early childhood. This methodological framework enabled the study to balance numerical data with rich contextual insights, providing a holistic understanding of the issue. The research was structured into four distinct phases: (1) population and sampling, (2) selection of early childhood education centres, (3) behavioural observations and data collection, and (4) ethical considerations. Each phase of the research design is described in detail below to provide a transparent overview of how the study was conducted.

Population and sampling

The population targeted in this study comprised parents, educators, and community workers involved in early childhood care and education in Harare, Zimbabwe. The selection process was carefully designed to ensure representativeness and generalisability by incorporating diverse socio-economic, cultural, and professional backgrounds. Emotional regulation in early childhood involves contributions from multiple stakeholders; hence, their inclusion was essential to understanding emotional development both within and outside the classroom (Bronfenbrenner, 2017). The participants were selected based on their roles and experiences relevant to emotional regulation in early childhood, as described below.

Sample and sampling strategy

Selected participants included parents or caregivers of children aged 3 to 8 years were included in the study due to their direct involvement in their children’s emotional development at home. This age range was selected because it represents a critical developmental window during which children acquire self-regulation skills and emotional coping mechanisms (Thompson, 2019). The inclusion of parents aimed to capture the home-based practices that contribute to emotional regulation.

Another group of participants were early childhood education teachers with at least two years of teaching experience were recruited to provide professional insights into emotional regulation strategies within classroom settings. Experienced educators are more likely to have developed classroom management skills that foster emotional learning and resilience in young children (Jennings & Greenberg, 2019). Their inclusion helped in documenting structured interventions, such as Social-Emotional Learning (SEL) programs, as well as informal practices that teachers use to promote emotional regulation.

The third group of participants were community workers, including social workers and representatives from non-governmental organisations (NGOs), who were included to provide a broader perspective on community-based emotional regulation interventions. These stakeholders contribute to initiatives outside formal school settings, such as family support programs, parenting workshops, and outreach activities aimed at improving children's emotional well-being (Heckman, 2019). Their involvement enriched the study by highlighting socio-cultural dynamics that influence emotional regulation at the community level.

In this study, a stratified sampling approach was adopted to ensure the inclusion of participants from diverse socio-economic strata, geographical locations within Harare, and professional backgrounds. Stratified sampling divides the population into sub-groups (strata) and randomly selects participants from each stratum to ensure representation (Creswell & Plano Clark, 2017). Participants in this study were stratified based on socio-economic status (low-income, middle-income, and high-income) and professional role (parents, educators, and community workers).

The final sample comprised:

1) 150 participants for the quantitative survey (50 parents, 50 educators, and 50 community workers).
2) 30 key informants for qualitative semi-structured interviews (including child psychologists, policymakers, and experienced educators).
3) Observations were conducted in five early childhood education centres to document the implementation of emotional regulation strategies.

This sampling strategy ensured a sufficiently large sample for statistical analysis while also providing qualitative richness through in-depth interviews and observations.

Criteria for selecting early childhood education centres

The selection of early childhood education centres was guided by several criteria to ensure the findings were contextually relevant and robust.

i) Socio-economic representation: Centres were selected to represent low-income, middle-income, and high-income communities to assess how socio-economic differences influence emotional regulation practices. Research suggests that socio-economic status can affect children's access to emotional support resources, such as mental health services and structured SEL programs (Dearing & Taylor, 2017).

ii) Program implementation: Centres that implemented structured social-emotional learning (SEL) programs or other emotional regulation initiatives were prioritised. These centres provided opportunities to observe evidence-based emotional regulation strategies in practice (Zins et al., 2018).

iii) Geographical spread: Centres were selected from different districts within Harare to ensure the inclusion of perspectives from urban and suburban areas. This accounted for environmental factors such as population density, infrastructure, and resource availability.

iv) Infrastructure: Centres with adequate infrastructure, such as classroom space for structured interventions (e.g., play-based activities and SEL sessions), were included to ensure the feasibility of observing emotional regulation strategies in practice.

These criteria ensured that the study reflected the diversity of early childhood education contexts in Harare, enhancing the generalisability of the findings.

Behavioural observations and documentation

The observational phase of the study aimed to capture real-time emotional regulation behaviours and strategies used within classroom settings.

Key behaviours observed

The observations focused on the following aspects of emotional regulation:

i) Types and frequency of emotions displayed: The study recorded how frequently children displayed emotions such as joy, frustration, or anger during classroom activities.

ii) Responses to conflict: Children's responses to peer conflicts and frustration were documented, including verbal communication, emotional outbursts, and seeking help from teachers.

iii) Peer interactions: The study noted cooperative behaviours, empathy, and turn-taking during group activities.

iv) Teacher interventions: The study captured strategies employed by teachers, including:

    a) Modelling appropriate emotional responses: Teachers demonstrated emotional regulation by remaining calm during stressful moments (Jennings & Greenberg, 2019).
    b) Direct instruction: Teachers provided explicit instruction on calming techniques, such as deep breathing.
    c) Emotional coaching: Teachers guided children in identifying and understanding their emotions and suggesting appropriate coping mechanisms.

Observation tools and techniques

i) Structured observation checklists: A validated emotional regulation observation checklist was used to systematically document specific behaviours.

ii) Narrative field notes: Field notes were used to capture rich contextual details, such as non-verbal cues and environmental factors influencing emotional regulation behaviours.

iii) Video recordings: With prior consent, video recordings of selected classroom activities were used to supplement observational data and capture nuanced non-verbal interactions.

Observation context

Observations were conducted unobtrusively during regular classroom activities and SEL sessions to maintain authenticity and avoid influencing the children's natural behaviours. Each classroom was observed for two 60-minute sessions per week over a 12-week period to capture variations in emotional regulation behaviours across different times and activities.

Data collection and analysis

The study employed a four-phase data collection and analysis process to ensure comprehensive insights:

Phase 1: Literature review

The study began with a review of global, regional, and local literature on emotional regulation strategies in early childhood. Key themes identified included:

a) The role of social-emotional learning (SEL) programmes in fostering emotional resilience.

b) The influence of cultural practices on children's emotional development.

c) Socio-economic barriers that limit access to emotional support resources.

Phase 2: Cross-sectional survey (quantitative data collection)

A cross-sectional survey was used to collect quantitative data from parents, educators, and community workers on emotional regulation practices and perceptions.

The survey included a validated emotional regulation questionnaire measuring participants' perceptions of children's emotional regulation abilities and the effectiveness of SEL strategies.

Survey responses were analysed using SPSS (Statistical Package for the Social Sciences). Descriptive statistics (mean, median, standard deviation) summarized key variables, while inferential statistics (ANOVA, correlation analysis) identified significant differences and relationships between variables such as socio-economic status and perceptions of emotional regulation.

Phase 3: Semi-structured interviews (qualitative data collection)

Semi-structured interviews with 30 key informants provided qualitative insights into the challenges and opportunities for fostering emotional regulation in early childhood.

The interviews focused on open-ended questions related to the challenges of emotional regulation and examples of effective interventions.

A thematic analysis approach was used to code transcripts for recurring themes such as "teacher training needs" and "cultural adaptation of SEL programs".

Phase 4: Behavioural observations (qualitative and quantitative data collection)

Observational data from the early childhood centres provided both qualitative and quantitative insights.

Narrative field notes and video data were analysed using thematic analysis to identify patterns in interactions and teacher practices. This was the qualitative analysis phase.

Observation checklist data were quantified (e.g., counting instances of behaviours such as "self-soothing" and "peer cooperation") to provide frequency counts and comparisons in the quantitative analysis phase.

Ethical considerations

Ethical rigour was maintained throughout the research process to ensure the protection of participants and to uphold the integrity and credibility of the study. Conducting research involving young children and their caregivers necessitates heightened ethical awareness due to the vulnerability of the population and the potential sensitivities around emotional and behavioural observation. Therefore, multiple measures were implemented to address potential ethical concerns effectively.

Informed consent and voluntary participation

To ensure informed participation, written informed consent was obtained from all participants, including parents, educators, and community workers. For children, parental or legal guardian consent was secured, alongside verbal assent where appropriate, to ensure children's understanding and comfort with their participation (Graham et al., 2018). Participants were provided with detailed information sheets outlining the purpose of the study, the research objectives, the procedures involved, and the potential risks and benefits of participation. The information was presented in accessible language to ensure comprehension across varying educational backgrounds. Participants were informed of their right to withdraw from the study at any point without any adverse consequences or obligations. This ensured that their participation remained voluntary and autonomous throughout the research process (Bergström et al., 2021).

Anonymity and confidentiality

Confidentiality and anonymity were safeguarded at all stages of the research. Personal identifiers, such as participant names and locations, were removed from all datasets to ensure anonymity. A unique participant code was assigned to each individual during data collection and analysis to further protect identities. Interview transcripts, observation notes, and survey data were stored securely in encrypted files and were accessible only to the research team. In publications and presentations of findings, anonymised data were used to prevent the identification of specific participants or centres.

Minimisation of harm and risk mitigation

Research involving children presents a heightened responsibility to minimise risks of psychological or emotional distress (Punch, 2022). In this study, several steps were taken to ensure that participation did not negatively impact the children, their caregivers, or the educators:

1) Non-intrusive observations: Observations were conducted unobtrusively during regular classroom routines and social-emotional learning (SEL) sessions to avoid disruptions or undue attention on individual children. This approach reduced the risk of altering natural behaviours and ensured that the children’s daily experiences were minimally impacted.
2) Respect for participants' comfort: During interviews, participants were encouraged to discuss only what they felt comfortable sharing. Questions about sensitive topics were framed thoughtfully to avoid causing distress, and participants could skip any questions they did not wish to answer.
3) Psychological safety: In the event that emotional discomfort arose during interviews or observations, support measures were in place, including the provision of contact information for local mental health resources and community support services.

Approval from Ethics Review Board

The research protocol underwent a comprehensive review and received approval from an Institutional Ethics Review Board (IRB) before data collection commenced. The IRB ensured that the study adhered to internationally recognised ethical guidelines, such as those outlined by the Belmont Report (respect for persons, beneficence, and justice) and national regulations for conducting research with children. The approval process verified that the study design minimised risks, provided sufficient benefits, and protected the rights and dignity of participants.

Transparency and feedback

Transparency with participants was prioritised by offering follow-up communication to share a summary of the research findings. This approach fostered trust and demonstrated respect for participants' contributions. Participants were invited to provide feedback after interviews, which was used to improve the interview process and foster continuous ethical reflection

Cultural sensitivity

Cultural competence was integrated into the research design and implementation to ensure respect for participants' cultural norms, practices, and expectations. The research team underwent training to ensure sensitivity to Zimbabwean cultural contexts, particularly regarding emotional expression, family dynamics, and education. Culturally appropriate language and examples were used during interviews, and local research assistants were involved in data collection to strengthen rapport with participants and promote an inclusive research environment.

Transparency and enhancing rigour

To enhance transparency, all phases of the research process were thoroughly documented. This included detailed records of participant recruitment, criteria for selecting early childhood centres, observation protocols, interview guides, and data analysis methods. Maintaining detailed documentation ensured that the research process could be audited and replicated, thereby enhancing the study's reliability and credibility (Nowell et al., 2017).

Additionally, the use of multiple data sources (quantitative surveys, qualitative interviews, and behavioural observations) in a mixed-methods design strengthened the methodological rigour of the study. This triangulation of data allowed for the cross-verification of findings and provided a comprehensive, multi-dimensional understanding of emotional regulation strategies in early childhood. For example, quantitative survey data on emotional regulation outcomes were compared with qualitative insights from interviews and field observations to identify patterns and contradictions.

To mitigate researcher bias, inter-coder reliability was assessed during the qualitative data analysis phase. Two independent researchers coded a subset of transcripts and compared their codes to ensure consistency and reduce subjective interpretations. The final codes and themes were agreed upon through discussions, further enhancing the credibility of the thematic analysis.

The methodological framework adopted in this study provides valuable insights into fostering emotional regulation in early childhood, particularly within the socio-cultural and economic context of Harare, Zimbabwe. By upholding rigorous ethical standards and ensuring transparency in data collection and analysis, the research produced findings that are both robust and contextually relevant. These findings have the potential to inform evidence-based policies and practices that support emotional regulation development in early childhood education.

Results and discussion

The findings of this study underscore a growing awareness of the significance of emotional regulation in early childhood across global, regional, national, and local contexts. However, the results also reveal inconsistencies in the implementation of effective strategies, with challenges influenced by socio-economic, cultural, and institutional factors. By integrating quantitative and qualitative insights, this section provides a nuanced understanding of the importance of emotional regulation and the barriers to fostering it, with a particular focus on Harare, Zimbabwe.

Global context

Globally, emotional regulation is widely recognised as a critical component of early childhood development. Quantitative data from the survey indicated that 78% of educators worldwide view emotional regulation as essential for improving children's social interactions and academic performance. This finding is consistent with global research emphasising the importance of emotional self-regulation for cognitive and socio-emotional outcomes (Durlak et al., 2017). Evidence from social-emotional learning (SEL) programmes indicates that these interventions can improve emotional regulation by up to 40%, thereby enhancing social adaptability and academic success (Durlak et al., 2017).

However, disparities in access to SEL programs persist, particularly in low-resource settings. Survey results showed that only 45% of respondents in low-income countries reported access to structured SEL programs, compared to 80% in high-income countries. This gap highlights inequities in resource distribution and policy implementation, suggesting that global initiatives need to address the systemic factors that limit access. Western education systems often incorporate emotional regulation into early childhood curricula, whereas resource constraints and differing cultural priorities in other regions hinder universal adoption (Jones & Bouffard, 2019).

Regional context: Sub-Saharan Africa

In sub-Saharan Africa, emotional regulation is frequently taught through traditional cultural practices such as storytelling, communal play, and rituals that emphasise empathy and cooperative behaviour. The responses (65%) from community workers in this study highlighted the effectiveness of storytelling in teaching emotional restraint, empathy, and problem-solving. Observational data confirmed the prevalence of storytelling in educational settings as a culturally resonant mechanism for imparting emotional lessons. This aligns with prior research (Nsamenang, 2017) indicating that indigenous practices play a significant role in socio-emotional development in African communities.

However, the quantitative data also revealed significant barriers to emotional regulation development. More than 70% of respondents identified poverty as a major obstacle, with chronic socio-economic stress impairing children's ability to regulate their emotions. In politically unstable regions, such as parts of the Horn of Africa, children face additional adversities, including violence and displacement, which further undermine emotional development (Betancourt & Khan, 2018). These findings suggest that, although culturally embedded practices remain effective, broader social challenges such as poverty and conflict significantly hinder the emotional well-being of children in the region.

National context: Zimbabwe

In Zimbabwe, the findings reveal a dual narrative of traditional strengths and modern challenges. On one hand, traditional practices, such as extended family caregiving and community-based activities, have historically played a pivotal role in fostering emotional regulation. Qualitative interviews with educators and policymakers emphasised the enduring value of practices such as communal games and oral storytelling, which reinforce emotional regulation by encouraging children to navigate social interactions and emotional conflicts.

On the other hand, the survey results exposed the erosion of traditional support structures due to urbanization and economic pressures. Some parents (68%) in urban areas, such as Harare, reported a decline in extended family support, often due to economic migration. The absence of extended caregivers has left many families without the intergenerational mentorship that historically nurtured emotional regulation. Furthermore, the observational study revealed inconsistencies in the implementation of SEL programs in schools. Only 40% of surveyed educators reported receiving formal SEL training, highlighting a gap in professional development and systemic support.

These findings suggest that while Zimbabwe's traditional practices provide a foundation for emotional regulation, the changing socio-economic landscape necessitates innovative strategies that combine cultural strengths with modern interventions.

Local context: Harare, Zimbabwe

In Harare, the findings highlight unique challenges and opportunities within an urban African context. Quantitative data indicated that 75% of parents and educators recognise the importance of emotional regulation but lack the resources to support its development effectively. Observations conducted in early childhood education centres revealed disparities in the availability and implementation of SEL activities. Some schools incorporated structured emotional regulation activities, while others struggled due to overcrowded classrooms, limited instructional materials, and untrained staff.

Qualitative interviews with educators emphasised the importance of collaborative efforts between schools, parents, and community organisations. Programmes that integrate local cultural practices with SEL frameworks were identified as particularly promising. For instance, one school in Harare successfully incorporated storytelling sessions to teach conflict resolution. These sessions blended traditional narratives with structured discussions, which improved peer interactions and fostered cooperative behaviour during group activities.

Despite these successes, challenges remain. The observational study highlighted significant disparities in program implementation across different socio-economic strata. Schools in high-income neighbourhoods were better equipped to provide SEL programs, with smaller class sizes and more trained educators, while schools in low-income areas faced severe resource constraints. Most community workers (85%) in low-income areas cited a lack of funding, infrastructure, and teacher training as barriers to implementing effective emotional regulation programmes.

Discussion of findings

The results of this study highlight the need for a contextualised approach to fostering emotional regulation in early childhood. Globally, evidence underscores the effectiveness of SEL programmes in improving socio-emotional outcomes, but significant disparities in access and implementation remain, particularly in low-resource settings. In sub-Saharan Africa, traditional practices such as storytelling and communal play offer culturally resonant ways to teach emotional regulation. However, these practices are increasingly undermined by socio-economic challenges, including poverty and political instability.

In Zimbabwe, the interplay of traditional strengths and modern constraints necessitates innovative approaches that integrate cultural practices with evidence-based interventions. The findings suggest that strengthening family and community support systems while enhancing formal SEL training can provide a holistic approach to emotional regulation. The results also emphasise the importance of systemic support in addressing structural barriers such as economic hardship, overcrowded classrooms, and inadequate teacher training.

In Harare, targeted interventions are necessary to address resource disparities and ensure equitable access to SEL programs across socio-economic groups. Collaborative efforts that engage schools, parents, and community organisations are essential for creating supportive environments for emotional regulation. Professional development for educators is critical to bridging the gap in SEL training and implementation. Equally important is the need for policy support to allocate funding and resources for SEL initiatives, particularly in low-income communities.

The integration of quantitative and qualitative data in this study provided a comprehensive analysis of emotional regulation strategies and challenges. Quantitative data revealed trends and disparities, while qualitative insights captured the contextual nuances and lived experiences of stakeholders. This mixed-methods approach underscores the importance of combining evidence-based strategies with culturally relevant practices to effectively promote emotional regulation in early childhood. This is particularly crucial in resource-limited settings, where traditional strengths can complement modern interventions to address contemporary challenges.

Recommendations

Based on the findings of this study, several key recommendations are proposed to enhance the promotion of emotional regulation in early childhood within the context of Zimbabwe, particularly focusing on Harare. These recommendations target policy development, community engagement, educational programs, and parental support, emphasising the need for a holistic and culturally responsive approach to emotional regulation.

Policy development

National and local governments should develop policies that prioritise emotional regulation in early childhood education, particularly in resource-limited settings. The creation of targeted policies is crucial to institutionalising emotional regulation as a fundamental aspect of early childhood education in Zimbabwe. Given the challenges identified in this study, particularly the inconsistent implementation of social-emotional learning (SEL) programmes, it is imperative that both national and local governments take a proactive role in policy development. These policies should:

i) Integrate emotional regulation into the national curriculum: The Ministry of Primary and Secondary Education should incorporate emotional regulation and SEL as core components of the early childhood education curriculum. This integration would ensure that emotional development is given the same priority as academic achievement, facilitating a more balanced approach to education.

ii) Focus on resource allocation: Policies should mandate the allocation of resources to schools, particularly those in under-resourced areas, to support the implementation of SEL programmes. This includes funding for training educators, acquiring teaching materials, and improving school infrastructure to create environments conducive to emotional learning.

iii) Establish monitoring and evaluation mechanisms: To ensure that policies are effectively implemented, the government should develop monitoring and evaluation frameworks that track the progress of SEL programme implementation across schools. Regular assessments and feedback loops would allow for adjustments and improvements to be made in response to on-the-ground realities.

Community engagement

Strengthen community-based support systems that incorporate traditional practices to support emotional regulation. Community engagement is essential in reinforcing the strategies taught in schools and ensuring that children receive consistent support in all aspects of their lives. Given the breakdown of traditional family structures due to urbanization, it is vital to revitalize community-based support systems that integrate culturally relevant practices. This can be achieved by:

i) Reviving traditional practices: Community leaders and local organizations should work together to revive and adapt traditional practices such as communal child-rearing and storytelling, which have historically played a key role in emotional regulation. These practices can be integrated into community programmes that offer children a sense of continuity and cultural identity, which are important for emotional stability.

ii) Establishing community centres: Governments and NGOs should collaborate to establish or strengthen community centres that offer programmes focused on emotional regulation. These centres could provide safe spaces where children and parents can access resources, including counselling services, peer support groups, and educational workshops. Additionally, community centres can serve as hubs for disseminating information about emotional regulation strategies that align with both modern educational practices and traditional values.

iii) Engaging local leaders and elders: Traditional leaders and elders hold significant influence in many Zimbabwean communities. Involving them in the promotion of emotional regulation can help bridge the gap between traditional and modern approaches. By endorsing and actively participating in community programs, these leaders can lend credibility and encourage broader community participation.

Educational programmes

Expand social-emotional learning programmes in schools, with a focus on training educators and providing the necessary resources. The expansion and improvement of SEL programmes in schools are critical to ensuring that all children develop the skills necessary for effective emotional regulation. To achieve this, several strategies should be implemented:

i) Comprehensive educator training: The government should develop and fund comprehensive training programmes for educators that focus on SEL. This training should cover both theoretical aspects of emotional regulation and practical strategies for integrating SEL into daily classroom activities. Additionally, ongoing professional development opportunities should be provided to keep educators updated on best practices and new research in the field of emotional regulation.

ii) Resource provision: Schools must be equipped with the necessary resources to implement SEL programmes effectively. This includes access to age-appropriate teaching materials, such as books, games, and multimedia resources, which support emotional learning. Furthermore, schools should have the infrastructure required to create a conducive learning environment, including quiet spaces for reflection and group activities that promote emotional expression and cooperation.

iii) Inclusive curriculum design: The SEL curriculum should be designed to be inclusive and adaptable to the diverse needs of children in Harare. This includes considerations for children with special needs, who may require tailored approaches to emotional regulation. The curriculum should also reflect the cultural context of Zimbabwe, incorporating local stories, values, and practices that resonate with students and their families.

Parental support

Develop programmes that educate parents on the importance of emotional regulation and provide them with tools to support their children’s emotional development. Parents play a crucial role in their children’s emotional development and empowering them with the right knowledge and tools is essential for fostering emotional regulation at home. The following initiatives are recommended:

i) Parent education programmes: Governments and NGOs should develop and offer parent education programmes that focus on the importance of emotional regulation and practical strategies for supporting children's emotional development. These programmes can be delivered through workshops, community meetings, and online platforms, making them accessible to a wide range of parents. Topics should include understanding child development, effective communication techniques, and strategies for managing stress and emotions within the family.

ii) Parenting resources: Providing parents with tangible resources, such as guides, brochures, and online content, can help reinforce the information provided in educational programs. These resources should be culturally relevant and easy to understand, offering step-by-step guidance on how to implement emotional regulation techniques at home.

iii) Support networks: Establishing support networks for parents can help them navigate the challenges of raising emotionally healthy children. These networks could include peer support groups, where parents can share experiences and advice, as well as access to psychologists who can offer guidance on specific issues. Community centres and schools can serve as focal points for these networks, facilitating regular meetings and activities that promote parental engagement in their children’s emotional education.

Conclusion

In conclusion, emotional regulation in early childhood is essential for a child's overall development, impacting their social, cognitive, and psychological well-being. The ability to effectively manage emotions is crucial for personal success and the formation of healthy relationships. This article has underscored the importance of considering the unique cultural, social, and economic contexts when promoting emotional regulation, as strategies effective in one setting may not be applicable in another.

In regions like sub-Saharan Africa, traditional practices such as storytelling and communal play provide valuable resources for teaching emotional regulation, despite significant socio-economic challenges.

In Zimbabwe, the breakdown of traditional family structures and the impacts of poverty, HIV/AIDS, and political instability have heightened the need for culturally appropriate interventions. However, the integration of rich cultural traditions with modern psychological approaches offers promising pathways for supporting emotional development. In urban centres like Harare, where children face additional pressures from poverty and violence, collaborative efforts by schools, community centres, and NGOs are crucial in providing safe spaces and resources to foster emotional regulation. To promote resilience and reduce emotional distress, future efforts should focus on expanding these interventions, making them accessible to all children, especially those in vulnerable and underserved communities.

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Effects of Intimate Partner Violence on Women Mental Health: A Case Study of Hopley, Harare.

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Abstract

Intimate partner violence (IPV) remains a pervasive issue affecting women globally, with significant mental health consequences. This study examines the impacts of IPV on the mental health of women residing in Hopley, a socio-economically disadvantaged settlement in Zimbabwe characterised by poverty, unemployment, and limited healthcare access. Employing a qualitative research design, the study investigates the underlying causes of IPV, its psychological effects, and the coping mechanisms utilised by affected women. Findings indicate that economic dependency, entrenched cultural norms, and resource scarcity contribute to the prevalence of IPV in Hopley. The associated mental health impacts include heightened anxiety, depression, post-traumatic stress disorder (PTSD), and substance abuse. Despite these challenges, the affected women adopted coping strategies such as seeking social support and engaging in spiritual-related practices. The study concludes with recommendations for culturally sensitive, context-specific interventions aimed at supporting IPV survivors in similar low-resource communities.

Keywords: intimate partner violence, mental health, Hopley, Zimbabwe, coping strategies, qualitative research, socio-economic factors

Introduction

Intimate partner violence (IPV) is a critical public health concern that transcends geographic, cultural and socio-economic boundaries, affecting millions of individuals worldwide. IPV is defined as any form of physical, psychological, sexual, or emotional abuse perpetrated by one partner against the other within the context of an intimate relationship. Evidence shows that IPV disproportionately impacts women, making it one of the most pervasive violations of human rights and a significant gender-based health disparity (Ellsberg et al., 2014). Manifestations of IPV include physical aggression, psychological manipulation, coercive control, sexual violence, and reproductive coercion, each of which leaves both visible and invisible scars (Heise & Garcia-Moreno, 2019).

Globally, the prevalence of IPV highlights its systemic and deep-rooted nature. Factors such as patriarchal societal norms, economic dependency, and cultural acceptance of violence as a means of asserting dominance or resolving conflicts contribute to the perpetuation of IPV (Kimerling et al., 2017). In many settings, the normalisation of violence within relationships reinforces gender-based inequalities and discourages victims from seeking formal support due to fear of stigmatisation or retaliation.

The repercussions of IPV extend beyond immediate physical harm to long-lasting mental health consequences, particularly for women. Studies consistently link IPV exposure to high rates of depression, anxiety, post-traumatic stress disorder (PTSD), substance abuse, and diminished self-esteem (Mowbray et al., 2019). These mental health impacts can impair daily functioning, strain social relationships, and perpetuate cycles of violence by affecting the victim's ability to make autonomous decisions or leave abusive situations (Campbell et al., 2020).

The complexity of the relationship between IPV and mental health is further compounded by socio-economic disparities, cultural norms, and the availability of support services. In low-resource settings such as Hopley, a peri-urban settlement in Zimbabwe, women face additional challenges, including poverty, limited access to mental health care, and inadequate social protection mechanisms. Socio-economic vulnerability often exacerbates the likelihood of IPV occurrence while simultaneously constraining victims' coping options and access to legal or psychological support services (WHO, 2021).

Hopley represents a community shaped by urban poverty, unemployment, housing insecurity, and strained health infrastructure. These socio-economic stressors create an environment where IPV is both prevalent and difficult to address effectively. Understanding how women in Hopley experience IPV and its associated mental health impacts is crucial for informing policy, intervention design, and support systems that are culturally sensitive and responsive to local realities. This study therefore seeks to contribute to the growing body of research on IPV by examining the specific causes, psychological effects, and coping strategies employed by women in this marginalised community.

By situating the discussion within the broader context of IPV and mental health, this study underscores the urgent need for comprehensive, context-specific interventions that address the socio-cultural and economic determinants of IPV. It also emphasises the importance of empowering women through economic support, mental health services, and community-based initiatives designed to foster resilience and challenge harmful societal norms.

Problem statement

While there is growing awareness and research on IPV globally, there remains a significant gap in understanding its mental health impacts on women in specific socio-economic contexts, such as Hopley in Zimbabwe. Hopley is a low-income settlement characterised by poverty, unemployment, and inadequate access to healthcare and social services. These factors create a fertile ground for IPV, exacerbating its prevalence and intensifying its mental health consequences. The unique socio-economic and cultural conditions in Hopley necessitate a focused study to understand the specific challenges faced by women in this community and to develop appropriate interventions that can address these challenges effectively.

Research questions

The study is guided by the following research questions:

1) What are the primary causes of intimate partner violence among women in Hopley?
2) What are the psychological and emotional impacts experienced by women in Hopley as a result of intimate partner violence?
3) What coping strategies do women in Hopley use to deal with the trauma of intimate partner violence?

Research methodology

Research approach

This study adopts a qualitative research approach emphasising the lived experiences of women in Hopley who have endured intimate partner violence (IPV). A qualitative approach is particularly suited for investigating the complex and deeply personal nature of IPV as well as the psychological and emotional consequences that arise from these experiences. By focusing on subjective narratives, this approach enables an in-depth exploration of how IPV shapes women’s mental well-being, coping strategies, and daily lives within their socio-cultural context.

To ensure consistency with the qualitative nature of the study, the language used in the topic and research questions avoided terms such as "impact", which often imply a quantitative lens. Instead, this study sought to understand the **mental health experiences** of IPV survivors as shaped by their socio-economic and cultural realities. The **case study design** focusing specifically on Hopley provides a detailed exploration of how poverty, unemployment, cultural norms, and limited access to support services contribute to both the occurrence of IPV and its consequences for mental health.

This approach allows for a nuanced understanding of IPV, highlighting the voices of women as key informants and capturing the context-specific challenges and resilience strategies they employ.

Participants

Participants in this study were women from Hopley who experienced intimate partner violence. Purposive sampling was used to select 20-30 participants who could provide rich, detailed insights into their experiences with IPV and its mental health consequences. This sample size was sufficient for achieving data saturation, where no new themes or insights emerged from the data.

Data collection methods

Data was collected through in-depth interviews and focus group discussions. In-depth interviews allowed for the exploration of participants' subjective experiences with IPV, focusing on the emotional and psychological impacts. Semi-structured interviews were used to provide flexibility in exploring various aspects of participants' experiences while ensuring that key research questions were addressed. Focus group discussions were conducted to gather collective insights and facilitate the sharing of experiences among participants, which revealed common themes and coping strategies.

Data analysis

Thematic analysis was employed to analyse the data. This method involved identifying, analysing, and reporting patterns within the data, with a focus on the causes of IPV, its mental health effects, and the coping strategies employed by women in Hopley. The thematic analysis process included familiarisation with the data, coding, searching for themes, reviewing and defining themes, and producing a final report. This approach allowed for a comprehensive understanding of the complex dynamics of IPV and its mental health impacts in the specific context of Hopley.

Ethical considerations

Given the sensitive nature of the study, ethical considerations were paramount. Participants were fully informed about the study's purpose, and informed consent was obtained from participants before their participation. Confidentiality was maintained by assigning pseudonyms to participants and ensuring that identifying information is removed from the data. Participants were assured of their right to withdraw from the study at any time without negative consequences. Additionally, the study would provide referrals to support services for participants who may need assistance with IPV-related issues.

Results and discussion

The results of this study revealed a complex interplay of socio-economic and cultural factors that contributed to the prevalence of intimate partner violence (IPV) in Hopley. The findings highlighted that economic dependency, entrenched cultural norms, and limited access to resources significantly exacerbated women's vulnerability to IPV. The study identified several mental health consequences faced by women, including high levels of anxiety, depression, post-traumatic stress disorder (PTSD), and substance abuse. These findings are consistent with global and regional patterns of IPV-related effects.

The discussion interpreted these findings in the context of existing literature on IPV and mental health. This reinforces that socio-economic hardship and cultural acceptance of violence play a critical role in perpetuating IPV and its associated mental health burdens. The findings underscored the need for policy interventions that address not only the immediate safety of IPV survivors, but also the broader structural factors contributing to their continued vulnerability.

The study also emphasised the importance of developing community-based interventions tailored to the socio-economic and cultural realities of Hopley. These interventions should prioritise culturally appropriate and sustainable support mechanisms such as accessible mental health services, economic empowerment programmes, and community advocacy initiatives aimed at challenging harmful gender norms. Additionally, the results suggested that strengthening informal support systems such as peer support networks and community-based counselling could provide IPV survivors with crucial coping resources in low-resource settings like Hopley.

Contribution to extant knowledge

This study contributes to the understanding of the mental health impacts of intimate partner violence in the specific context of Hopley, Zimbabwe. By exploring the experiences of women in this community, the research provides valuable insights into the socio-economic and cultural factors that influence IPV and its mental health consequences. The findings underscore the importance of developing targeted interventions that are culturally and contextually appropriate, aimed at supporting women who experience IPV in low-resource settings. The study also highlights the need for improved access to mental health services and support systems in Hopley, to address the profound psychological impacts of IPV and enhance the overall well-being of women in this community.

Findings of the study

The findings of this study revealed that intimate partner violence (IPV) in Hopley was driven by a combination of socio-economic, cultural, and structural factors, which collectively shaped the experiences of women and influenced their mental health outcomes. Economic dependency emerged as a significant factor contributing to IPV, with many women reporting that their lack of financial independence prevented them from leaving abusive relationships. Unemployment limited economic opportunities, and the absence of formal support systems exacerbated this dependency, fostering a cycle of abuse where women remained trapped in violent relationships due to their inability to provide for themselves and their children. Cultural norms and beliefs also played a crucial role in perpetuating IPV as many women reported that societal expectations normalised male dominance and the use of violence as a way for men to assert control. Some participants shared that they had internalised these cultural narratives, believing that enduring abuse was part of their role as wives or partners, which further delayed their attempts to seek help.

In terms of mental health consequences, the study found that IPV survivors in Hopley experienced a range of psychological and emotional challenges. Anxiety and depression were the most commonly reported symptoms, with many women describing persistent feelings of fear, sadness, and hopelessness. These feelings were often accompanied by sleep disturbances, nightmares, and chronic fatigue, indicating prolonged emotional distress. Several women also exhibited symptoms consistent with post-traumatic stress disorder (PTSD), including flashbacks of violent incidents, emotional numbness, and heightened startle responses. Substance abuse emerged as another coping mechanism for some survivors, who turned to alcohol or other substances in an attempt to numb their emotional pain. However, this often compounded their vulnerability and led to further social isolation and financial strain.

Despite these challenges, the findings also highlighted the resilience and resourcefulness of the women in Hopley. Many women coped with their experiences by seeking social support from friends, neighbours, and family members who offered emotional comfort and practical assistance. Others relied heavily on spiritual practices such as prayers and participation in religious gatherings, which provided them with a sense of hope and community belonging. However, formal support services, such as counselling and mental health care, were severely limited in the area, leaving many survivors without access to professional psychological support. The absence of easily accessible legal and protective services further compounded their vulnerability, as most women felt that reporting incidents of IPV to the authorities would not lead to meaningful protection or justice.

Overall, the findings demonstrated that IPV in Hopley was both a deeply personal and systemic issue, with economic hardship, cultural norms, and institutional gaps reinforcing the cycle of violence and its mental health impacts. These results underscore the need for comprehensive interventions that address the socio-economic drivers of IPV, challenge harmful cultural narratives, and expand access to culturally sensitive mental health and legal support for women in low-resource settings.

Recommendations

Based on the findings of the study, several recommendations can be made:

i) Development of culturally appropriate interventions: There is a need for interventions that are sensitive to the cultural context of Hopley, including community-based programmes that involve local leaders and stakeholders in addressing IPV.

ii) Improvement of mental health services: Enhancing access to mental health services in Hopley is crucial. This could involve training local healthcare providers in mental health care and establishing support networks for IPV victims.

iii) Economic empowerment programs: Programs aimed at improving the economic independence of women in Hopley could reduce their vulnerability to IPV by addressing the power imbalances that often underpin abusive relationships.

iv) Community education and awareness: Raising awareness about the harmful effects of IPV and challenging cultural norms that condone violence against women is essential. Educational campaigns ought to focus on promoting gender equality and healthy relationships.

v) Strengthening legal frameworks: Advocating for stronger legal protections for IPV victims in Zimbabwe, including better enforcement of existing laws and policies, could provide women with the necessary tools to escape abusive relationships.

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Factors Affecting Adherence to Treatment among Mental Health Patients: A Case Study of Clients with Mood Disorders at the Mental Health Wellness Clinic in Harare

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Abstract

This study investigated the factors affecting adherence to treatment among mental health patients. A qualitative analysis of clients with mood disorders attending the Mental Health Wellness Clinic in Harare was conducted. The study employed the case study research design where semi-structured interviews, focus group discussions and key informant interviews were utilised to collect data from a sample of patients recruited through convenience sampling. Data was thematically analysed and organised into themes informed by the research objectives and questions. Findings from the research highlight that the patient related factors affecting adherence to treatment among the patients with mood disorders include client insight, denial and client's attitude. These are mainly attributed by the patient themselves. In addition, the study also indicated several environmental factors affecting compliance with treatment such as finance, stigma, lack of social support and religious and cultural beliefs. These can emanate from the patient's micro and macro environment. Furthermore, results from the study indicate five medical-related factors which affect compliance to treatment and these include doctor-to-patient relationship, medication side effects, treatment regimen and accessibility to mental health services. These mainly emanate from the health service provision part of the treatment process. Results also provided an opportunity for a treatment adherence model that could be used to increase compliance. Future studies on the statistical significance of such a model concerning compliance are strongly recommended.

Keywords: adherence, pharmacotherapy treatment, mood disorders, mental health.

Introduction

Various Western and Oriental researchers have conducted a myriad of studies on factors affecting adherence among mental health patients. However, this research area gets scantier when it comes to regional studies in Africa and even worse in Zimbabwe. Major psychiatric disorders, primarily mood disorders, are a rising public health concern that attribute 14% to the global burden of diseases, but the management of these disorders has been challenging mainly due to non-adherence to medical treatment (Semahegn et al., 2020). According to the World

Health Organization (WHO) (2013), psychiatric disorders represent a leading cause of morbidity and mortality worldwide, with approximately 970 million individuals suffer from a diagnosed psychiatric disorder. It is therefore important to understand the factors leading to non-adherence in order to effectively manage the treatment outcomes.

In Thailand, data from the National Epidemiology of Psychiatric Comorbidity Survey indicated that 14.3% of Thai nationals had been diagnosed with a psychiatric disorder. The most commonly diagnosed psychiatric disorders in Thailand include anxiety disorder, major depressive disorder, substance-use disorders, and schizophrenia, respectively (Department of Mental Health, 2018). In 2010, the prevalence of schizophrenia in the Thai population aged 15 to 59 years was approximately 8.8 per 1000 people (Department of Mental Health, 2018).

A study in America has estimated the rate of long-term medication therapy compliance was between 40% and 50% and it is further estimated that 50% of chronic psychiatric patients are not taking medication as prescribed after six months (Rafii, Fatemi, Danielson, Johansson & Modanloo, 2014). The study also reported that men were more likely to discontinue treatment without physician consent and that this variance may be due to socio-cultural differences (Rafii et al., 2014). Similarly, several studies on therapeutic non-compliance have been conducted in developed countries. The studies revealed that treatment in terms of compliance not only includes medication, but also diet, exercise, or lifestyle changes, therefore there is a need to explore actual factors of treatment compliance (Gebeyehu et al., 2019).

In addition, global studies have indicated that non-adherence rates among clients with severe mental illness ranged between 30% and 65% and this greatly increases the risk of illness exacerbation and hospitalisations (Gebeyehu et al., 2019). Non-adherence also has major economic cost for health services. The annual cost to the National Health Service (NHS) in the United Kingdom was estimated to be £342 million at 2009/2010 prices, with 60% of this accounted for by inpatient admissions (Young, Rigney & Shaw 2011). Medication non-adherence has serious consequences for individuals as well as the country and having psychiatric disorders often resulting in 3.7 times higher rates of relapse and exacerbation of psychotic symptoms, increased aggression and worse prognosis, more violent than adherent patients, higher hospitalisation, and poorer community adjustment (Cutler & Everett, 2010; Higashi et al., 2013).

Furthermore, psychiatric disorders are associated with several negative consequences, such as reduced individual well-being, increased family burden, and barriers to employment and financial stability (Higashi et al., 2013). Numerous psychopharmacological, psychosocial interventions, case management, problem-solving, and motivational interviewing treatments that improve patients' symptoms and overall functioning associated with severe psychiatric disorders have been identified (Higashi et al., 2013). However, uptake of and adherence to efficacious psychopharmacological approaches remain low, with only about 50% of patients with severe psychiatric disorders such as schizophrenia and bipolar disorder reporting adherence to prescribed medications and other treatments (Higashi et al., 2013).

In Africa, a study conducted in Ethiopia found that 55.2% of patients with severe mental disorders were non-adherent to their medication and therapeutic interventions (Gebeyehu et al, 2019). The study recommended continual awareness creation among professionals and engaging significant others for good social support system and continual treatment alliance is strongly commended for adherence (Gebeyehu et al., 2019). Findings from this study were in line with global non-adherence rates among patients with severe mental illness between 30 and 65% (Yang et al., 2012; Kassis et al., 2014). This finding was also consistent with a study conducted in Nigeria 54.2% and 55.7% (Ibrahim et al., 2015).

In Zimbabwe, the Global Burden of Disease Study (2017) estimates a population prevalence of 0.5% for persons diagnosed with bipolar disorder, 0.1% for schizophrenia, 0.3% for epilepsy, 1.5% for major depressive disorder (MDD), 0.7% for drug use disorders, 1.3% for alcohol use disorders and suicide accounts for 1.8% of all deaths. Compared to the southern sub-Saharan Africa region, Zimbabwe has a similar prevalence of each disorder except MDD, which is estimated to be slightly more prevalent (2.4%) across the region (Global Burden of Disease Study, 2017). This high prevalence in persons diagnosed with mental disorders in Zimbabwe is further worsened by the severe shortage of mental health practitioners, with an estimated 18 psychiatrists (17 of them in Harare) or approximately 0.1 per 100,000, 917 psychiatric nurses (6.5 per 100,000) and 6 psychologists (0.04 per 100,000) (Global Burden of Disease Study, 2017).

In this regard, there is a need for effective treatment in order to minimise straining the few health care resources available and hence it is critical to minimise the rate of non-adherence as this would in turn reduce the rate of recurrence of illnesses, pre-hospitalisation and readmissions. However, in Zimbabwe, there is scantiness of studies exploring treatment non-adherence and its associated factors among patients with mood disorders. Therefore, this study is aimed at covering this gap through assessing determinant factors affecting treatment compliance. Furthermore, it provides information for mental health care providers to utilise and make an informed decision to address the best interests of patients with mood disorders leading to effective treatment initiatives.

Background and setting

Noncompliance to psychotherapeutic and psychopharmacological treatment has been found to predict worse outcomes for mental health patients in Zimbabwe including relapse, rehospitalisation and delays in achieving remission, violence such as reported aggression and arrests, suicide, and premature death. In this regard, it is critical that mental health practitioners become aware of these factors and try to proactively support patients in order to minimise noncompliance. Patients' failure to take medication or treatment as prescribed represents a significant barrier to effective psychopharmacological and psychotherapeutic treatment (Thompson & McCabe, 2012).

Besides undesirable impact on clinical outcomes, non-compliance also causes an increased financial burden for society through excess urgent care visits, hospitalisations and higher treatment costs (Sabaté, 2003). Additionally, therapeutic non-compliance has indirect cost implications due to the loss of productivity. Hence, in order to formulate effective strategies to contain the problem of non-compliance, there is a need to systematically review the factors that contribute to non-compliance. An understanding of the predictive value of these factors on non-compliance would also contribute positively to the overall mental health sector.

No study known to the researcher has been conducted regarding adherence to treatment in Zimbabwe except for areas such as HIV & AIDS and there is limited research regarding adherence among mental health patients. In addition, literature has clearly stated that the study of factors affecting adherence forms the foundation required to come up with effective initiatives that can assist in improving adherence among mental health patients (Thompson & McCabe, 2012). Thus, this study focused on identifying these critical factors.

Objectives of the study

The following objectives guided the study:

i) To identify factors affecting compliance to treatment among mental health patients.

ii) To suggest recommendations on initiatives that can be adopted to maximise compliance.

Research questions

The following questions guided the study:

1) What factors are affecting compliance to treatment among mental health patients?
2) What initiatives or interventions can be adopted to maximise compliance/ adherence to treatment?

Methodology

Approach

The qualitative research approach was chosen to investigate and present detailed information concerning treatment adherence among mental health patients. Qualitative approach draws from interpretivist and constructivist paradigms that seek to have a deep understanding of people's lived experiences. (Denzin & Lincoln, 2011). Thus, it was most appropriate for this study to gain an understanding of underlying factors that cause non-adherence to treatment among mental health care patients.

Design

The research used the case study as a design to establish the factors that led to non-treatment adherence among mental health patients. A case study is a research strategy and an empirical inquiry of a phenomenon within real-life context (Yin, 2017). Case studies are based on an in-depth investigation of a single individual, group or event to explore the causes of underlying principles thus, making it appropriate for this study.

Population and sampling

Inclusion criteria

The study included clients aged 18 years and above who presented with mood disorders as diagnosed by the diagnostic statistical manual (DSM-5) and who were receiving treatment (medication or therapy) during the past 12 months. In addition, the study included participants of both genders irrespective of their marital status, educational level, socioeconomic status, and place of residence.

Sample

A sample of 20 participants was selected through convenience sampling. Convenience sampling is a type of non-probability sampling that involves the sample being drawn from that part of the population that is close to hand (Creswell, 2014). In this case, clients who were accessible at the clinic and available to participate in the interview and focus groups were included in the sample. In addition, this type of phenomenological research requires a minimum of between 5 to 20 participants as a sample (Sauro, 2015). Thus, the chosen sample of 20 participants was more than enough to adequately explore the phenomena in this research.

Demographic data and population characteristics

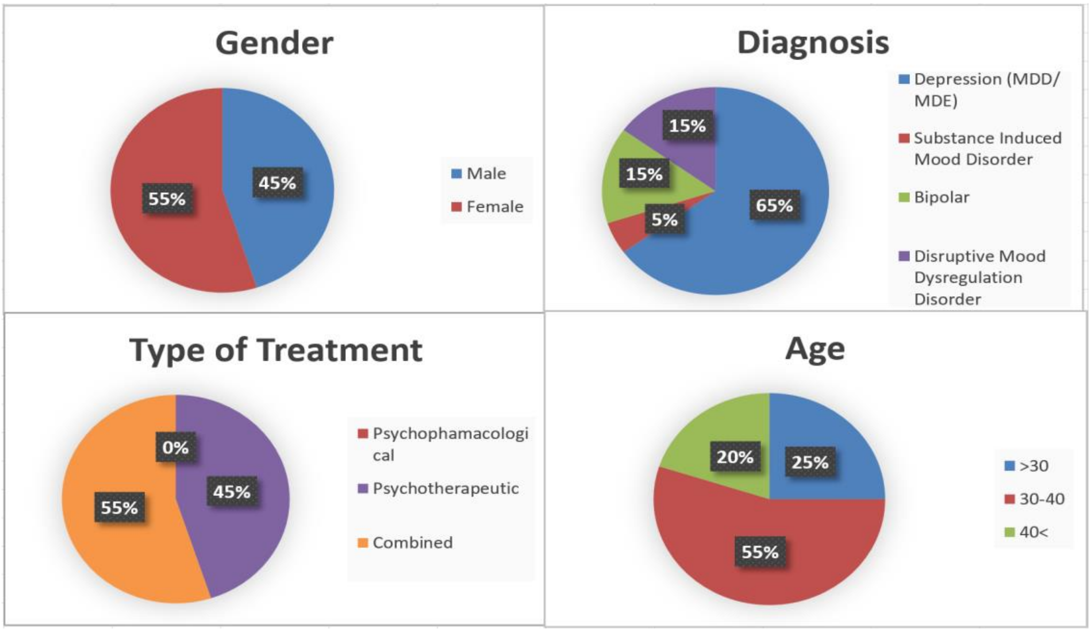

Figure 1: Demographic Data

Data collection instruments

This study used interviews and focus group discussions to understand the factors that led to non-treatment adherence among mental health patients. Creswell (2014) suggests that when conducting a case study, it is more effective to use a variety of data collection procedures or multiple information sources for reconstructing and analysing the case which include, but not limited to documents and interviews. In this regard, this study conducted both focus group discussions and interviews to investigate the experiences of diverse participants, collect multiple types of evidence, and triangulate the data. The study utilised semi-structured interview questions used as a guide during both the focus group discussions and interviews. When using semi-structured questionnaires during focus group discussions, the interviewer had a set of questions but there was room for developing ideas and questions during discussions (Creswell, 2014). In addition, key informant interviews (KII) with two critical staff members at the Mental Health Wellness Clinic were conducted to validate the findings on the objective to establish medical reasons for noncompliance.

Research procedure

Clients who had been noncompliant to treatment were identified through their case file history and the researcher engaged each participant to introduce the research and acquire their consent to participate in the research. The researcher also engaged the participants to identify the most convenient time for scheduling the focus group discussion and invite the participants to attend. The focus groups were divided into two groups of five people in each group. Information from the focus group discussions was to be consolidated for analysis.

In addition to the above, each participant took part in a 30minute interview conducted. Interviews allowed for in-depth follow ups to focus group discussions and they also allowed the researcher to capture individual factors affecting the diverse participants. Lastly, interviews were also conducted with two staff members at the clinic in order to validate the data gathered from both focus group discussions and Interviews.

Data analysis and interpretation

Qualitative research generated a wealth of data which required further processing and refinement. The data generated in this study was analysed through thematic content analysis by reading through the responses from in depth interviews and focus groups and identifying patterns across the data to derive themes. The above method of analysis was appropriate for the research design.

Results

Patient- related factors affecting compliance

Findings from the research highlighted that the patient related factors affecting compliance to treatment among the patients include client insight, denial and client’s attitude.

Client insight

Participants indicated that ignorance, inadequate understanding, poor knowledge and perceptions of the illness and medication contributed to their inability to accurately comply with treatment. One of them stated that:

> “When I went to the clinic, the doctor explained to me that the treatment will take about eight sessions (two months) and he prescribed antidepressants. However, after taking the antidepressants for 3 days, some of the symptoms disappeared and I thought I was back to normal; so, I stopped taking the medication. A few days later I relapsed, symptoms were worse than before, and I had to go back to the doctor and start the treatment all over again.”

Findings indicated that a lack of insight and perceptions about the illness can cause the clients to prematurely cease treatment or fail to get the prescribed medication. In addition, other participants indicated that they had to conduct several research studies on their own in order to get more insight regarding their diagnosis, and that is how they were convinced to adhere to treatment.

Denial

Secondly, the issue of denial was also highlighted by a few participants as a factor that affected their adherence to treatment. One participant stated that:

> "When the doctor said that I had bipolar, I couldn't believe it because I had seen several people with bipolar on TV and I did not behave the same way as they did."

In this regard, the participant did not purchase the prescribed medication until she had an intense episode that almost got her fired from work. Another stated that they did not consistently adhere to treatment appointments for psychotherapy as they had not fully accepted the diagnosis. Therefore, they only went to the clinic when necessary and; in addition to this, they did not want to consider themselves as "crazy" so they never took the diagnosis seriously. However, they sometimes went for appointment out of fear that what the doctor said could be true.

Client's attitude

Most participants agreed that their personal attitude and willingness to get better had been a major contributor towards adhering to treatment. One participant said:

> "I lacked motivation to get better as the thought of having depression and the symptoms rendered me hopeless and reduced my willingness to adhere to prescribed interventions."

Another agreed with this and indicated that:

> "I lacked commitment and did not follow the treatment regime based on how I felt at any given moment and; with depression, it's really difficult to ever feel like doing anything productive."

Thus, participants agreed that lack of internal motivation and willingness to get better was a deterrent to the treatment process and affected the anticipated therapeutic outcome and wellbeing of a client. Other participants indicated that their attitude was so bad that they sometimes forgot to take their medicine and could not make an effort to set a reminder. One participant also stated that:

> "The depression also made me paranoid; and I did not initially trust the process and that the therapist had good intentions to help me get better. So, I was sceptical and resisted getting help at first."

Thus, one's medical condition also played a part in their psychological attitude towards life and treatment.

Environmental factors affecting compliance

Findings also indicated several environmental factors affecting compliance to treatment such as finance, stigma, lack of social support and religious and cultural beliefs.

Economic circumstances

Participants indicated that not being financially stable and one's socioeconomic status had an impact on adherence to treatment. Feedback from focus group discussions revealed that participants paid $60 for an hourly session with the mental health service provider and those with medical aid had shortfalls of up to $30 per session. On top of this, those going through combined treatment procedures, which included both medication and therapy also needed money to purchase the relevant drugs for their treatment. One participant indicated that this made his family "less cooperative in their supporting role during the treatment plan as they felt it was too expensive and this affected his ability to attend all prescribed therapy sessions." Another participant indicated that:

> "I am completely dependent on family for everything so sometimes I could not turn-up for sessions because there was no money for paying for the session or even for bus-fare to find transport to attend the session."

Findings indicated that this was one of the top issues raised by most participants as a hindrance to their ability to adhere to treatment due to their socioeconomic status, lack of resources and being unable to afford the cost of medicine.

Stigma

Most participants raised the issue of stigma as one of the environmental factors affecting adherence. Participants highlighted that there was a lot of stigma associated with mental health issues which made it difficult to even tell people that one is in therapy for a mental health condition. One participant stated that:

> "People think that visiting the psychologist automatically means that you are now mentally incapable of making your own decisions and this is embarrassing."

Another participant added that:

> "Society does not accept that black men should seek therapy; and this made it difficult to openly disclose resulting in some appointment being missed as I ran out of excuses to give to explain my absence from work."

Thus, several clients missed appointments because of the fear of being socially ostracised. Some participants also discussed that hiding their diagnosis helped them in their effort to maintain their dignity. Such participants indicated that they even hid their diagnosis from their partners for fear of how it would impact on their relationship and their perception of them. This affected their adherence as they could not take the medication when the partner was around. In this regard, their fear of what the community would say and the fear of being rejected affected their ability to consistently adhere to medication.

Lack of social support

Lack of social support was the main factor that affected the majority of participants in one way or another from adhering to medication. Participants accentuated that the availability of support in the form of family, friends, or caregivers to assist and remind them about their medication increased their ability to comply with treatment. However, when this support is not available, it has an opposite effect towards their adherence. One participant indicated that:

> "Outside therapy there was no one to share my struggles and this made me resign."

This indicated that failure to receive extra support made the client eventually quit the treatment process. Another participant added that:

> "I now stick to my medication because my dad used to remind me to take my medication; and now, I remember on my own."

Thus, this client managed to change their adherence with the help of family support.

However, findings also showed that if the home environment is not supportive, this could lead to non-adherence as one participant stated that:

> "My toxic home environment perpetuated my depression and made adherence difficult even just simply turning up for my sessions was hard."

Thus, continuous exposure to social or home environments that triggered the condition under treatment made it difficult for participants to remain committed to their treatment regimen. Another participant also added that:

> "It was difficult to adhere to treatment when I was staying in Chitungwiza because I always found myself hanging out with the people I used to abuse drugs with; so, I would do the same and miss my medication and felt embarrassed to turn up for the sessions. Eventually, I moved location so as to be on track with my treatment."

Thus, positive or negative influence from the client's family or social structure have an impact on adherence. Participants also indicated that some families in the case of severe mental illnesses such as severe bipolar or depressive episodes may intentionally or unintentionally give incorrect dosages of medication. One participant realised this whilst doing a pill count after a series of severe episodes. In addition to the above, criticism from friends, work pressures, family pressures have a bearing on the ability for one to receive support that fosters treatment adherence as some workplaces may not allow you to attend sessions during working hours. Thus, having a negative bearing on the client's ability to adhere to treatment.

Religious and cultural beliefs

Participants also indicated religious and cultural beliefs as one of the factors affecting adherence. During focus group discussions, participants indicated that some families encouraged prayer and exorcism as a solution to their challenges and refused to believe the doctors' diagnosis. One participant indicated that, after getting the diagnosis, the family concluded that, instead of wasting money on expensive therapy sessions and medication, they would take the client to a prestigious church for exorcism. However, the symptoms did not disappear; and they eventually followed the treatment regimen even though some of the family members were still opposed to it. In addition to the above, participants indicated that some of their family members associated mental health issues with witchcraft hence sometimes they were forced to hide their condition from them.

Medical-related factors affect compliance

Findings from the study indicated four medical related factors that affect compliance to treatment; and these included doctor to patient relationship, medication side effects, treatment regimen and accessibility to mental health services

Practitioner - client compatibility

Participants indicated that effects of non-adherence to treatment could be caused by practitioner and client compatibility. They indicated that it is important for mental health practitioners to avoid making a client feel like a pay check to the medical practitioner as genuine interest in the client's life is not expressed or felt, either causing the client to stop treatment all together or prolonged illness. In addition to this, participants also highlighted that the practitioner's lack of patience, poor interest and follow up may cause the client to stop treatment. Thus, failure to achieving a personal relationship with health care providers could lead to non-adherence to treatment.

Medication side effects

Findings from the study indicate that it was of great concern to some participants and their families that medication had side effects that might affect their everyday life. Some participants highlighted that they became overweight, others felt drowsy and indolent the whole day, which led them and their families to perceive the medication as harmful for them. Thus, participants were worried more about the side effects of medication and disregarded the drugs' effectiveness. Other side effects experienced by participants included agitation, restlessness, tremors, feeling jittery, irritability, sedation, feeling sleepy, difficulty in thinking or concentration, dizziness, nausea, dry mouth and constipation. One participant stated that:

> "I was sceptic about the medication after reading about the side effects of the medication and skipped some of the doses."

In addition, some participants also indicated that they were scared of getting addicted or over becoming dependent on the medication; and were therefore not willing to regularly take tablets. In this regard, the negative side effects experienced by clients affected their willingness to regularly comply with the treatment. Some of them did not experience the symptoms, but researched on them from the internet and became sceptics.

Accessibility to healthcare services

Participants indicated that accessibility to healthcare service providers was also another factor contributing to adherence. They indicated that they were no mental healthcare facilities in local clinics or close to most residential areas and they had to travel to the central business district for appointment and to access medication. This could be a financial burden as well as an inconvenience. In addition, some of the prescribed medications were sometimes either not available or too costly for clients, which prolonged treatment plan or disrupted their ability to comply with the doctors' instructions. Other participants indicated that sometimes the prescribed medication was not available in pharmacies that accept the client's medical aid provider. This meant that they had to pay cash even when they had a valid medical aid. Furthermore, participants indicated that most practitioners were only available during working days and working hours and this sometimes made it difficult to attend sessions if one was not excused from work during the specific time they were booked for their appointment. Hence, one participant indicated that they failed to adhere as:

> "Appointment times just could not align with my work schedule."

Treatment regimen

Complexity and length of treatment regimen was another medical related factor that participant indicated as affecting adherence. Participants indicated that knowledge of how to take medicine, duration of treatment period could cause one to defer treatment. One of the participants stated that “the medication and session take a long time to complete and show results making it easy to sometimes skip sessions or taking medication”.

Lack of social support

Findings from both interviews and focus group sessions indicate that, lack of social support was the most influential factor that was highlighted by almost every participant during the one-on-one interviews. It was also highlighted in all focus group discussions and almost all participants had an experience with this factor. This was followed by the issue of medication side effects. All participants who were on psychopharmacological treatment mentioned the issue of side effects as a cause for their non-adherence and some of them did note take their medication regularly as a result. The third highest ranking factor was that of economic circumstances. Most participants indicated that the cost of the sessions and medication sometimes forced them to abscond from taking the medication until they were financial able to do so and sometimes without informing the doctor.

Discussion

Findings from the research highlight that the patient related factors affecting compliance to treatment among the patients include client insight, denial and client’s attitude. These three factors may seem different; but, in a way, they are interrelated as adequate knowledge and understanding about the diagnosis not only increases client insights, but it also influences clients in denial and might even affect the client’s attitude towards the treatment process. These findings are aligned to findings from the literature which states that, patients who had no insight into their disorder and treatment were significantly associated with medication non-adherence (Gebeyehu et al., 2019). This result is also similar to the study reported in India that suggested that patient insight in their illness leads to ease of acceptance of treatment initiatives (Maan, Hussain, Heramani & Lenin, 2015). Thus, the presence of insight towards the disease and their treatment plays an important role in medication adherence. Research also states that awareness of illness among mental health patients is widely related with two theories; and these are lack of awareness caused by psychological defence mechanisms as a form of refusal to face the perceived illness, or the presence of cognitive disorders that prevent them from understanding their illness better, especially in bipolar or depression (Amador et al., 1991). This aligns with results from the study as participants also indicated denial as a factor that affected their ability to comply with treatment.

In addition, several studies also found that an unhealthy or negative attitude towards treatment is one of the factors causing non-adherence to treatment of mental health issues and this could be resolved by psychoeducation (Sajatovic et al., 2021). Thus, knowledge and awareness can be effective motivators in the case of patience with bipolar or depression and can influence both client insight and attitude.

In addition to the above findings, the study also indicated several environmental factors, such as finance, stigma, lack of social support and religious and cultural beliefs, that affect compliance to treatment. These findings show that over and above the client related issues, there are also factors that can emanate from the client's micro and macro environment that could affect the client's ability to adhere to treatment procedures. This also aligns with results from past studies that revealed that economic circumstances, availability of health insurance, sustainable financing and affordable prices are also environment related factors that have been identified to affect adherence amongst mental health patients (Chukwujekwu & Adesokun, 2017). In this regard, the homeless, unemployed and poor patients with unstable economic circumstances live in an unfavourable environment that mitigate adherence to treatment.

In addition to this, the issues of religion and culture that were highlighted in this study were also identified as obstacles to compliance. Participants indicated that this stems from different ideologies and environments as some religious sects in Zimbabwe do not allow their members to seek medical attention regardless of their health condition or mental disorder. Other religions believe in exorcism of mental disorder as they perceive the patients as victims of demonic possession. In other cultures, they believe that mental disorders could be witchcraft. This is also in line with studies that established that there is a significant relationship between spiritual well-being and medication adherence in individuals diagnosed with mental disorders (Sajatovic et al., 2021).

Furthermore, findings also illustrate that for the effective provision of care for mental health disorders, it is necessary that the patient, the family and the community who support him or her also play an active role. Social support received by patients from other members of their community was consistently reported as an important factor affecting health outcomes and behaviours. Studies also show that there is substantial evidence that peer support among patients can improve adherence to therapy while reducing the amount of time devoted by the health professionals to the care of chronic conditions (Sabate, 2003)**.** Furthermore, regarding social support, a study by Gebeyehu et al. (2019) highlighted that participants who had no social support were significantly associated with non-adherence. This finding was supported by Chukwujekwu and Adesokun (2017) who reported in their study that social support provides the cue for patients to take their medication on time as it minimises fear, burden and anxiety related to the illness, especially for the elderly patients who need constant reminders.

In addition, lack of social support was revealed as the main factor that inhibited the majority of participants from adhering to medication in this study. Findings from the focus group discussions and interviews indicated that this factor had a direct effect on most of the other factors such as economic factors, denial, clients' insight, religious and cultural beliefs. Social support is therefore one of the most critical factors that could either negatively or positively affect adherence. In this regard, even though the client might not have insight, family members may be able to find ways to assure that patients take their medication through various interventions, and this also applies to religious beliefs. In terms of economic circumstances, families and communities could come up with several ways to assist patients to access their medication, and some may assist with transportation to sessions. Some companies even pay medical insurance for their employees thus providing the much-needed social support to patients.

Findings from the study indicate four medical related factors that affect compliance to treatment, and these include doctor to patient relationship, medication side effects, treatment regimen and accessibility to mental health services. Correlational studies have also revealed positive relationships between adherence of patients to their treatment and provider communication styles characterised by providing information, "positive talk" and asking patients specific questions about adherence by (Chukwujekwu & Adesokun, 2017). Thus, clarity of diagnostic and treatment advice has a positive effect on adherence to treatment initiatives. Other important factors that positively correlated with adherence were continuity of care (follow-up) after receiving a prescription, warmth and empathy of the health provider as well as the ability of the health providers to share information, build partnerships, and provide emotional support (Maan, Hussain, Heramani & Lenin, 2015). In addition, patients who are satisfied with their health provider and medical regimen and view themselves as partners in the treatment process and are actively engaged in the care process, have better adherence behaviour and health outcomes (Sabate, 2003). Findings such as these can guide providers to create a treatment relationship that reflects a partnership with their patients and supports the discussion of therapeutic options, the negotiation of the regimen and clear discussion of adherence (Maan, Hussain, Heramani& Lenin, 2015). Thus, more structured, thoughtful and sophisticated interactions between provider and patient are essential if improvements in adherence are to be realised. The issue of side effects was also a major issue raised in the study. This is because the perceived side effects have an impact on the activities of daily life of people with bipolar and depression. This issue was raised by participants going through both psychotherapy and psychopharmacological treatment because of the drugs they were required to take. Clients also react differently to the drugs hence the psychiatrist is only able to adjust or prescribe alternative drugs after clients have already experienced side effects and this becomes one of the determinants of treatment adherence.

Conclusion

In summary, findings from the research highlight that patient related factors affecting adherence to treatment among the patients with mood disorders include client insight, denial and attitude. These were mainly attributed to by the patient themselves. In addition to the above findings, the study also established several environmental factors affecting compliance to treatment such as finance, stigma, lack of social support and religious and cultural beliefs. These could emanate from the patient's micro and macro environment. Furthermore, findings from the study identified four medical related factors that affect compliance to These included doctor to patient relationship, medication side effects, treatment regimen and accessibility to mental health services. These mainly emanate from health service provision part of the treatment process.

Recommendations

First, there is a need for intense psycho-education with clients and ensuring acknowledgment of diagnosed condition by client; a personal connection and open relationship between health care provider and client and commitment from clients to prescribed treatment plan by health care provider and pharmacist would eliminate some of the patient related factors affecting adherence. The client's personal efforts to achieve normal living through advice of medical practitioners, as well as a safe, healthy, nurturing and supportive environment surrounding the client for their future wellbeing is also important. Educating clients about the pros and cons of the medication and adequate information on how to take drugs is also important during psychoeducation. In addition to this, it is critical to educate the patient on the nature of their diagnosis and what to expect in terms of symptoms.

Furthermore, social support is critical in ensuring that clients did not forget to take medication and it is important for health practitioners to involve family members when prescribing and explaining treatments so that they can effectively support clients. This ensures that the client receives assurance, emotional support and monitoring when necessary.

Furthermore, there is a need for increased awareness on the importance of mental health and available support structures. Continuous engagement of clients through digital platforms and tracking applications that update the doctor or client's family is also necessary. It is also necessary to empower and educate people in their local communities about mental health issues so as to stop the stigma and to assist them to support those community members with mental health challenges. This approach would assist to break the stigma such that mental health illnesses could be viewed as normal illnesses. Furthermore, mental health services and medication should be made available even to the poorest of people so as to increase access. There is also a need to ensure medical aid service providers cover all consultation fees without shortfalls.

In order to identify factors that strongly predict compliance and design a scientific model that could assist mental health care practitioners to proactively curb any possibilities of noncompliance, future quantitative studies on the relationship between these factors and compliance among mental health patients are therefore recommended.

Intervention model

Patient's insight and attitude +Medical Related Support + Favourable environmental factors + Social Support = Increased Rate of Compliance

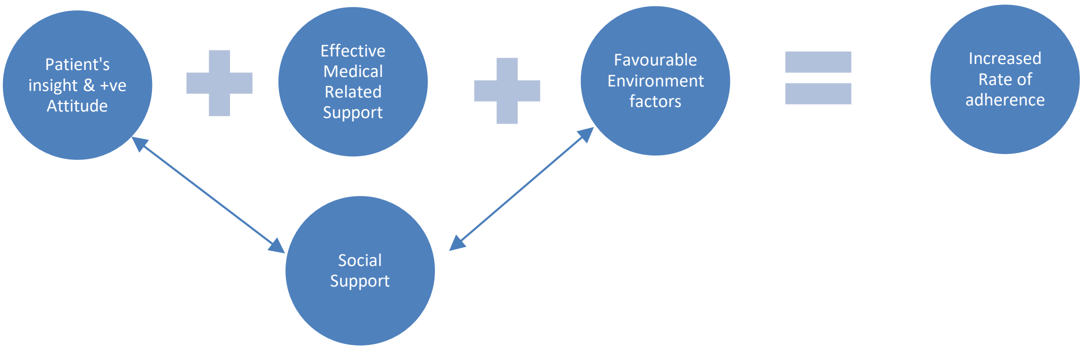

Figure 2: Intervention model

It is clear from the findings of the study that each factor above contributes in its own way toward increasing the rate of compliance from the clients that participated in the study. A combination of all 3 factors ensures that the client would receive adequate support. It is also critical to separate social support from the factors above as the study presented that it was a recurring and most influential factor. Findings also showed that most patient related, and environmental related factors can be positively influenced by an effective social support structure. However, there is a need to do a quantitative study of the factors presented in order to scientifically measure the extent to which they are correlated to compliance.

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Psychosocial Needs and Coping Strategies of the Displaced Community of Tokwe-Mukosi

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Abstract

This qualitative study investigated the psycho-social challenges and basic physical needs of individuals displaced by the Tokwe- Mukosi dam disaster. Fourteen participants, evenly split between genders, were purposively sampled from Nuanetsi in Mwenezi and the Chingwizi transit camp. Using a qualitative exploratory descriptive design, the researcher employed semi-structured interviews to gather data on pre-evacuation, evacuation, and post-evacuation experiences. Thematic analysis was utilised to identify key themes from the transcribed interviews. Findings revealed that the displaced individuals faced significant challenges, including loss of economic resources, water, and housing, leading to feelings of vulnerability, marital issues, and fear. Coping strategies utilised by the community of Tokwe-Mukosi included the social support, coping as a family, acceptance of fate, optimism and alcohol use in trying to adapt to the situation. The paper highlights the urgent need for psychological support and government involvement in disaster preparedness plans to aid recovery and resilience among the affected populations.

Keywords: Tokwe-Mukosi, displacement, psycho-social needs , coping strategies, disaster

Introduction

In recent years, the number of forcibly displaced populations has risen dramatically. Global forced displacement, which includes refugees, internally displaced persons (IDPs), and asylum seekers, reached 65.5 million in 2016 (UNHCR, 2016). This figure increased to 70.8 million in 2018 (UNHCR, 2018) and continued to grow, reaching 79.5 million displaced individuals worldwide in 2019 (UNHCR, 2019). The Tokwe-Mukosi dam disaster in early 2014 serves as a stark reminder of the significant impact that natural disasters could have on communities. Heavy rains and subsequent mudslides resulted in the evacuation of approximately 2500 families, disrupting their lives and causing substantial material and emotional losses. The United Nations Children Fund (2014) reported that about 26% of affected households were relocated, yet many remained in temporary shelters, facing dire conditions. This study sought to explore how these individuals experienced their displacement and the psychological effects that ensued. The research was guided by the following objectives:

i) To establish the reasons for displacement of the Tokwe-Mukosi residents

ii) To explore and identify the key psychosocial needs of the displaced individuals from Tokwe-Mukosi

iii) To examine coping strategies employed by the displaced community in response to their circumstances,

iv) To explore emotional impacts of displacement on individuals

Literature review

Reasons behind displacement of people

The psychosocial needs and coping strategies of displaced communities are profoundly shaped by the socio-economic and political challenges they face. Events such as the Tokwe-Mukosi Dam disaster lead to significant social distress, adversely affecting both livelihoods and mental well-being. Notably, the Tokwe-Mukosi displacements starkly highlighted Zimbabwe's deficiencies in disaster preparedness, suggesting that the country has been increasingly vulnerable to displacements in recent years. Hove (2016) argues that the flood victims of Tokwe-Mukosi effectively became victims of the state due to the Zimbabwean government's failure to provide adequate support following the disaster. However, this perspective is disputed by the International Peace Institute (as cited in Chendume (2016)), which avers that "no country is immune from the forces of nature". Nonetheless, the Zimbabwean government's response to the needs of those displaced by the Tokwe-Mukosi floods has been widely perceived as inadequate (Human Rights Watch, 2015; OCHA, 2014).

Forcibly displaced individuals encounter trauma stemming from war, natural disasters, and human rights abuses, in addition to issues such as family separation, food insecurity, inadequate shelter, and health risks (Sahin et al., 2021). Historical examples in Zimbabwe, such as the construction of Lake Kariba and the Osborne Dam, further underscore the enduring impacts of forced relocation. Approximately 57,000 Tonga people were displaced with minimal compensation, disrupting their traditional lifestyles (Terminski, 2013).

Various classifications have been employed in studies, including internal displacements (Mooney, 2005), climate-induced displacements (Cohen & Bradley, 2010), dam-induced displacements (Terminski, 2013), development-induced displacement (Smith, 2001), and mining-induced displacement (Downing, 2003). Nonetheless, these classifications are generally linked to the underlying causes of displacement. The Tokwe-Mukosi displacements can be categorised as disaster-induced displacements. Rusvingo (2014) identifies the Tokwe-Mukosi displacements as disaster-induced, particularly following the Zimbabwean government's declaration of the floods as a national disaster in February 2014.

The Osborne Dam project, for instance, relocated about 700 families to remote areas without offering future benefits (Chiri, 2011; Nhodo et al., 2020). Similarly, the Gwayi-Shangani Dam project displaced communities without providing any direct advantages (Chiri, 2011). While existing literature addresses specific displacement cases, there remains a notable gap in comprehensive studies that examine the cumulative socio-economic effects of various dam projects in Zimbabwe. Furthermore, qualitative accounts of the experiences of displaced individuals are often lacking, thereby limiting our understanding of their challenges.

Psychosocial needs

Displaced individuals frequently endure heightened stress and trauma, which could result in post-traumatic stress disorder (PTSD). Sandhya (2024) emphasises the urgent need for mental health interventions to address these challenges. The emotional consequences often include anxiety and depression, highlighting the importance of comprehensive mental health care.

Social support systems are vital for fostering resilience, as they provide essential emotional and practical assistance (Nhodo & Ojong, 2023). In the absence of these supports, displaced persons may experience isolation and distress. Jayakody et al. (2022) observe that inadequate access to basic necessities such as housing, food, and healthcare further exacerbates insecurity and marginalisation. The lack of suitable relocation sites has led to human rights violations, intensifying feelings of insecurity and loss (Chendume & Tarisayi, 2023).

Moreover, there is a significant deficiency in adequate mental health services, with many individuals unable to obtain the necessary support (Bader et al., 2009). The focus on physical needs often overshadows mental health, resulting in unmet psychosocial requirements (Kaiser et al., 2020). Conversely, while the emphasis on mental health is crucial, some argue that immediate physical needs, such as shelter and food, should take precedence in humanitarian responses, as these are foundational for any subsequent psychosocial support to be effective.

Coping strategies

Despite facing considerable challenges, displaced individuals exhibit impressive resilience through various coping strategies. Nhodo and Ojong (2023) emphasise the emergence of new local institutions that promote community support and resilience. The community engages in collective efforts to address their needs, fostering a sense of solidarity and shared purpose (Nhodo & Ojong, 2023). Conversely, while local coping strategies are vital, the overarching lack of state support and inadequate housing solutions can hinder long-term recovery and resilience, perpetuating cycles of vulnerability and marginalisation (Jayakody et al., 2022). These institutions assist individuals in collectively addressing their challenges and strengthening social ties. Due to resource scarcity, many displaced people adapt their livelihoods by moving from traditional income sources to alternative survival methods like market gardening (Chendume & Tarisayi, 2023). Participation in community activities and maintaining social connections help alleviate the psychological effects of displacement, as noted by Salihu et al. (2024). However, there is a noticeable lack of empirical research assessing the long-term effectiveness of these coping strategies and how cultural factors shape them in diverse displaced communities.

Emotional impacts of displacement

The emotional consequences of displacement are significant and complex, often leading to PTSD, anxiety, and depression. Bodvarsdottir and Ellikit (2004) noted that survivors of the Iceland earthquakes experienced high rates of PTSD, highlighting the lasting psychological effects of such disasters. Similarly, Sandhya (2024) opined that displaced individuals experience heightened levels of stress and trauma, often leading to post-traumatic stress disorder (PTSD). The construction of the dam led to the disintegration of family ties and cultural values, further intensifying feelings of loss and grief among the displaced (Mutangi & Mutari, 2014). The reliance on local institutions for support highlighted the emotional strain and the need for community resilience in the face of marginalisation (Nhodo & Ojong, 2023).

Conversely, while the emotional impacts of displacement are predominantly negative, some individuals may find new opportunities for community building and resilience through collective action and support networks, which can foster a sense of agency amidst adversity.

This review focuses on the psychosocial needs of displaced individuals, their coping strategies, and the emotional ramifications of displacement. However, existing studies often overlook the differences in emotional impacts across demographics like age, gender, and socio-economic status. Moreover, longitudinal research tracking the emotional health of displaced individuals over time could yield important insights into the enduring effects of displacement.

Theoretical framework of disaster literature

Farberow (1978) identified four emotional phases individuals experience after a disaster: heroic, honeymoon, disillusionment, and reconstruction. Understanding these phases could guide effective mental health interventions and community support strategies in the aftermath of a disaster. These phases are also crucial for understanding family reactions and coping strategies in the Tokwe-Mukosi community.

In the heroic phase, community members were engaged in altruistic efforts to save lives and property, fostering strong communal bonds. The honeymoon phase, lasting from one week to six months, saw the community unite in hope and shared experiences, enhancing resilience.

However, the disillusionment phase, lasting up to two years, brought disappointment as promised aid faltered, potentially weakening communal ties. Finally, the reconstruction phase encouraged individuals to take responsibility for rebuilding their lives, promoting renewed unity and emotional support.

By linking Farberow's emotional phases to the experiences of the Tokwe-Mukosi community, we can better understand their psychosocial needs and coping strategies. Each phase provides valuable insights into the emotional landscape of displaced individuals, highlighting the importance of community support, mental health interventions, and realistic expectations in the aftermath of a disaster.

Methodology

The study employed an exploratory descriptive research design to investigate the challenges and coping strategies of displaced individuals from Tokwe-Mukosi. This design was chosen for its flexibility in examining various aspects of the participants' experiences. A purposive sampling method was used, involving fourteen participants aged 25 to 90, who were primarily from professional backgrounds such as farming, teaching, trading, building, and fishing. The participants were evenly split between males and females. Semi-structured interviews were conducted, with the interview instrument initially developed in English and translated into

Shona. The interview guide covered pre-evacuation, evacuation, and post-evacuation experiences. Ethical clearance was obtained, and participants provided informed consent, ensuring confidentiality and clarity regarding data handling. Thematic analysis was employed to identify and group the data into meaningful themes and subthemes. Figure 1 shows the map of Tokwe-Mukosi.

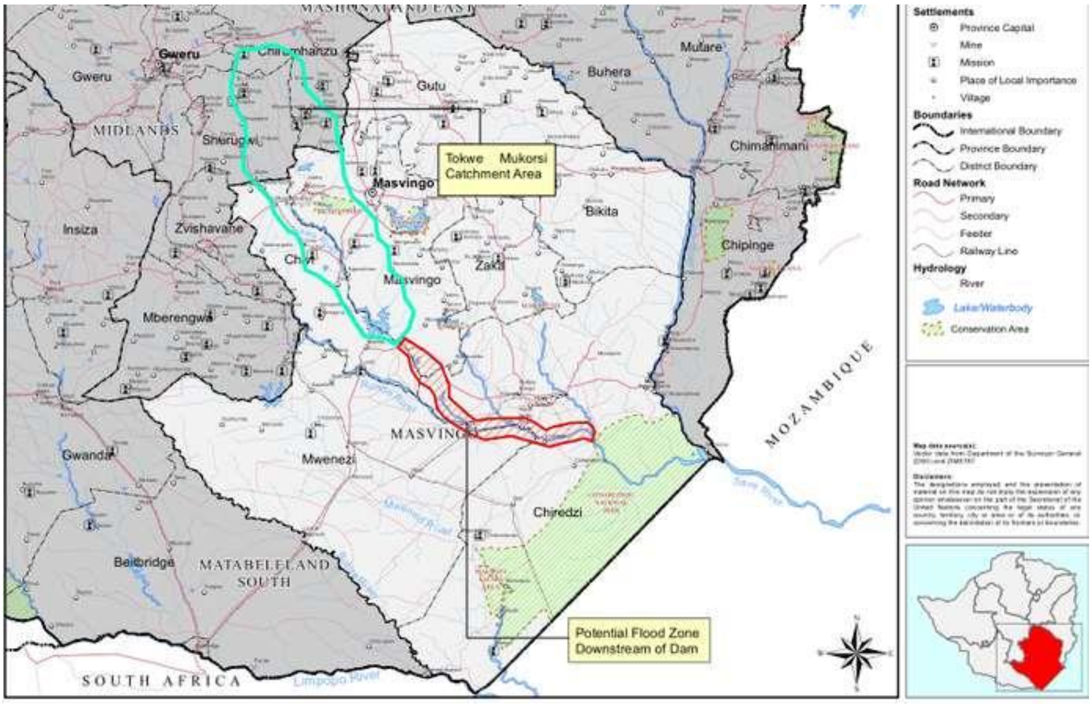

Figure 1: The map of Tokwe-Mukosi

Source: UN Office for the Coordination of Humanitarian Affairs (2014)

Findings

Reasons for displacement of Tokwe-Mukosi

The displacement of the Tokwe-Mukosi community exemplifies how natural disasters and human actions could dramatically disrupt lives. Severe flooding from heavy rains devastated their homes and uprooted many residents, exposing their vulnerability to environmental changes. Additionally, government decisions regarding forced evacuations intensified the crisis. Many individuals shared their painful experiences, highlighting the combined effects of natural calamities and man-made policies on their situation.

Natural disasters as a primary cause of displacement

Flooding

A 38-year-old female participant shared:

> "I woke up, my house now full of water and it looked like a swimming pool. I thought it was a dream but it was real. The floods had been caused by the heavy rains."

Nature's power

A 50-year-old male teacher recounted:

> "We were left shocked, but we could do nothing; it was a disaster at level 12. We were not anticipating such catastrophic results, but we can't stop nature**.**"

Government role and accountability

Man-made displacement

A 56-year-old widow recounted:

> "In March 2014, I saw people rushing with their belongings. Our community had earlier refused to leave, but the government sent troops, and we were forced out of the village."

She further reflected on the abruptness of the relocation*:*

> "We did not know that one day we would be displaced because of that peg made by the government"**.**

Psychosocial needs of the displaced individuals from Tokwe-Mukosi

Loss of economic resources

Participants reported significant losses in livelihoods, including property, crops, and financial stability. This economic strain heightened feelings of vulnerability and anxiety about the future. Participants described severe food and housing insecurity following the floods. A 39-year-old woman from Zunga village shared her despair:

> "The floods came and destroyed all what I considered basic... I was left insecure, crying... What were they going to eat?"

She highlighted her distress over losing everything except the lives of her children.

Health insecurity

The lack of adequate health facilities left residents vulnerable to diseases, particularly cholera. A 78-year-old headman reported that:

> "A lot of people died of cholera at Chingwizi especially children."

He noted the inadequacies of local clinics, stating:

> "Most of the clinics just give injections... there are no proper toilets."

Water and housing insecurity

Many participants lost access to clean water and adequate housing, leading to further health risks and instability in their living conditions. A 25-year-old woman lamented:

> "When we lived at Tokwe-Mukosi, we could easily fetch water... Now it is different; the place is not habitable, water that is available is salty."

A father of four described the struggles at the camp:

> "A lot of trucks filled with water from UNICEF came... After many hours of waiting, you could only get 5 litres... Sometimes we sacrifice having a bath because there is no water."

Financial insecurity and marital problems

Many participants reported financial instability due to the loss of property and livelihoods. A former fisherman lamented the loss of his source of income after being displaced from the dam. Farmers who once thrived on agriculture found themselves without land. A 57-year-old farmer expressed despair, saying:

> "I'm left with nothing that marks my humanity. Promised compensation has not materialised. My cattle have died or were lost during evacuation, and we urgently need financial assistance to rebuild our lives."

At Nuanetsi Ranch, a 35-year-old woman observed an increase in marital issues, saying:

> "We have seen many marriages breaking down here due to infidelity. One neighbour was caught sleeping with a young girl, and it's clear this place fosters immorality."

A 28-year-old builder added that poverty led to frequent arguments with his wife, especially over food, stating:

> "Life is hard; if we were given plots of land, it might ease family tensions. Without help, many couples will divorce, often staying together only for the children."

Destruction of property and resources

One widow continued:

> "Those who were building the dam began to let the water out, which caused us to be relocated because our houses, cattle kraals, and our farming plots had been washed away."

Educational disruption

The headmaster expressed his concerns:

> "I was now anxious about being transferred to a school I imagined with new people. Were they going to understand me?"

Coping strategies

The victims of Tokwe-Mukosi employed various coping strategies, including social support, resilience, acceptance of fate, family unity, alcohol use, and optimism. These strategies were essential for adapting to the challenges they faced during the impact, evacuation, and post-evacuation phases.

Social support

Many participants highlighted that social support was the most crucial strategy for adapting to the challenges of displacement. This support came in various forms, including tangible resources like food, clothing, tents, transportation, and drinking water. Intangible support included emotional comfort and uplifting messages from churches. Out of 14 individuals interviewed, eight favoured social support.

A 70-year-old widow noted how social support was vital:

> "Transport provided by NGOs and the Red Cross helped us move from flooded areas to relief camps. I am grateful to fellow Zimbabweans who united to offer food aid and tents for shelter against bad weather during the rainy season. The churches also provided emotional comfort that instilled hope in us."

A 34-year-old male trader reflected:

> "I lost my house, cattle, and customers. For three months, I felt dead inside. However, the Roman Catholic Church came to our aid with food, water, and emotional support. Their prayers transformed my mindset, helping me and my family recover gradually. A group of musicians also sang songs that inspired us; I can now laugh with my family and neighbours."

A female participant addressed a sensitive issue:

> "We are thankful to the group from Bulawayo called the Makosi Extra for bringing us sanitary pads. Life was tough; some had resorted to using tree leaves."

Resilience

The study found that participants demonstrated resilience, largely due to their personalities and socialisation, with religion playing a significant role in teaching them to endure tough situations. A 40-year-old former farmer stated:

> "If you don't work hard here in Chingwizi, poverty will worsen. My father taught me to be strong, and I must 'sweat blood' to provide for my family. The

> Tokwe=Mukosi floods challenged us to be strong. As a Christian, I believe we must be resilient in difficult times."

A 34-year-old single mother echoed this sentiment:

> "As a single woman, I must be strong. Sometimes, I have to act like a man. When we received food rations, some tried to take them from us, but I stood my ground. I learned to be tough during my time as a trader in Tokwe-Mukosi."

Coping as a family

The research highlighted that individuals with extended families coped better during difficult times. Families offered both emotional support and practical aid like food, shelter, and transportation. One female respondent shared:

> "With my mother-in-law and my husband's younger brother, we helped each other transport food, belongings, and livestock when the disaster struck. Being part of a family reduces panic compared to facing the situation alone. Here in Chingwizi, we are united and share our experiences, providing comfort to one another."

Alcohol use

In challenging times, some respondents turned to alcohol as a coping mechanism. They argued that drinking provided an escape from their problems. A 70-year-old man remarked:

> "Don't judge people for drinking beer; it's a way to cope. We are fortunate to have a businessman selling beer for just two dollars. When we drink together, it lifts our spirits and helps us comfort one another."

Accepting fate

Five participants expressed that they felt powerless against the floods and had no choice but to accept government evacuation orders. An elderly woman with poor eyesight stated:

> "They left us here to suffer in Chingwizi. What can we do? Nothing! Can we force them to help us if they refuse? We will survive with what we have, and if we die, that's the end."

Two women mentioned their desperation:

> "We had to use tree leaves as sanitary pads because we couldn't afford cotton wool."

Optimism

When asked about their future, many participants expressed hope. A male trader stated:

> "If God allows me to live, I know all this will pass, and I will have my own place again. I lost my house and belongings, but I will work hard to acquire something better."

These coping strategies reflect the resilience and adaptability of the Tokwe Mukosi community in the face of adversity.

Emotional impacts of displacement on individuals

Trauma and loss

The teacher described how the floods left a painful mark on him:

> "I was pained to see my four-roomed house left submerged in water."

This aligns with Bodvarsdottir and Ellikit's (2004) findings that survivors of natural disasters, such as the Iceland earthquakes, often suffer high rates of PTSD, indicating a deep-seated psychological toll that extends beyond the initial event.

Shock and disbelief

Another participant, reflecting on the aftermath, stated:

> "Imagine being forced to flee from your original place to another place you don't know because of a natural disaster. I thought that was the end of me."

Bereavement

The displacement experienced by the community not only led to food shortages, but also resulted in the loss of lives, particularly among the young. A 58-year-old widow, who was a farmer and had two children, tragically lost her youngest child, a 5-year-old, due to a snake bite. She expressed that her daughter was her only source of comfort, and seeing her picture brings her to tears. Nevertheless, as a Christian, she finds solace in surrendering her troubles to God.

A 28-year-old builder recounted the loss of his uncle, who died as a result of violence at Chingwizi. He stated:

> "I lost my uncle, my only relative. He was injured during a stampede at Tokwe-Mukosi when a large group protested against the camp officials. Despite my help in getting him to the hospital, he did not survive. I still feel bitter about his painful death; it lingers in my memory."

Another respondent, a 56-year-old man, shared a heart-breaking experience:

> "The flood came and washed away the graves of our loved ones. Whenever I look at this lake, I think of my father, mother, and wife. I will never be able to visit their graves again."

Anticipation and uncertainty

Fear of the future

Participants shared their worries about future displacements*:*

> "We were given a warning to seek transfer letters all of us. I was scared of what was to come."

Discussion

Reasons for displacement

The Tokwe-Mukosi Dam disaster illustrates how natural disasters act as primary catalysts for displacement. Participants described the sudden and devastating effects of flooding, with one woman recalling, "When I woke up, my house was now full of water". This echoes Sahin et al. (2021) who reflect on the immediate destruction and subsequent human psychological turmoil after a disaster,

A 50-year-old teacher noted the overwhelming nature of the disaster, aligning with Hove's (2016) assertion of inadequate disaster preparedness in Zimbabwe. The role of the Zimbabwean government is crucial, as illustrated by a 56-year-old widow who recounted being forcibly displaced: "the government sent troops, and we were forced out of the village." This highlights the inadequacies and coercive nature of governmental responses, consistent with findings from Human Rights Watch (2015). The disconnect between government actions and the realities faced by displaced individuals underscores systemic failures in disaster management. Furthermore, the historical context of displacements, such as those caused by Lake Kariba, emphasises the long-term impacts and the challenges of rebuilding lives without adequate support.

Psychosocial needs of displaced individuals

The psychosocial needs of individuals displaced by the Tokwe-Mukosi disaster reveal profound vulnerabilities, particularly concerning economic, health, and housing insecurities. Participants reported significant losses in livelihoods, which heightened feelings of anxiety and instability. A 39-year-old woman articulated her despair over food insecurity and the loss of basic resources, reflecting findings by Jayakody et al. (2022) that inadequate access to necessities exacerbates marginalisation and distress. Health insecurity, highlighted by a 78-

year-old headman's account of cholera outbreaks, underscores the critical need for adequate healthcare facilities, aligning with Sandhya's (2024) emphasis on mental health interventions. The lack of clean water and adequate housing further compounds health risks, as demonstrated by a 25-year-old woman's lament about the uninhabitable conditions post-displacement.

Financial instability has also led to an increase in marital problems, with participants indicating that poverty fosters tension and infidelity, mirroring insights from Nhodo and Ojong (2023) on the importance of social support systems for resilience. The destruction of property, as noted by a widow, illustrates the lasting impacts of forced relocations, while educational disruptions create additional anxiety for families, as shared by the headmaster. Overall, these findings align with literature indicating that the absence of social supports and mental health services can exacerbate the trauma experienced by displaced individuals (Bader et al., 2009; Kaiser et al., 2020). The need for a balanced approach that prioritises immediate physical needs while integrating mental health support is crucial for effective humanitarian responses**.**

Coping strategies

The coping strategies employed by the Tokwe-Mukosi victims reflect their resilience and adaptability in the face of adversity. Participants identified social support as crucial, with many relying on tangible resources and emotional comfort from churches and community groups, echoing Nhodo and Ojong (2023) on the importance of local institutions in fostering solidarity. Resilience, shaped by personal and religious beliefs, was evident in statements from individuals determined to endure hardships, aligning with the literature on coping mechanisms in crisis situations. However, while local strategies are vital, the overarching lack of state support can hinder long-term recovery, perpetuating cycles of vulnerability (Jayakody et al., 2022). The reliance on alcohol for coping, as noted by some participants, highlights the psychological toll of displacement. Acceptance of fate emerged as a common sentiment, illustrating a sense of powerlessness that can undermine resilience. Optimism about the future, despite current challenges, reflects a hopeful outlook, consistent with findings by Salihu et al. (2024) that maintaining social connections is crucial for psychological well-being. Yet, there remains a gap in empirical research evaluating the long-term effectiveness of these coping strategies across diverse displaced communities.

Emotion impact of displacement

The emotional impacts of displacement on individuals from Tokwe-Mukosi are profound and multifaceted, encompassing trauma, loss, shock, and uncertainty. Participants' accounts reveal deep psychological scars, aligning with Bodvarsdottir and Ellikit (2004), who noted high rates of PTSD among natural disaster survivors. The loss experienced by individuals, such as the widow mourning her child, exemplifies the bereavement and grief that intensify feelings of helplessness. Fear of the future further compounds these emotional struggles, echoing Sandhya's (2024) findings on the heightened stress and trauma faced by displaced individuals. The disruption of family ties and cultural values, as noted by Mutangi and Mutari (2014), exacerbates these emotional challenges. Conversely, some participants find opportunities for resilience through community support networks, which can foster agency amid adversity.

Farberow's (1978) theoretical framework therefore highlights the emotional phases experienced post-disaster, illustrating how communal bonds can shift from the heroic and honeymoon phases to disillusionment as aid falters. Understanding these phases is critical for developing effective mental health interventions that address the evolving psychosocial needs of displaced individuals. Overall, while the emotional consequences of displacement are predominantly negative, community resilience plays a vital role in facilitating recovery and rebuilding lives.

Conclusion

The findings from the Tokwe-Mukosi community reveal a complex interplay of factors contributing to displacement, including severe flooding and forced evacuations. The emotional impacts are profound, with participants experiencing trauma, loss, and uncertainty about the future. Many reported significant economic and health insecurities, exacerbating their vulnerability. Coping strategies such as social support, resilience, and family unity emerged as vital for navigating these challenges. However, issues like financial instability and marital problems also surfaced, indicating the multifaceted nature of their struggles. Overall, these results underscore the urgent need for targeted interventions to address both the immediate and long-term needs of displaced individuals.

Recommendations

Enhanced psychological support: Stakeholders ought to establish mental health services within disaster response frameworks to address the psychological needs of displaced individuals.

Community resilience programmes: Community support networks ought to promote resource sharing and emotional support among survivors.

Training for disaster responders: Disaster response teams must be equipped with training in mental health first aid to better address the emotional needs of affected populations.

Research and policy development: The academia must undertake further research into the long-term psychological impacts of displacement to inform policy and improve disaster preparedness strategies.

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Exploring the Psychological Strain on Rural Families Due to Substance Abuse Disorders: A Case of Masvingo Rural

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Abstract

Substance abuse disorders is a critical issue affecting many communities, with rural areas often facing unique challenges that exacerbate its impacts. This research paper explores the psychological strain experienced by families in Masvingo rural as a result of substance abuse disorders. The study employed a qualitative research approach and utilised random sampling to select a group of 20 participants. By using in-depth interviews with rural community members, the study examined the social, emotional, and mental health consequences faced by rural families. Barriers to accessing mental health facilities in rural communities were also explored. Key findings indicated heightened levels of stress, anxiety, depression, and family conflict stemming from substance abuse disorders in rural settings. To address the challenges of substance use disorders, it is recommended mental health services ought to be expanded and community-based support programs ought to be implemented in rural areas. Educational campaigns and stigma reduction initiatives should also be developed to encourage individuals to seek help without fear of judgment. Additionally, strengthening collaboration among local healthcare providers, social services, schools, and community organizations, along with advocating for increased funding, is crucial to support affected families and reduce psychological strain.

Keywords: substance use disorders, rural, psychological strain, Masvingo

Introduction

Substance use disorders, including the use of illegal substances, misuse of prescription medications, and excessive consumption of alcohol, remain a pervasive public health concerns worldwide (Lo et al., 2020). Approximately 31 million persons have substance use disorders, throughout the world (Maraire et al., 2020). Mupara et al. (2021) weighed in and said that alcohol and substance abuse has been a long-standing public health challenge across the globe, including in Africa. While the impacts of this issue are felt across diverse communities, rural areas often confront unique challenges that amplify the psychological toll on families. Substance abuse disorders affects not only the user but also others directly or indirectly (Barerah, 2018). In agreement, Maraire et al. (2020) contend that the problem of substance abuse disorders in Zimbabwe has had negative effects to the individual, family, community and nation at large. The detrimental use of alcohol and other substances has been reported to cause devastating consequences on individuals, families, and societies (Mupara et al, 2021). Ndasauka and Kayange (2019) corroborated this view by saying that the abuse of substances has a notable impact to the African continent in terms of negative health consequences to the persons with substance abuse disorder, emotional stress to their loved ones, heavy financial burden on individuals, families and societies.

Understanding the nuances of this issue is crucial in developing tailored interventions and support systems to address the specific needs of rural populations. Specifically, there is a need for a more contextualised research that explores the psychological strain on rural families due to substance use disorders, as well as the coping strategies and support systems they utilise. This study sought to address this research gap by employing a qualitative research approach to gain a deeper understanding of the lived experiences of rural families affected by substance abuse disorders. By examining the complexities of substance abuse disorders in the context of rural communities, this study sought to inform the development of targeted interventions and support systems that address the unique needs of rural populations (UNICEF, 2023; Marandure et al., 2023).

Literature review

Existing research on the impacts of substance abuse disorders on rural families highlights the multifaceted nature of this challenge. Studies have consistently found that rural communities face disproportionately higher rates of substance abuse disorders compared to their urban counterparts (Rigg & Monnat, 2015; Monnat & Rigg, 2016). This disparity is often attributed to socioeconomic factors such as limited employment opportunities, lower educational attainment, and higher poverty levels, which can contribute to increased substance abuse disorders as a coping mechanism (Keyes et al., 2014).

Substance abuse disorders have traditionally been viewed as an urban and inner-city problem. However, with the past decade’s increase in prevalence of substance abuse disorders and substance-related mortality in rural areas, there is growing international recognition that the problem of substance use has spread to rural settings across the globe, (United Nations, 2017). Typically, rural life is characterised by closely knit relations and is highly conservative. The advent of substance abuse disorders in rural areas is potentially posing a threat to the existence of the conservative life in rural communities. However, it is important to note that the family institution remains the source of strengths and support for individuals. Lander et al. (2013) contend that the family unit remains the primary source of attachment, nurturing, and socialisation for humans in our current society. Factors such as geographic isolation, limited access to treatment options, economic instability, and social stigma contribute to the complex dynamics surrounding substance abuse disorders in rural settings.

The psychological toll on rural families manifests in various ways. Scholars have documented elevated levels of stress, anxiety, and depression among family members affected by substance abuse disorders (Goodwin & Sias, 2014; Pullen & Oser, 2014). Abdullahi and Sarmast (2019) agree and claim that chronic substance abuse disorders is heavily related with risk of cognitive impairments and dementia. Abdullahi and Sarmast (2019) further assert that substance abuse disorders can lead to psychological effects such as stress, personality traits like high impulsivity, depression, anxiety, eating and personality disorders, as well as other psychiatric disorders. These emotional and mental health challenges could, in turn, exacerbate family conflicts, disrupt child-parent relationships, and undermine the overall cohesion and functioning of the household (Barnard & McKeganey, 2004; Shumway et al., 2011).

Furthermore, the lack of accessible and culturally appropriate mental health services in rural areas can hinder the ability of families to seek professional support, leading to prolonged psychological distress (Sawyer & Gale, 2006; Boyle et al., 2017). In seconding this view, Cherry et al. (2017) posit that access to mental health care and appropriate follow-up are both problematic. The stigma associated with substance abuse disorders and mental health issues in rural communities can also discourage individuals from seeking help, further compounding the challenges faced by affected families (Howard et al., 2009; Fortney & Booth, 2001). Worth noting is that, more often than not, most persons with substance abuse disorder become hostile to their families, turning rebellious, defiant, and exhibiting irrational anger (Maraire et al., 2020). These unbecoming behaviours by persons with substance abuse disorders expose their families to tensions. Substance abuse disorders are fast becoming the lead cause of death, mental disorders, unproductivity, and disintegrated families (Volkow, 2020). These adverse effects can have long-lasting implications for the well-being and cohesion of rural communities.

It is important to note that while there is a growing body of research on the challenges faced by rural communities, the specific psychological strain on families due to substance abuse disorders remains a significant knowledge gap (Warner & Leukefield, 2001). Despite the growing rates of substance abuse disorders in rural areas, the emotional toll on family members, caregivers, and loved ones has received limited attention (Mardani et al., 2023). The existing literature has largely ignored the unique cultural, social, and economic contexts of rural communities, leaving a significant void in our understanding of the intersection of substance abuse disorders and family well-being in these areas. The aims of the current study sought to address this knowledge gap by exploring the psychological strain on families in rural communities affected by substance abuse disorders, and examining the ways in which they navigate the challenges of such disorders within their social and cultural contexts.

Research questions

This study sought to address the following research questions:

1) What are the primary psychological impacts experienced by rural families due to substance abuse disorders?
2) How do factors specific to rural settings, such as geographic isolation and limited access to resources, contribute to the psychological strain on rural families?
3) What interventions can be implemented to mitigate the psychological consequences of substance abuse disorders and support the well-being of rural families?

Problem statement

Substance abuse disorders pose a significant threat to the well-being of rural families, with psychological strain being a prevalent and concerning consequence. The unique challenges faced by rural communities, including limited access to mental health services and the pervasive social stigma surrounding substance abuse disorders, further exacerbate the psychological toll on families. To address the needs of rural populations and promote the overall resilience and well-being of rural families, it is crucial to understand the dynamics of substance abuse disorders in rural areas and; consequently, develop targeted interventions.

Method

Population and sampling

This study targeted rural families affected by substance abuse disorders in rural communities of Masvingo district. A purposive sampling strategy was employed to recruit participants who had experienced the impact of substance abuse disorders first hand. The sample consisted of 20 rural community members, including 10 family members of individuals struggling with substance abuse disorder, 5 community leaders, and 5 service providers who work with affected families. Participants were recruited through local community organisations and word of mouth. The selection criteria for participants included: (1) having a family member who had struggled with substance abuse disorders, (2) living in a rural community, and (3) willingness to share their experiences and perspectives.

Data collection instruments

The data collection instrument used in this study was a semi-structured interview guide, which was developed based on a comprehensive review of the literature on substance abuse disorders in rural areas. The guide consisted of 15 open-ended questions that explored the following themes: (1) experiences of living with a family member struggling with substance abuse disorder; (2) impact of substance abuse disorders on family relationships and dynamics; (3) coping strategies and support systems; and, (4) perceptions of available resources and services. The interview guide was pilot-tested with three participants to ensure its relevance and effectiveness in eliciting rich and detailed responses. The pilot test results led to minor revisions to the interview guide to improve its clarity and comprehensiveness.

Data collection procedures

Data were collected through in-depth, face-to-face interviews with participants, which lasted approximately 45 - 60 minutes each. Interviews were conducted in a private setting, and participants were assured of confidentiality and anonymity. The interviews were conducted over a period of two months, and data collection ceased when saturation was reached, as indicated by the repetition of themes and the lack of new information emerging from the interviews.

Data analysis

This study employed a qualitative approach using discourse analysis to examine the experiences of rural families affected by substance abuse disorders. Data consisted of semi-structured interviews transcribed verbatim. Analysis proceeded in two stages. First, initial coding identified recurring themes and patterns within the transcripts. Second, these codes were grouped into broader categories reflecting the major discourses related to family dynamics, access to healthcare, community resources, and coping strategies. This involved examining the ways participants constructed their identities, negotiated power dynamics, and navigated stigma within their communities. The analysis focused on identifying dominant and counter-discourses, exploring the relationships between language use, social context, and lived experiences. Thematic saturation guided the decision to conclude data collection.

Ethical considerations

Informed consent was sought from the participants. The researcher explained to them that the information collected was strictly for academic purposes and they were free to drop out from the research whenever they felt like stopping. They were also assured that their identities would be kept anonymous.

Findings and discussion

The findings of this study indicate that rural families face significant psychological strain due to the impacts of substance abuse disorders. The principal themes and discourses that emerged from the research are presented in the following sections.

Heightened levels of stress, anxiety, and depression

Participants reported elevated levels of emotional distress among family members, stemming from the financial burdens, relationship conflicts, and feelings of hopelessness associated with substance abuse disorders. One participant had this to say:

> "As a couple we are not employed. We rely on working in other people's fields with my children. When we get paid for our services, my husband demands the money in order to purchase his drugs. As a family we are struggling to put food on the table, but he does not care. All he needs is the constant supply of his drugs".

This response is loaded with indications of psychological challenges faced by the family. The participant was much stressed and her emotional being was affected by the behaviour of her husband living with substance abuse disorder.

Another participant indicated that:

> "My son is now insane due to abusing drugs. His talk does not make any sense and the whole family is worried about his behaviour".

Mukwenha et al. (2021) said that substance abuse disorders predispose to short and long-term psychiatric complications, including stress, depression, anxiety, suicide, and even psychosis. The unpredictable nature of substance abuse disorder can create a constant state of anxiety and fear within the family.

Another participant interviewed expressed fears of uncertainty about the future of her son living with substance abuse disorder:

> "To be honest with you I am very worried about my son's future. What will become of him really? No-one would get married to an addict like him. He is a wasted individual."

The comments indicate that the parent felt that her son's future is already ruined due to the harm caused by substance abuse. Furthermore, partners experienced uncertainty and a loss of trust with their loved ones with a substance use disorder. One female respondent said that:

> "My husband is no longer the man I fell in love with. He has changed drastically ever since he started abusing drugs. I am not sure about the future of our marriage because when drunk he becomes violent, and it is not pleasing at all".

This constant emotional strain experienced by the respondent could lead to a toll on mental health.

Disruption of family dynamics

In the current study, substance abuse disorders was found to disturb family cohesion and undermine parenting abilities. One respondent said:

> "There is a lot of confusion in the whole family ever since our eldest son began abusing drugs and substances. Our extended family is accusing us of failing to reign in our son and hence tarnishing the family's name in the community. "

This agrees with Lander et al. (2013) who contend that substance abuse disorders disturb family unity and negatively impact the social, emotional, and academic well-being of children in affected households. Paul et al. (2024) add that substance abuse disorders have emerged as a growing threat in contemporary society, eroding our cultural fabric day by day. Substance abuse disorder can significantly impair communication within families. The fear of judgment, combined with the unpredictable behaviour of individuals with a substance abuse disorder can create a communication breakdown. Open and honest conversations become difficult, further isolating family members.

Substance abuse disorders affect families in a number of ways. Another participant interviewed revealed that:

> "Witnessing a loved one struggle with substance abuse disorder can be similar to a grieving process. "

The harmful use of substances constitute one of the most severe public health and socio-pathological threats facing adolescents and young people and it has some long-term impacts on their well-being and future (UNICEF, 2020). Substance abuse disorders have the potential of hurting the whole family, the community and even the country at large. This could lead to feelings of helplessness, anger, and depression.

Barriers to accessing mental health support

Participants highlighted that mental health services were very limited in rural areas. One participant said:

> "Our local clinic is far away from here so when a relative abuse drugs and other substances, we fail to take him there and just keep him at home. "

This is consistent with Palomin et al. (2023)'s findings that individuals living in rural areas are at increased risk of developing mental health condition with limited access to mental health clinicians and healthcare facilities. Mahasoa and Mokoena (2019) argue that, despite efforts made to prevent and treat substance abuse disorders related problems, there are challenges in accessing treatment facilities. From the quoted scholars, it is evident that mental health facilities are very scarce in the rural areas posing a great challenge to people struggling with substance abuse disorders.

Respondents also highlighted that fear of stigma and labelling discourages them from seeking mental health services therefore exacerbating the psychological strain on families. Another participant said:

> "It is very difficult for me to open up about my drug abuse challenges for fear of being labelled '*rombe'*[1] by the community".

Stigma towards people with a substance use disorder, as well as the internalisation of that stigma by substance users, is widespread (Hammarlund et al., 2018). It is important to note that some families are going to the extent of hiding the information when one of their family members has a substance abuse disorder as a way of avoiding stigma. In concurrence, Mardani et al. (2023) highlighted that many families face the challenge of getting help because they try to hide the substance abuse disorder problem of one of their members by limiting their communication and thus experience serious challenges when asking for help and support. Another respondent indicated that:

> "If people get to know that one is abusing drugs and other substances, they will avoid interacting with you, giving you a lot of labels and that can isolate families and prevent them from seeking help. "

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[1] An idle stroller; a vagabond; a loafer; a tramp. · A wanderer; a rover; a rambler. (VaShona Project., n.d.).

Families experiencing such a scenario would therefore suffer in silence. It was also revealed that shame could lead to feelings of guilt, worthlessness, and social withdrawal, hindering communication and open dialogue within the family unit.

Lack of community-based resources and support networks for substance abuse disorders mitigation

Respondents noted that rural families often lack access to community-based programs and support systems specifically designed for those struggling with substance abuse disorders, leaving many to cope with the challenges alone. A participant revealed that:

> "As a community, we do know where to go and get help with one of us abusing drugs and substances. We end up giving them home remedies."

Rural areas are often geographically isolated, making it difficult for individuals to access specialised treatment facilities and support services.

Accessibility of healthcare in rural areas is globally impeded by physical, material, human, financial and managerial resources and societal barriers in the healthcare system (Mangundu et al., 2020). These findings illustrate that rural communities are experiencing substance abuse disorders challenges. The contextual factors given above contribute to the amplified psychological strain experienced by rural families due to substance abuse disorders.

Despite the challenges faced due to substance abuse disorders, rural families possess inherent strengths like strong family bond that could be a source of strength and support. Also, sharing of experiences through connecting with other families facing similar challenges through the use of support groups could create a sense of community and belonging. Sharing experiences and offering mutual support to families affected by substance abuse disorders could foster hope and resilience. Furthermore, setting clear boundaries around acceptable behaviour could be crucial for protecting the well-being of other family members. This allows the individuals with substance abuse disorder to face the consequences of their actions and provides a framework for healthy interactions.

Discourse of blame and shame

The narratives of rural families affected by substance abuse disorder reveal a pervasive discourse of blame and shame. The language used by participants suggests that they internalise the stigma associated with substance abuse disorder, perpetuating a sense of guilt and responsibility for the condition. For instance, one participant stated "

> "Our extended family is accusing us of failing to reign in our son and hence tarnishing the family's name in the community."

This discourse of blame and shame not only exacerbates the emotional burden on families, but also reinforces the notion that substance abuse disorder is a personal failure rather than a complex social issue.

Moreover, the fear of stigma, as suggested by the label "*rombe*," stated in one of the verbatim statements articulated by a participant demonstrates how societal perceptions can inhibit help-seeking behaviours. This internalisation of stigma reflects a broader cultural narrative that associates substance abuse disorder with moral failing, further isolating families and preventing them from accessing necessary support. Such discourse reveals the urgent need for community-based interventions that address these systemic barriers.

Research has shown that stigma and shame are significant barriers to seeking help for substance abuse disorder (Corrigan et al., 2014). The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), emphasises the importance of understanding substance abuse disorder as a medical condition rather than a moral failing (American Psychiatric Association, 2013). Community-based interventions that focus on education and support could help reduce stigma and encourage families to seek the help they need (Livingston et al., 2012).

Discourse of lack and limitation

The findings also highlight a discourse of lack and limitation, which perpetuates the picture that rural areas are inherently disadvantaged. Participants frequently mentioned the scarcity of resources, lack of access to healthcare, and limited community-based programmes. This discourse of lack and limitation reinforces the idea that rural areas are powerless to address the issue of substance abuse disorders, and that external intervention is necessary. However, this discourse also obscures the agency and resilience of rural communities, neglecting the potential for community-led initiatives and solutions.

The discourse underscores the isolation experienced by rural families. Participants highlighted a lack of knowledge about available support, articulating a sense of helplessness when faced with substance use disorder. Phrases like, "*we end up giving them home remedies*", illustrate the reliance on informal, often ineffective coping strategies, emphasising the inadequacy of existing support structures.

Participants’ accounts of limited access to mental health services resonate with broader structural inequalities in rural healthcare. The phrase, “*Our local clinic is far away*”, encapsulates the geographical and logistical barriers that exacerbate the psychological strain on families. This highlights systemic failures in healthcare provision, where rural settings lack adequate mental health resources.

Discourse of family and community

One prominent theme that emerged from the data was the disruption of family dynamics caused by substance abuse disorders. The narratives of rural families affected by substance abuse disorders also reveal a strong discourse of family and community. Participants emphasised the importance of family bonds, community support, and shared experiences. For instance, one participant stated:

> "Sharing experiences through support groups can create a sense of community and belonging."

This discourse of family and community highlights the potential for collective action and mutual support, which could be leveraged to address the issue of substance abuse disorders in rural areas.

The discourse surrounding family cohesion reveals how substance abuse disorders create a rift in familial relationships. Statements like, "*… confusion in the whole family*", and accusations from extended family members illustrate the social stigma surrounding substance abuse disorder. These narratives reflect societal expectations of familial responsibility and the shame associated with perceived failure in managing a family member’s substance abuse disorder.
This perspective aligns with Lander et al. (2013), who argue that substance abuse disorder disrupts not only interpersonal relationships but also the broader social fabric. The expression of grief related to witnessing a loved one’s struggle with substance abuse disorder further underscores the emotional burden carried by family members. This marks substance abuse disorder as a multifaceted social issue that transcends the individual.

Discourse of powerlessness and helplessness

The findings also revealed a discourse of powerlessness and helplessness, which is reflected in the participants' sense of frustration and despair. Participants frequently mentioned feeling overwhelmed and unsure of how to address the issue of substance abuse disorders. The language used by participants highlights the sense of isolation and helplessness that they felt in the face of these challenges. This discourse of powerlessness and helplessness can be regarded as a coping mechanism, thereby allowing families to avoid taking responsibility for addressing the issue. However, it also reinforces the notion that substance abuse disorders are an insurmountable problem, rather than a challenge that could be addressed through collective action and community-led initiatives.

Discourse of psychological strain

Participants frequently employed emotive language to convey their distress, indicating a deep psychological impact. Phrases like "*struggling to put food on the table*" and "*constant supply of his drugs*" reflect the conflict between financial hardship and substance abuse disorder. This discourse illustrates how substance abuse disorder not only disrupts individual lives but also imposes a collective burden on family dynamics. The language used suggests a sense of helplessness and frustration, positioning the person with a substance abuse disorder as a source of ongoing emotional turmoil.

Furthermore, the expressions of fear regarding the future, such as, “*What will become of him really?*” signify a profound uncertainty that pervades family relationships. This narrative highlights the psychological toll of substance abuse disorder, framing it as a chronic crisis rather than a temporary setback. Such discourse emphasises the need for community support and intervention as families navigate these challenges with limited resources.

Discourse of hope and resilience

Despite the challenges and difficulties faced by rural families affected by substance abuse disorders, the narratives also reveal a discourse of hope and resilience. Participants emphasised the importance of setting clear boundaries, fostering open communication, and promoting mutual support. This discourse of hope and resilience indicate a potential for community solidarity and the potential for rural families to overcome the challenges posed by substance abuse disorders, and to develop strategies for coping and recovery. This resilience narrative challenges the dominant discourse of victimhood, positioning families as active agents in their struggles.

Conclusion

This study has illuminated the profound psychological burdens that substance abuse disorders have on rural families. The findings highlight the multifaceted nature of this issue, with rural communities facing unique challenges that exacerbate the emotional, mental, and social impacts on families. Factors such as geographic isolation, limited access to mental health resources, and pervasive social stigma collectively contribute to the heightened levels of stress, anxiety, depression, and family conflict experienced by those affected by substance abuse disorders. However, by understanding these challenges and fostering resilience, families can navigate this difficult terrain. It is therefore crucial to promoting open communication, encourage access to mental health services and foster community-level support networks to mitigate the adverse impacts of substance abuse disorders and promote the overall well-being of rural families.

Recommendations

Based on the findings of this study, it is recommended that the availability and accessibility of mental health services in rural communities be expanded in order to address the challenges emanating from substance abuse disorders. Community-based support programmes that provide counselling, and peer-to-peer support for individuals and families affected by substance abuse disorders need to be implemented in rural areas. Also, community leadership is implored to develop educational campaigns and stigma reduction initiatives aimed at destigmatising substance abuse disorders and mental health issues in rural communities, encouraging individuals to seek help and support without fear of negative judgment or social consequences. There is a need for strengthening the collaboration between local healthcare providers, social services, schools, and community organisations to create a comprehensive support network for rural families impacted by drug and substance abuse disorders. This world ensure seamless access to the resources they require. Finally, rural community leadership is encouraged to advocate for increased funding and policy initiatives that prioritise the mental health and well-being of rural communities. This would address the systemic disparities that contribute to the heightened psychological strain on rural families.

Reflections

As part of researchers' reflections, the study affirms that there is indeed a problem of substance abuse disorders in Masvingo district's rural areas. The study findings further confirmed that substance abuse disorders were therefore wreaking havoc in rural families. However, it was not only the individuals with a substance abuse disorder that were affected by the scourge, but also the family, and the community at large. Substance abuse disorders predispose individuals to short and long-term psychiatric complications, including stress, depression, anxiety, suicide, and even psychosis (Mukwenha et al., 2021). The establishment of many substance abuse disorder rehabilitation centres throughout the rural areas could go a long way in addressing rural families' mental wellbeing.

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Prevalence and Determinants of Depressive Disorders among PhD Students at a Local University in Masvingo, Zimbabwe

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Abstract

Research on mental wellbeing among university students has predominantly focused on experiences of undergraduate students while overlooking doctoral students. This study sought to examine the prevalence and determinants of depressive disorders, as well as coping strategies employed by PhD students at Great Zimbabwe University in Masvingo, Zimbabwe. A convergent mixed methods research design, wherein both quantitative and qualitative data were collected simultaneously in a single-phase approach, was utilised on a convenience sample of 20 PhD students. Quantitative data were collected through a self-administered survey instrument comprising: (i) a socio-demographic questionnaire and, (ii) the patient health questionnaire (PHQ-9) to screen for depression; while qualitative data were collected through in-depth interviews using a semi-structured interview guide. Quantitative data were statistically analysed, while qualitative data was thematically analysed to examine the prevalence, determinants and coping strategies for depression respectively. Findings revealed a moderate prevalence of depressive disorders among PhD students; while the university environment, high academic work-loads, financial hardships, lack of student support services, and concerns about an uncertain job market and future, were the key determinants precipitating depressive symptoms. On coping strategies, participants indicated that they sought family support, turn to religion, and talk over their feelings with friends or partners when they feel stressed rather than wait for physical problems to develop. The study recommends that universities should offer comprehensive psycho-social support to PhD students and that supervisors should strive to make use of participatory approaches that improve the mastery of new skills and performance of PhD students.

Keywords: depressive disorders, determinants, coping, PhD students.

Introduction

Mental health is just as important as physical health. It is considered an indispensable component of health by the World Health Organisation (WHO, 2017). Psychological and mental health problems among university students are identified as an escalating public health problem worldwide (Aljaber, 2020; January, Madhombiro, Chipamaunga, Ray, Chingono & Abas, 2018). Studies have established that university students are more susceptible to depression and anxiety than the general population (Ibrahim, Kelly, Adams, & Glazebrook, 2013). However, previous studies have tended to focus on either medical students only or undergraduate university students, and have largely ignored PhD research scholars. Lavecque, Anseel, De Beuckelaer, Van der Heyden and Gisle (2017) contend that the mental health and well-being of PhD students should be a genuine concern for policymakers and researchers given that the work of PhD students constitutes a major source of scientific advancement, which has a direct bearing on the quality of life in communities.

Depression is a common psychiatric disorder characterised by symptoms of persistent feelings of hopelessness, dejection, low mood and a reduced ability to enjoy life that significantly interferes with normal functioning (APA, 2013). It has been designated as the leading cause of social and physical disability and loss of productivity and the fourth leading cause of total disease burden worldwide (WHO, 2002). In the *Depression and other common mental disorders: Global health estimates report*, WHO (2017) estimated the prevalence of depression worldwide to be 322 million, and predicted that the condition would be the second driving reason for disability by the year 2020.

The key determinants for depression have been noted as a combination of personal, psychological, social, genetic and environmental factors (Ahmed et al., 2020; Leethu et al., 2021). Depression is generally described in layman's terms as low mood that lasts for a prolonged time (at least two weeks) and affects a person's everyday life. In Zimbabwe's Shona language, it is commonly referred to as '*kufungisisa*', meaning 'thinking too much', although the term is not specifically the equivalent of 'depression' as a common mental health condition (Patel, Simunyu & Gwanzura, 1995). Depression makes everything harder to execute and seem less worthwhile. A depressed student is likely to lose their self-confidence, find academic tasks too challenging and hard to do, perform poorly and perceive their education as nothing worthy, but an exercise in futility.

The more accurate term for depression in contemporary nomenclature is 'depressive disorders', which has a variety of clinical manifestations including disruptive mood dysregulation disorder, major depressive disorder, persistent depressive disorder, premenstrual dysphoric disorder, and depressive disorder due to another medical condition (Aljaber, 2020; APA, 2013). According to the Diagnostic and Statistical Manual of Mental Disorders (5th edition), depressive disorders are characterised by the presence of sadness, emptiness, or irritable mood, accompanied by somatic and cognitive changes (APA, 2013). Other symptoms include persistent feelings of hopelessness, dejection, low mood and a reduced ability to enjoy life that significantly interferes with normal functioning. The psycho-social demands of university education in general pose the risk of depressive disorders among tertiary students.

Depression is widely identified as a bane in university students. Prevalence rates among tertiary students are estimated to be six times more than the general population (Evans et al., 2018). In an extensive review of literature on the prevalence of depression among university students globally, Ibrahim et al. (2013) revealed that reported prevalence rates among students ranged from 10% to 85%. The authors suggested that depression rates as reported by students are far higher than those found in the general population (Ibrahim et al., 2013).

According to January et al. (2018), there has been a remarkable growth of university student numbers in sub-Saharan Africa within the last 30 years, and hence the need to understand the prevalence and antecedents of common mental disorders among this group in the population. Several studies have investigated the prevalence of depressive disorders amongst university students (Asante & Andoh-Arthur, 2015; January et al., 2018; Ibrahim et al., 2013). A study among undergraduate students in Nigeria found a prevalence rate of 32.2% (Peltzer et al., 2013). Among Kenyan university students, a moderate prevalence rate of 35.7% was found whilst 5.6% reported severe depressive symptoms (Othieno et al., 2014). An equally high level of depression was recorded by Ibrahim et al. (2012) in Egypt with 37% of the students scoring above the threshold for moderate depression.

In keeping with the challenges of depression in university settings, there is scant literature on affected students in postgraduate programmes. A multiplicity of studies on common mental disorders among university students have predominantly focused on medical or undergraduate students (Aljaber, 2020; Asante & Andoh-Arthur, 2015; Maziti & Mujuru, 2021) and largely ignored doctoral level students, notwithstanding the growth and increase in PhD enrolments globally. The few studies on PhD students conducted in high income countries (HICs) have revealed that they also face significant mental health challenges. According to Lavecque et al. (2018), approximately one-third of PhD students are at risk of having or developing a common psychiatric disorder. According to their survey, 51% of respondents had experienced at least two symptoms of poor mental health, indicating psychological distress. Moreover, 32% reported at least four symptoms, indicating a risk for common psychiatric disorders, which was more than twice the prevalence among highly educated comparative groups. A similar survey on PhD students in two public universities in Kerala, India, reported that close to 70% of the students suffered from mild to severe depressive disorders (Leethu, Hense, Kodali & Thankappan, 2021). The study revealed that factors that commonly caused depressive disorders in PhD students were extended working hours, academic stress, lack of supervisory support, financial insecurities and uncertainties over future career prospects .

There is a high number of PhD candidates and graduates in many countries including Zimbabwe. This could be due to encouragement by government policy both at national and international levels. Although universities were traditionally regarded as low stress environments, research on occupational stress among academics indicates that it is alarmingly widespread and on the rise (Lavecque et al., 2017). Consequently, there are increasingly high numbers of media reports on incidents of depression, anxiety, burnout, emotional exhaustion and suicide among academics. Although a couple of studies have been conducted on prevalence of depression among undergraduate university students, (January et al., 2018; Maziti & Mujuru, 2021), no study known to the researcher has specifically examined the prevalence and determinants of depressive disorders among PhD students in Zimbabwe. It is in light of this general dearth of research on depressive disorders among doctoral students that this study sought to fill the apparent gap and add to the growing global body of literature on the prevalence of mental health issues in academia.

In order to effectively deal with the problems of common mental disorders (CMD), particularly depressive symptoms in PhD students, there must be an understanding of the prevalence, stressors or determinants, as well as coping strategies against depression in this sample of students. The objectives of this study were: 1) to measure the prevalence of depressive symptoms among PhD students at Great Zimbabwe University; 2) to establish the determinants and/or stressors that precipitate depressive disorders among PhD students at Great Zimbabwe University; and 3) to establish the coping strategies that PhD students at Great Zimbabwe University employ to minimise the stressors and their undesirable effects.

Method

Approach and design

The study employed the mixed methods research approach. According to Johnson, Onwuegbuzie and Turner (2007: p123), "Mixed methods research is the type of research in which a researcher or team of researchers combines elements of qualitative and quantitative research approaches (e.g., use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the broad purposes of breadth and depth of understanding and corroboration". Integration of qualitative and quantitative methods allowed for both depth and breadth in understanding the prevalence and determinants of depressive disorders, as well as the coping strategies.

The study adopted the convergent mixed methods research design wherein both quantitative data (survey) and qualitative data (in-depth interviews) are collected simultaneously in a single phase approach (Creswell & Creswell, 2018). The key assumption of this approach is that both quantitative and qualitative data provide different types of information (scores on instruments and detailed views/ meanings of participants) yielding complementary results (Campbell & Fiske, 1959; Creswell & Creswell, 2018). This design allowed for simultaneous measurement of different variables notably socio-demographic characteristics such as age, gender, employment status, number of children/dependants, amongst others, to observe how such differences might correlate with depression, which was the critical variable of interest (Bethlehem, 1999).

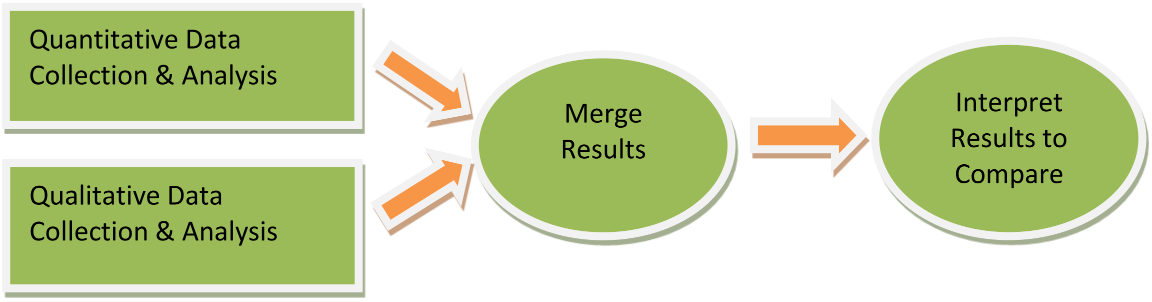

Figure 3.1: Convergent Design (One-Phase Design) by Creswell and Creswell (2018)

Participants

GZU consists of 7 schools, 35 departments, and offers over 40 post-graduate study programmes, including those at doctoral level. The target population for this research was the PhD students enrolled at GZU. Guided by records kept by relevant departments at the university, a representative simple random sample was drawn. A sample of 30 students was targeted for the study, because this was big enough to generate significant quantitative data while also small enough for manageable qualitative in-depth interviews. Eligible participants in this study were currently the registered PhD students, and those willing to participate. Unregistered PhD students, those who exhibited serious psychological distress or crisis, and those unwilling to participate in the study were excluded.

Data collection

Data were simultaneously collected through a survey instrument and semi-structured in-depth interviews prearranged as follows:

Section A: Quantitative survey

Part A of the questionnaire probed participants for socio-demographic characteristics such as gender, age, number of children/dependants, doctoral year/level, income ranges of the research participants, amongst others. Part B comprised the patient health questionnaire 9-item scale (PHQ-9). The patient health questionnaire (PHQ-9) identifies psychological distress and potential cases of depressive symptoms (Kroenke, Spitzer & Williams, 2001). It is a 9-item scale based on the DSM-IV-TR criteria for major depression. The scale is used routinely in general practice and has been used extensively across many low-to-medium income countries (Ferrari, 2016; MacLean et al., 2017; Abas, Weiss, Simms, Verhey, Rusakaniko, Araya & Chibanda, 2020). Each item is rated on a 4-point Likert-type scale ranging from 0 (*not at all*) to 3 (*nearly every day*). Example items include ‘feeling down, depressed or hopeless’ and ‘feeling tired or having little energy’. The maximum score is 27, indicative of severe depression and the minimum is 0, denoting no experiences of depression in the past two weeks. Scores can fall into one of five categories of severity of depression from minimal (0-4), mild (5-9), moderate (10-14), moderately severe (15-19), to severe depression (20-27). The PHQ-9 has been locally validated in a Zimbabwean primary care population with Cronbach’s $\alpha = 0.86$ (Chibanda et al., 2016).

Section B: Qualitative semi-structured in-depth interview

The last section of the instrument solicited in-depth answers on the determinants and coping strategies typically employed by PhD students to cope with the challenges, distress and depressive symptoms.

Ethical considerations

All the pertinent ethical principles guiding research were observed in conducting this study. Comprehensive details about the study were disclosed to the PhD students to obtain their express informed consent. Participants were requested to append signatures on pre-designed written informed consent forms that specified and reiterated their rights to privacy, anonymity, voluntary participation and right to withdraw at any point during the study. Confidentiality was emphasised and participants were guaranteed that no identifying information would be used on any manuscripts or in the final research report. Care was taken to minimise any risks and to ameliorate any psychological distress that participants may experience during the course of research.

Data analysis

Quantitative data were statistically analysed, while thematic analysis was utilised for the qualitative component. Quantitative data analysis included descriptive analyses of univariate statistics to describe prevalence and determinants of depressive mental health symptoms, and socio-demographic variables. Qualitative data was thematically analysed to understand the coping strategies. Descriptive statistical techniques enabled the researcher to organise, summarise and describe observations so as to make accurate and credible conclusions.

Findings

Quantitative component

Socio-demographic characteristics

Age

The respondents were asked to indicate the age ranges they could be identified in. Age bands were used which ranged from 25 to 60 years as the researcher felt that some respondents could feel uneasy at revealing their exact ages.

Table 1: Age (n =20).

Age range	No. of Respondents
25-34	7
35-44	4
45-54	6
55-60	3
Total	**20**

Most respondents were in the 25 to 34 age band. This was followed by respondents in the 45 to 54 age bracket. There were fewer respondents in the 35 to 44 and 55 to 60 age bands.

Gender

The participants in the study were made up of 60% female and 40% male.

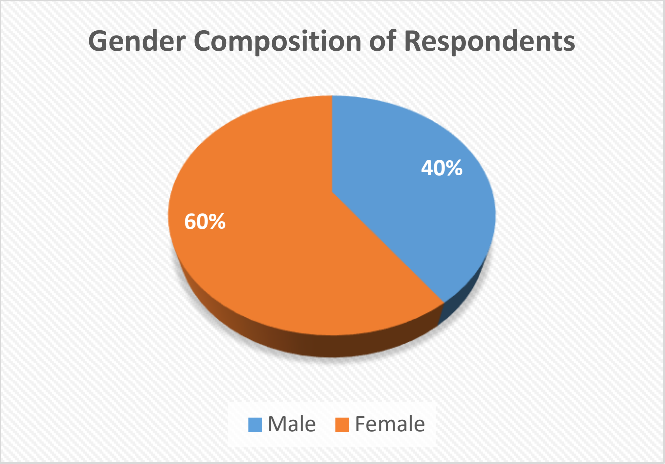

Figure 1: Distribution by gender

Prevalence of depressive disorders

The first objective of this study was to measure the prevalence of depressive symptoms in PhD students at Great Zimbabwe University. A frequency histogram showing results from the patient health questionnaire (PHQ-9) is presented below:

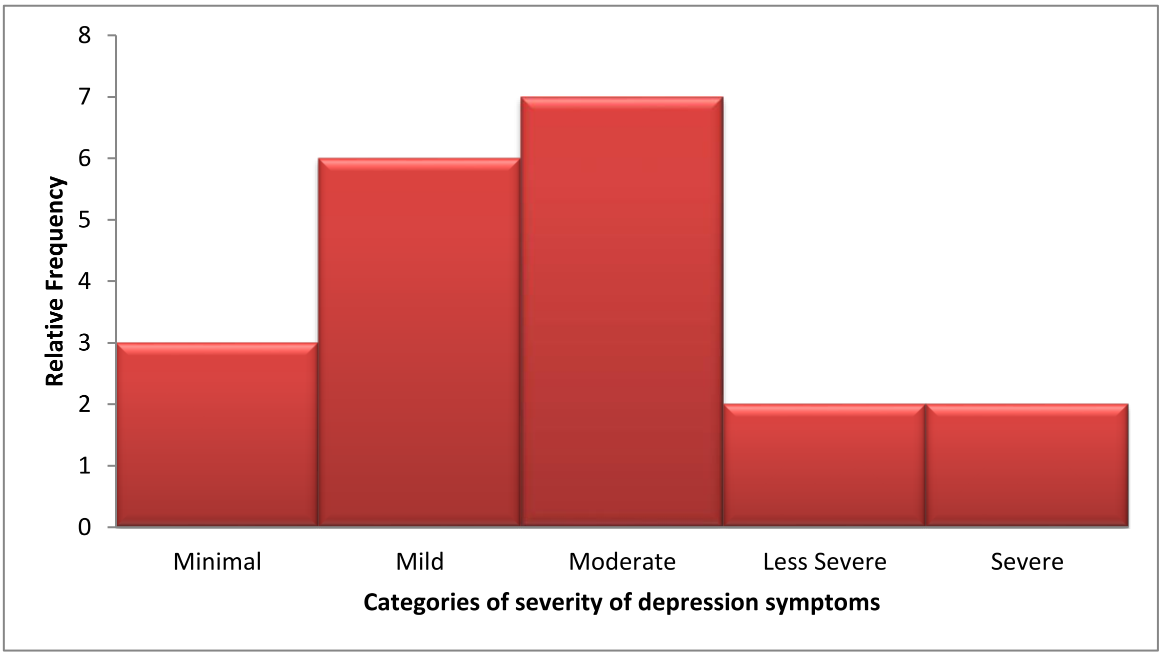

Figure 2: Results from the Patient Health Questionnaire (PHQ-9)

The above relative frequency histogram shows an increase in the number of pupils obtaining high marks in the first three questions of the developmental exercise. The range of 4 shows that most pupils did well in the second developmental exercise.

Item analysis from the PHQ-9

Table 2: Item-wise analysis of PHQ-9 (n=20).

Item	Not at all	Several days	Often	EveryDay
Little interest	2	8	10	0
Feeling down	1	9	10	0
Sleep problems	1	9	10	0
Tiredness	3	7	10	3
Eating problems	5	5	10	5
Family problems	0	10	10	0
Speech problems	0	0	0	0

In Table 2 above, the results from the depression screening tool show that the majority of participants showed symptoms ranging from little interest in daily activities; feeling down; having sleep problems; tiredness; eating problems; and family problems. No respondent indicated having experienced any speech problems.

Determinants of depression among PhD students

The second objective of the current study was to establish the determinants and/or stressors that precipitate depressive disorders among PhD students at Great Zimbabwe University. The main stressors or determinants of depressive disorders among PhD students at Great Zimbabwe University included the university environment; difficulty in mastering new skills; student's age; economic or financial hardships; student-supervisor disagreements; amongst other factors. These determinants are elaborated below:

The effect of the university environment on symptoms of stress

Below are the respondents' perceptions on the effect of the university environment on stress.

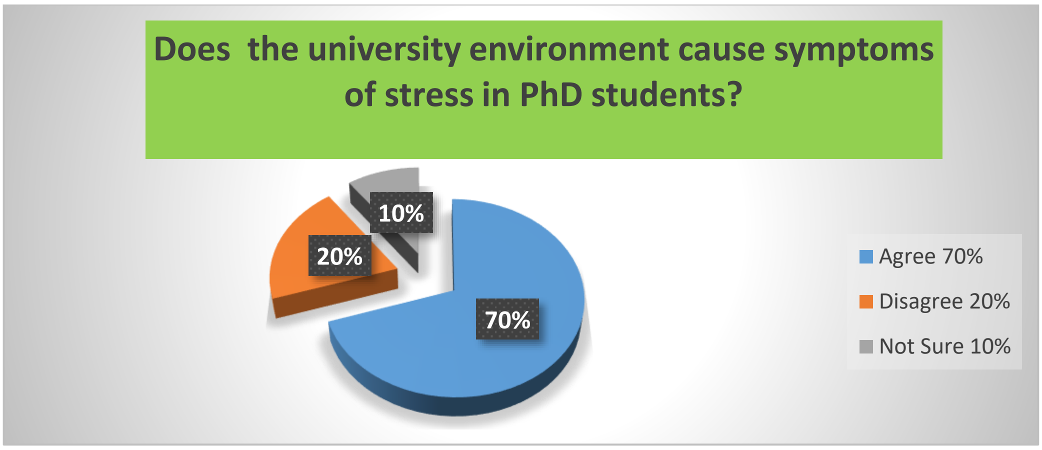

Figure 3: The effect of the university environment on symptoms of stress

The pie chart above shows that 70% of the participants agreed that they had challenges in adjusting to the university environment which caused them to experience symptoms of stress. On the other hand, 20% of the respondents disagreed that the university environment had a bearing on their stress symptoms. The other 10% indicated that they were not sure whether they were experiencing stress symptoms as a result of failing to adjust to the university environment or not. Basing on the responses of PhD students who took part in the study, the respondents felt that the university environment had a bearing on their suffering from stress, which is a determinant of depression.

Difficulties in mastering new skills

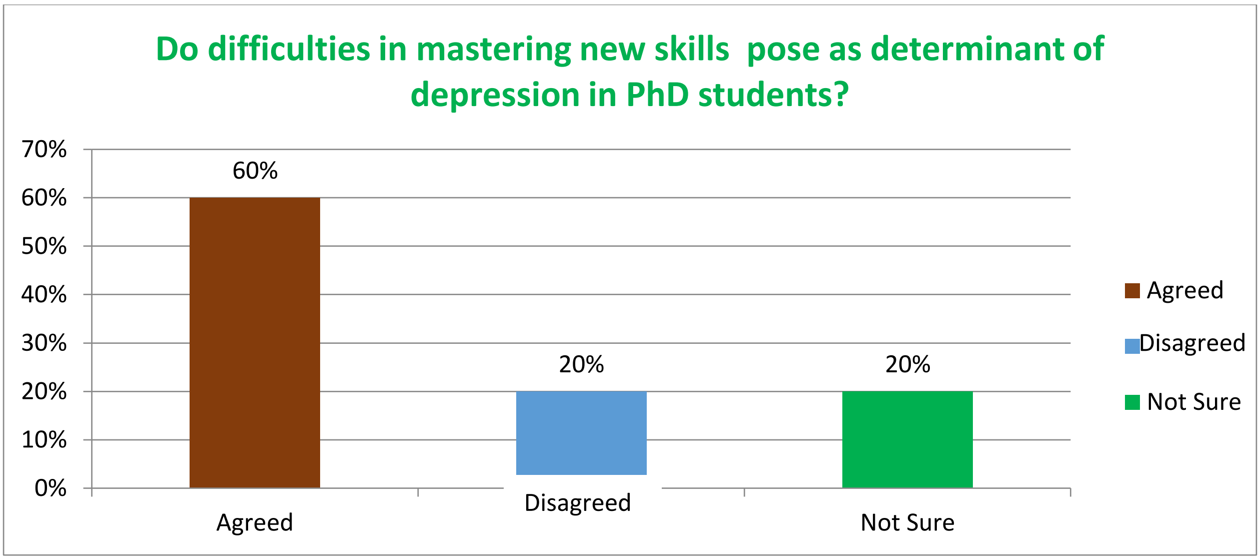

Figure 4: The effect of difficulties in mastering new skills as a determinant of depression

As shown above, 60% of respondents agreed that they identified difficulties in mastering new skills as stressors or determinants in causing depression. On the other hand, 20% of the respondents disagreed that failure to master new skills had an effect on suffering symptoms of depression. Only 20% of respondents were not sure as to whether failure to master new skills had an effect in causing symptoms of depression.

Age as a determinant of depression symptoms in PhD students

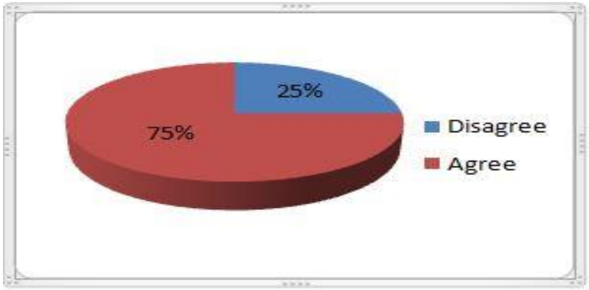

Figure 5: Age as a determinant of depressive symptoms

Results from figure show that most of the respondents, (75%) felt that a student's age had a bearing on one's susceptibility to depression; and (25%) believed that age had no effect on vulnerability to depression. It can be deduced from the responses that the students believed age is a risk factor for depression.

Qualitative component

Determinants of depression experienced by PhD students

The determinants of depressive disorders among PhD students at GZU were also qualitatively explored. The following is data collected from the qualitative questions that solicited and probed for stressors which precipitate symptoms of depression.

Table 3: Determinants of depressive disorders

Main Theme	Sub-themes
▪ Determinants or precipitants of depressive disorders	▪ Economic/ financial hardships ▪ High work-loads ▪ Student-supervisor disagreements ▪ Inadequate or lack of student support services ▪ Uncertain future / job market ▪ Social problems ▪ Health problems

Economic or financial hardships

Financial challenges emerged as one of the key concerns, potentially inhibiting students' academic performance and their mental health. All the students indicated that they were not on scholarship or receiving any grants to pursue the doctoral studies which strained their financial situation. One participant said:

> "I am paying my own tuition fees and given the economic situation prevailing in the country I am living from hand to mouth." (PhD Participant, male).

Another participant added that:

> "I am having challenges in balancing the financial costs of pursuing a PhD while at the same time paying my two children's school fees. My salary and total income is never enough. I am considering withdrawing and rather give my children the chance to learn." (PhD Participant, Male)

High work-loads

The respondents complained of high academic work-loads which were affecting the academic-work-life balance resulting in feelings of distress and life dissatisfaction. One respondent complained:

> "I have high workloads as a result of attempting to produce original research work. I search databases for hours on end trying to find and fill research gaps." (PhD Participant, female).

Another one simply stated that:

> "I never thought the PhD would be this demanding. I hardly spend any time with my family nowadays. Sometimes I ask myself if it is worth it at all". (PhD Participant, female).

Student-supervisor disagreements

The supervisor-student relationship was also fraught with disagreements, which often led to mistrust and strained relations. One of the respondents felt that the supervisors:

> "……. did not devote adequate time in guiding us or in making us adequately understand our research challenges." (PhD Participant, Male).

Another participant added that:

> "My supervisor seems to be always pre-occupied with their own livelihood activities and rarely gives feedback on time." (PhD participant, female).

Inadequate or lack of student support services and infrastructure

Some of the challenges indicated by respondents were primarily related to access to e-learning, library, administrative support, communication, student support services, and general use of technology outside campus. One respondent explained that:

> "These challenges compromise the quality of our PhD research work, inhibiting learning opportunities, and leaving us feeling demotivated and dejected." (PhD Participant, Female).

Another PhD student corroborated by pointing out that:

> "The GZU introduced doctoral level studies recently but unfortunately the infrastructure ordinarily expected of institutions awarding PhDs is not yet fully in place." (PhD participant, male).

Uncertain future / job market

Concerns about an uncertain job market and future were one of the key factors precipitating depressive symptoms in PhD students and inhibiting their academic performance. One participant said:

> "I registered for a PhD to enhance my chances to join University lectureship, however I leant of two other PhD holders in my field who are jobless as we speak. I am fearful by the time I complete my PhD there won't be any job opportunities anywhere" (PhD student, male).

Another participant simply stated that:

> "It is not a surprise anymore, to come across an unemployed Doctor here in Zimbabwe. I hope I won't be an addition to the statistics." (PhD student, female*)*.

Social problems

There were certain respondents who had to address pressing social problems as well as meeting the demands of academic work. This had a negative effect on coping as this respondent noted:

> "I am failing to effectively sail in my PhD course as a result of social problems that are affecting me. Presently, my wife is hospitalized, and she needs my assistance in running around procuring drugs and expects general spousal care from me." (PhD male participant).

Health problems

There were other students with lifelong and chronic health problems which made them susceptible to stress as this participant mourned:

> "I have pressing health problems which affect my PhD study. I am hypertensive and the stresses of my health condition sometimes limit my performance academically." (PhD Participant, female).

Coping strategies or mechanisms by PhD students

The qualitative component of the current study was also fully utilised to establish the coping strategies or mechanisms typically employed by the PhD students at GZU to ameliorate the stress and depressive disorders related to doctoral studies.

Table 4: Coping strategies by PhD students

Main Theme	Sub-themes
▪ Coping strategies by PhD students	▪ Turning to friends and spouses ▪ Spirituality or Religiosity ▪ Support groups ▪ Smoking and drinking

Friends and spouses

A significant number of participants indicated that they turned to friends and spouses for social support each time they suffered stress or symptoms of depression. Support received differed from tangible material things to emotional encouragement to continue working on their doctoral studies. One participant stated:

> "PhD work is so demanding sometimes you end up overwhelmed with work, and become withdrawn and isolated. Keeping social contact with friends is a sure way to cope with demands of academic life." (PhD Participant, female).

Another participant shared similar sentiments and pointed out that:

> "The emotional support from my wife and children gives me strength and motivates me to keep going to make them proud". (PhD Participant, Male).

Spirituality or religiosity

The majority of participants were firm believers in Christianity and believed that their belief in God helps them cope with all the adversity they encounter on their PhD journey. One participant mentioned that:

> "I believe in God, and I see all the hardships I come across as normal challenges of life meant to strengthen and not break you." (PhD Participant, female).

Support groups

Most of the respondents also shared that they joined support groups of fellow PhD students where they had discussions and shared latest developments. One participant brought out the dimension of a WhatsApp group by stating:

> "I belong to a WhatsApp group of Zimbabwean PhD students who are studying in different parts of the world, from USA, UK, China, India and across the Limpopo in South Africa. This group has helped me a lot in my PhD journey." (PhD Participant, Male).

Smoking and drinking

Although considered a maladaptive coping strategy, a notable number of male PhD students indicated that they do regularly turn to drinking alcohol and even smoking to ease the tension and pressure wrought by doctoral studies. One male participant stated:

> "I usually take a few drinks with my friends at a local bar in my home area to just relax and refresh my mind." (PhD Participant, Male).

Another PhD student mentioned that:

> "Without a cigarette I get nervous and tense. Smoking relaxes my nerves and helps me cope with tense and stressful situations." (PhD Participant, Male).

Discussion

The purpose of this study was to establish the prevalence and determinants of depressive disorders, as well as the coping strategies of the PhD students at a local university in Masvingo, Zimbabwe. The discussion is therefore organised around the three major headings of prevalence, determinants and coping strategies.

Prevalence of depressive symptoms

The current study established that PhD students at GZU exhibited mild to moderate symptoms of depression, with very few severe cases. Although there is a general dearth of literature on the prevalence of depressive symptoms amongst PhD students in Zimbabwe, the findings of this study generally concur with findings of studies conducted in other low-to-medium income countries such as India (Leethu et al., 2021; Deb et al. 2016); Ghana (Asante, & Andoh-Arthur, 2015); Kenya (Othieno et al., 2014) and even China (Liu, 2019). These studies reported mild to moderate prevalence of 37.7%, which is also consistent with a global survey by Evans et al. (2018). A study by Maziti and Mujuru (2021) also established a modest 37.5% general prevalence of depression among undergraduate students at GZU.

It remains notable that prevalence rates of depression among tertiary students are more than the general population by at least six times (Evans et al., 2018). Estimates range from 23.7% to 37.5% (Ahmed et al., 2020; Maziti & Mujuru, 2021; Liu et al., 2019; Levecque et al., 2017; Leethu et al., 2021). The consistently high prevalence rate of depressive symptoms amongst tertiary students, particularly PhD scholars, is a cause for concern. There is a need for concerted efforts by universities to address the increasing mental health needs of all students. Doctoral level studies are especially quite demanding and PhD students require special attention if their studies are to make a meaningful contribution to knowledge and impact society socially, economically or politically.

Determinants of depressive disorders

Factors that expose PhD students to depressive symptoms were also investigated. This study established a multiplicity of factors leading to depressive disorders. These include the university environment that presents many challenging and demanding situations such as adjusting to new environments, frequently high academic-workloads, economic and financial challenges, student-supervisor relations, mastering new skills, and uncertainty about the job prospects after graduation. These factors dovetail with what Wilstoon (2017), Leethu et al. (2021) also discovered in their earlier studies.

Respondents highlighted many factors by that predisposed them to depressive symptoms. These were related to access to administrative support, communication, student support services, and general use of technology outside campus. Due to the increased student populations and the attendant work load, most students did not get individual help like counselling as expected when they were experiencing psycho-social problems. This myriad of factors is enough for the students to fall into depression.

Some participants highlighted other key factors precipitating depressive symptoms in PhD students and inhibiting their academic performance. These factors included financial hardships, disagreements between student and supervisor, lack of student support services, and concerns about the uncertainty of the job market and the future. These findings are related to a related survey carried out by the WHO (2018). In the current study, financial challenges emerged as one of the key concerns, potentially inhibiting students' academic performance and their mental health. Some research scholars have also faced many financial hardships even when they got scholarships as such university sponsorship could be inadequate to meet their expenses (Woolston, 2017; Oswalt, 2018). Furthermore, such paltry amount would often be delayed, affecting even daily sustenance. All these determinants combine in complex fashion to elicit depressive disorders among PhD students.

Coping strategies or mechanisms

The study also established a number of notable coping strategies that were employed by PhD students to mollify the effects of distress. These include turning to friends and spouses for psychosocial support; spirituality or religiosity; support groups, and even other maladaptive mechanisms such as smoking and drinking alcohol. These findings are echoed by Atindanbila, and Abasimi (2011) who conducted a research on depression and coping strategies among university students in Ghana. Their research revealed that participants utilise cognitive coping strategies to cope with depression, more than other strategies such as medical, physical, social or spiritual strategies.

Findings of this study are consistent with, and validate Lazarus and Folkman's (1984) transactional theory of stress and coping (TTSC). The theory succinctly posits that there is a dynamic interaction between a PhD student and the university environment or the community that results in stress (Goh, Sawang & Oei, 2012). Stress occurs when the person–environment interaction exceeds coping resources and that threatens psychological and physical wellness of an individual (Merluzzi, Philip, Vachon & Heitzmann, 2011). If a PhD student does not possess sufficient assertiveness and cognitive coping skills, they may be at increased vulnerability to stress and depression.

Recommendations

After outlining the research findings and making some considerations the researcher came up with some recommendations for the stakeholders and future studies. The recommendations were as follows:

i) It is recommended that the supervisors should strive to make use of participatory approaches that improve the mastery of new skills and performance of PhD students.
ii) The universities should be capacitated to offer psychosocial support to those PhD students experiencing social and health problems.
iii) Universities should capacitate their student support services in areas like access to e-learning, library, administrative support and communication.

Conclusion

The results show that the participants mostly showed moderate symptoms of depression from the PHQ-9 test administered. There were few respondents reporting less severe and severe symptoms. Age and facing difficulties in mastering new skills were reported as risk factors for depressive symptoms among the PhD students studied. High workloads, social and health problems were some of the environmental determinants of depressive symptoms. Respondents also highlighted other factors like economic or financial hardships, disagreements between student and supervisor, lack of student support services, and concerns about an uncertain job market and the future were other key factors precipitating depressive symptoms in PhD students and inhibiting their academic performance. Some of the challenges, as indicated by respondents, were primarily related to access to e-learning, library, administrative support, communication, student support services, and general use of technology outside campus. It was also established that most of the participants had challenges in adjusting to the university environment, which caused them to experience symptoms of stress. On coping mechanisms, most students experiencing depressive symptoms got help from professionals such as psychologists and counsellors while some resorted to drinking and smoking to mask up their symptoms of depression. Despite suffering from depressive symptoms, the students surveyed felt that the PhD programme was instrumental in preparing candidates for satisfying careers.

Acknowledgements

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The Role of Guidance and Counselling in Promoting Mental Health Awareness among Adolescents at a Learning Centre in Bulawayo, Zimbabwe

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Abstract

This study utilises a mixed-methods approach to explore and provide a comprehensive analysis of the role of guidance and counselling in enhancing mental health awareness among adolescents at a high school in Bulawayo, Zimbabwe. The research aims to assess the current level of mental health awareness among students, evaluate the effectiveness of existing guidance and counselling programs, identify key mental health challenges, and gather feedback on potential improvements. Quantitative data was collected through a cross-sectional survey, while qualitative insights were obtained from semi-structured interviews and focus group discussions involving students, teachers, and school counsellors. The findings revealed that, while students were generally aware of the available mental health resources at the school, significant barriers persist, including pervasive stigma and a strong preference for external psychologists over school counsellors. Additionally, the existing guidance and counselling programmes are perceived as ineffective, irrelevant, and inadequate by the majority of students, highlighting critical gaps in the current support system. The study identifies substantial mental health challenges faced by students, such as excessive worry, anxiety, and persistent sadness, which are exacerbated by the limited effectiveness of current interventions. The research underscores the need for more robust mental health guidance and counselling framework, improved professional support, and greater student involvement in programme development. Recommendations include increasing the frequency and quality of mental health programmes, addressing stigma through targeted awareness campaigns, and integrating more specialized mental health professionals into the school setting. Data analysis involved both descriptive statistics and thematic analysis to provide a nuanced understanding of the effectiveness of mental health guidance and counselling and support at the high school level.

Keywords: mental health awareness, adolescents, guidance and counselling programs, stigma, mixed-methods research

Introduction

Mental health issues among adolescents have become a critical global concern as this age group is particularly vulnerable to emotional and psychological challenges due to the complex interplay of developmental, social, and environmental factors. Effective mental health guidance and counselling within schools is increasingly recognised as a vital strategy for addressing these challenges and promoting overall well-being. Schools offer a unique setting to implement preventive interventions and provide support, given their central role in adolescents' daily lives and their capacity to reach a large population of young people.

In Bulawayo, Zimbabwe, a high school presents an ideal environment to examine the role of guidance and counselling programs in fostering mental health awareness and support. Zimbabwe, like many low income countries (LICs), faces unique socio-economic and cultural challenges that impact mental health, including limited resources and prevalent stigma surrounding mental health issues. These factors complicate the implementation and effectiveness of school-based mental health programmes, making it imperative to understand the specific context and needs of students in this setting.

This study utilises a mixed-methods approach to gain a comprehensive understanding of the current state of mental health guidance and counselling at a high school in Bulawayo. By combining quantitative data from surveys with qualitative insights from interviews and focus groups, the research aims to provide a nuanced analysis of the effectiveness of existing mental health programs, the level of student awareness, and the gaps in current support systems. Despite the presence of mental health resources such as guidance counsellors, the study reveals significant issues, including pervasive stigma and a preference for external psychologists over school-based counsellors. These findings underscore the need for a more robust and responsive mental health guidance and counselling framework.

The objectives of this research are to assess the current level of mental health awareness among students, evaluate the effectiveness of existing guidance and counselling programs, identify key mental health challenges faced by adolescents, and gather constructive feedback from students, teachers, and parents. By addressing these areas, the study seeks to offer actionable recommendations for enhancing mental health support within the school setting and reducing the stigma associated with seeking help. The insights gained from this research would be valuable in informing policy changes, improving program design, and ultimately contributing to better mental health outcomes for adolescents in Bulawayo and similar contexts.

Literature review

Adolescence is universally recognised as a critical period for mental health, marked by significant emotional and psychological development. Globally, the importance of mental health guidance and counselling during this developmental stage is underscored by extensive research demonstrating its role in fostering well-being and preventing mental health issues. Effective mental health guidance and counselling in schools is pivotal in enhancing students' understanding of mental health, reducing stigma, and encouraging positive mental health behaviours. Studies have consistently shown that school-based mental health programmes can significantly improve mental health literacy, enabling students to identify symptoms early and seek appropriate help (Reinke et al., 2019; Weist et al., 2020). By embedding mental health guidance and counselling within the school curriculum, schools create an environment that supports open dialogue about mental health challenges, which is essential for reducing stigma and fostering a supportive atmosphere.

Across continents, evidence supports the effectiveness of well-designed school-based mental health programs. For example, research from North America and Europe highlights that programmes integrating interactive components and regular activities into the curriculum are particularly effective (Fazel et al., 2019). These programmes often combine classroom instruction with practical skill-building activities and peer support, creating a holistic approach to mental health guidance and counselling. Despite these successes, several barriers impact the implementation of these programmes, including inadequate funding, a shortage of trained mental health professionals, and poor programme evaluation (Karcher et al., 2018). These challenges underscore the need for enhanced resources and structural support to effectively address mental health in guidance and counselling settings.

In the context of Africa, and specifically Zimbabwe, the landscape of mental health guidance and counselling presents unique challenges and opportunities. While there is growing recognition of the need for mental health support in schools, stigma remains a significant barrier to the utilisation of mental health services. Research has shown that stigma can deter students from seeking help and exacerbate mental health issues (Corrigan & Watson, 2022). This reluctance is often driven by fear of negative judgment and social exclusion. Effective mental health interventions in Zimbabwean schools must address these stigma-related barriers through targeted guidance and counselling campaigns and the promotion of mental health awareness (Pescosolido et al., 2018). Creating a more inclusive and accepting school culture is crucial for encouraging students to seek help without fear.

Similarly, in South Africa, there has been increasing recognition of the need for school-based mental health services, particularly due to the country's high rates of youth mental health challenges linked to socio-political stressors, including high crime rates, poverty, and historical trauma (Pillay & Louw, 2019). Research emphasises the importance of culturally sensitive interventions and integrating community-based resources to address the mental health needs of South African adolescents (Herman et al., 2020). South African schools have been exploring ways to destigmatise mental health and integrate mental health professionals into the education system to meet the diverse needs of students.

In Kenya, efforts to improve adolescent mental health are gaining traction, though challenges remain. Kenyan schools have increasingly recognised the importance of guidance and counselling services to address issues such as substance abuse, depression, and anxiety among students (Omondi et al., 2017). However, barriers such as limited resources, lack of trained professionals, and cultural misconceptions around mental health continue to hinder the effectiveness of these programmes (Kenyatta University, 2021). Recent initiatives in Kenya have focused on training teachers and counsellors to identify and address mental health issues and incorporate mental health education into the broader school curriculum (Mwangi & Kamau, 2020).

From a school perspective, students' preferences for mental health professionals significantly impact the effectiveness of mental health services. Many adolescents express a preference for psychologists over school counsellors, perceiving psychologists as more specialised and impartial (Gonzalez et al., 2021). This preference highlights the importance of integrating specialised mental health professionals into school settings. Having access to professionals with advanced training can provide more effective support for complex mental health issues compared to general school counsellors.

Recent literature offers several recommendations for enhancing mental health guidance and counselling. Increasing the frequency and quality of mental health programmes, incorporating student feedback into its development, and reducing stigma through targeted initiatives are essential for improving its effectiveness (Kutcher et al., 2021). Additionally, professional development for educators is critical. It equips teachers with the skills to identify and address mental health issues effectively and ensures that interventions are based on evidence-based practices (Durlak et al., 2020). Involving students in the creation and evaluation of mental health programmes can make these interventions more relevant and engaging, thus enhancing their overall impact. This comprehensive approach to mental health guidance and counselling can better address the needs of students and improve mental health outcomes within school environments.

Aims of the study

The main aim of this study was to investigate the role of guidance and counselling in promoting mental health awareness of adolescents at a high school in Bulawayo, Zimbabwe. The study also sought to identify improvements in mental health support and guidance and counselling.

Study objectives

i) To assess the current level of mental health awareness of adolescents at a high school in Bulawayo, Zimbabwe.

ii) To evaluate the effectiveness of existing guidance and counselling programmes in enhancing mental health awareness of high school students.

iii) To identify the key mental health challenges faced by adolescents at a high school.

iv) To gather feedback from students on improving mental health guidance and counselling and support in a school setting.

Methodology

Research approach

The study employed a mixed-methods approach, combining both quantitative and qualitative research methodologies to achieve a comprehensive understanding of how guidance and counselling programmes enhance mental health awareness of adolescents. This approach enabled the collection of numerical data to assess the extent of mental health awareness and qualitative data to gain deeper insights into the participants' experiences and perceptions regarding mental health guidance and counselling.

Research design

A cross-sectional survey design was utilised for the quantitative component, allowing the collection of data from a large sample of students at a single point in time. This design facilitated an assessment of students' mental health awareness levels and the effectiveness of guidance and counselling interventions. For the qualitative component, a case study design was used within the online survey framework, which included open-ended questions to gather detailed personal experiences and perceptions of students, teachers, and school counsellors regarding mental health guidance and counselling.

Population

The study targeted adolescents attending a high school in Bulawayo, Zimbabwe. This population included students from various form levels.

Sample and sampling technique

A random sampling method was employed to ensure a sample across different grades within the high school. This technique helped capture diverse perspectives from various age groups and academic levels. The sample aimed to include a minimum of 30 respondents to achieve statistical significance.

Data collection procedure

Data were collected through an online survey that integrated both quantitative and qualitative elements. The quantitative section of the survey included topics such as awareness of mental health issues, sources of information, perceived effectiveness of guidance and counselling programmes, and attitudes towards mental health. The qualitative section featured open-ended questions designed to capture in-depth responses related to personal experiences with mental health guidance and counselling, and suggestions for improvement. The online format facilitated ease of distribution and response collection, ensuring broad participation.

Data analysis

Quantitative data were analysed using Statistical Package for Social Sciences (IBM Statistics Version 23). For qualitative data, thematic analysis was performed to identify patterns and insights from the open-ended responses. NVivo software was utilised to assist in organising and analysing the qualitative data systematically, coding responses into themes and sub-themes to provide a thorough understanding of the participants' experiences and perceptions.

Integration of quantitative and qualitative data

The integration of quantitative and qualitative data was achieved through comparison of numerical results with qualitative insights, validating and enhancing the understanding of mental health awareness and guidance and counselling programme impacts. The final report synthesised statistical evidence with detailed personal experiences, offering a comprehensive view of the research topic.

Ethical considerations

Ethical considerations were rigorously adhered to throughout the study. Informed consent was obtained from all participants, including locum-parental consent for minors, ensuring that participants were fully informed about the study's objectives, procedures, and their right to withdraw without penalty. Confidentiality and anonymity were maintained by removing personal identifiers from the online survey data. The study design was carefully crafted to minimise potential harm and distress to participants, and the findings were intended to contribute positively to understanding and improving mental health guidance and counselling.

Participants' profiles

Table 1 and Figure 1 below show the demographic characteristics of the participants. There were 15 males and 13 females who participated in the study, but 2 participants preferred not to reveal their gender. A majority of participants were Form 4 students (n=10), followed by Lower 6 students (n=8).

Table 1: Respondents' Age and Gender Cross-tabulation

		Respondents' Gender and Form Level			
		Respondents' gender			
		Male	**Female**	**Prefer not to say**	**Total**
Form Level	Form 1	1	2	0	**3**
	Form 2	0	1	1	**2**
	Form 3	1	0	1	**2**
	Form 4	6	4	0	**10**
	Form 5	4	4	0	**8**
	Form 6	3	2	0	**5**
Total		**15**	**13**	**2**	**30**

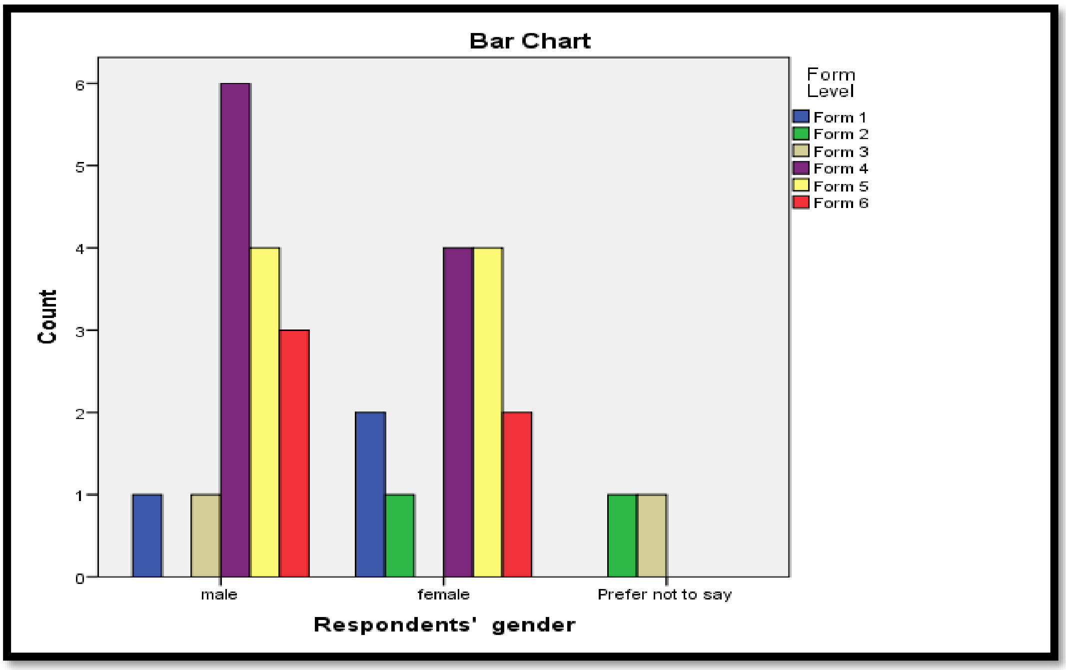

Figure 1: Respondents' gender and form level

Results

This section presents the study results. Researchers analysed data using Statistical Package for Social Sciences (IBM Statistics Version 23) and thematic analysis. The results are presented in the order of research objectives.

Level of mental health awareness among students

According to the results, only 5 participants (16.7%) lacked knowledge about where to get mental health services, as shown in Table 2 below. A fifth of the participants (20%) were slightly knowledgeable. The rest were moderately knowledgeable (26.7%), very knowledgeable (33.3%), and extremely knowledgeable (3.3%).

Table 2: Participants' knowledge about where to seek help for mental health issues

		Frequency	**Percent**	**Valid Percent**	**Cumulative Percent**
Valid	**Not at all knowledgeable**	5	16.7	16.7	16.7
	Slightly knowledgeable	6	20.0	20.0	36.7
	Moderately Knowledgeable	8	26.7	26.7	63.3
	Very Knowledgeable	10	33.3	33.3	96.7
	Extremely knowledgeable	1	3.3	3.3	100.0
	Total	30	100.0	100.0	

Most of the participants (80%) concurred that they had received information about mental health resources available at the school. A smaller percentage of participants (20%) denied receiving such information as shown in Table 3 below.

Table 3: Information about mental health resources at the school

	Frequency	**Percent**	**Cumulative Percent**
Yes	26	80	80
No	6	20	100
Total	**30**	**100**	

Half or 15 participants (50%) concurred that there is stigma associated with seeking mental health services at the school. A small fraction of the participants disagreed (6.7%), and 13 (43.3%) were neutral. A majority of participants who agreed that there is stigma were Form 4s (5), followed by Form 5 (3) and Form 6 students (3), as shown in Figure 2 below.

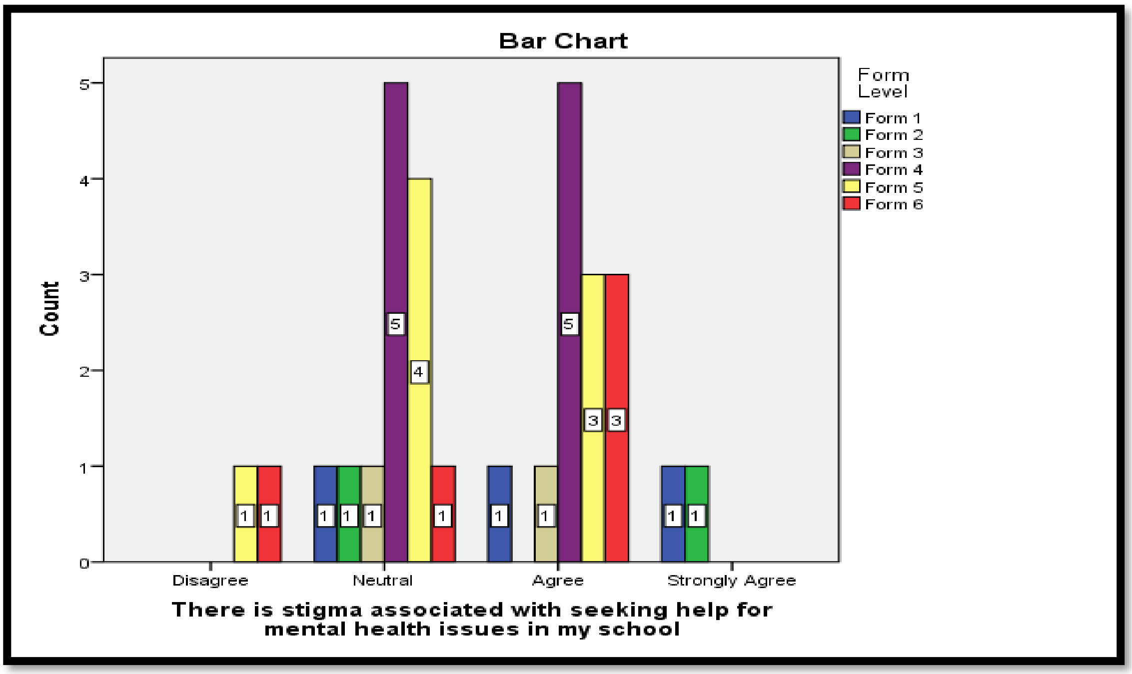

Figure 2: Stigma associated with seeking mental health services at the school

Figure 3 below shows that only 27% of participants reported being comfortable talking to a school counsellor about mental health issues. Almost a third of the participants (30%) were neutral while 43% were not comfortable.

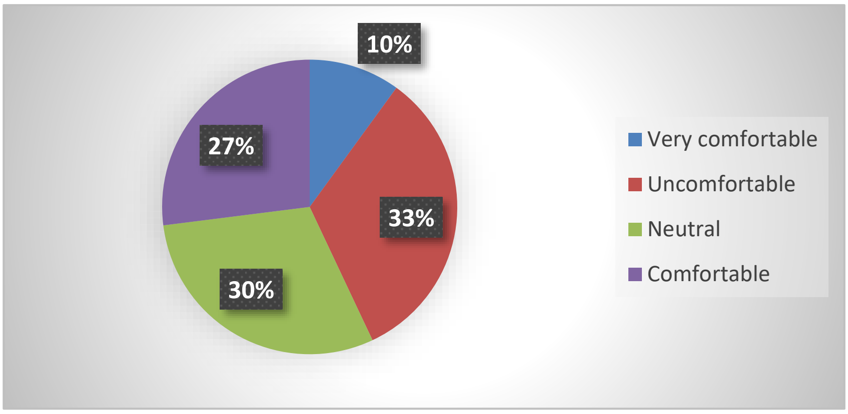

Figure 3: How comfortable would you feel talking to a school counsellor about a mental health issue?

Effectiveness of existing guidance and counselling programmes in enhancing mental health awareness

More than half of the participants (54%) believed that the school is not taking mental health issues seriously. Only a smaller percentage (3%) believed that mental health issues were prioritised at the school. Nearly half of the participants (43%) were not sure as shown in Figure 4 below.

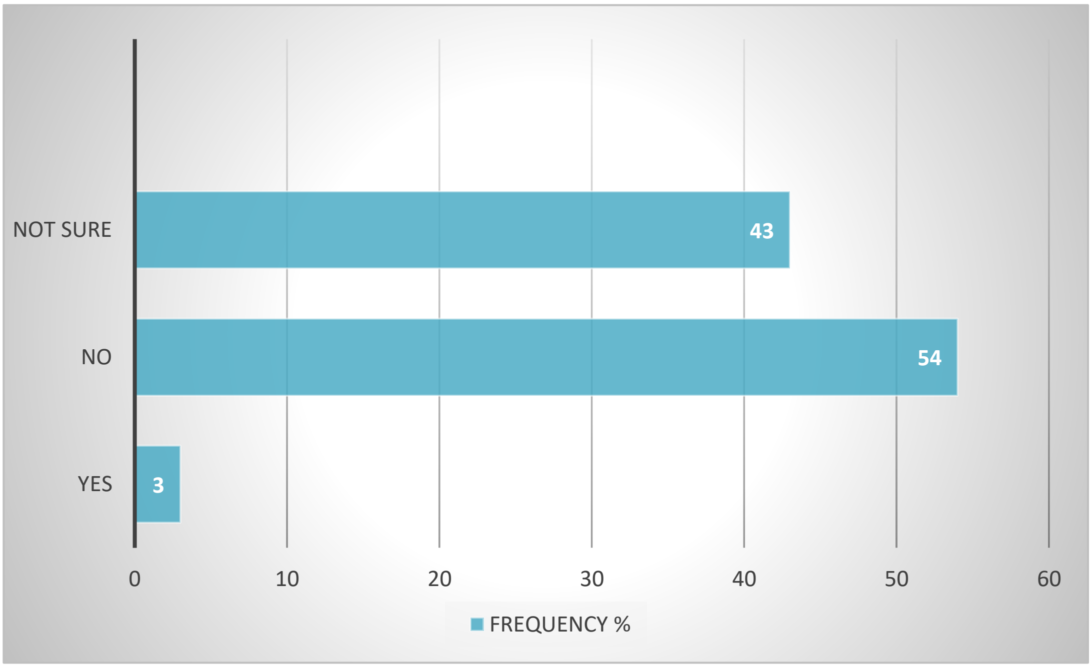

Figure 4: Are mental health issues taken seriously at your school?

Figure 5 below shows that a majority of participants (56.7%) believed that the mental health programmes at their school are slightly effective. A fifth of the participants (20%) reported that the programmes were not effective at all, and 23.3% deemed those programmes as moderately effective.

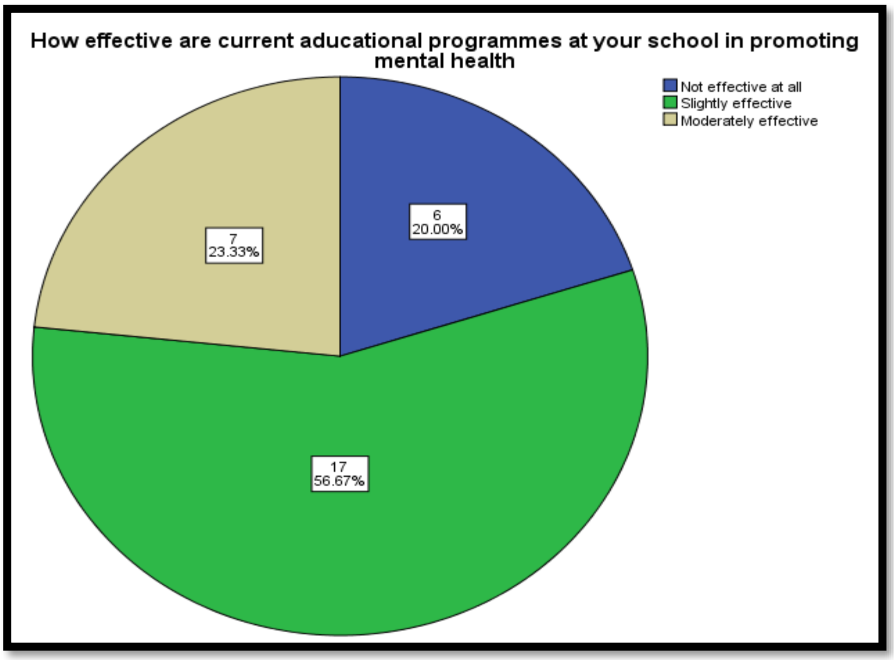

Figure 5: Effectiveness of current guidance and counselling programs in promoting mental health

Key mental health challenges faced by students

Most participants (60%) reported experiencing excessive worry and anxiety from time to time, and 17% reported experiencing it more often. Persistent sadness or depression occasionally affected 44% of the participants while 13 % experienced it more often. The results are clearly illustrated by Table 4 below.

Table 4: Mental health challenges faced by students

	Frequency				
	Never	Rarely	Sometimes	Often	Always
Persistent sadness or depression	10%	33%	44%	13%	0
Excessive worry or anxiety	3%	20%	60%	17%	0
Difficulty sleeping or insomnia	19%	37%	37%	7%	0
Social withdrawal or isolation	3%	50%	40%	7%	0

A greater percentage of male students, as shown in Figure 6 reported that they viewed talking to friends and family as ineffective in dealing with mental health challenges. Most female students believed that talking to friends and family is slightly effective (13.3%), moderately effective (16.7%), and very effective (13.3%).

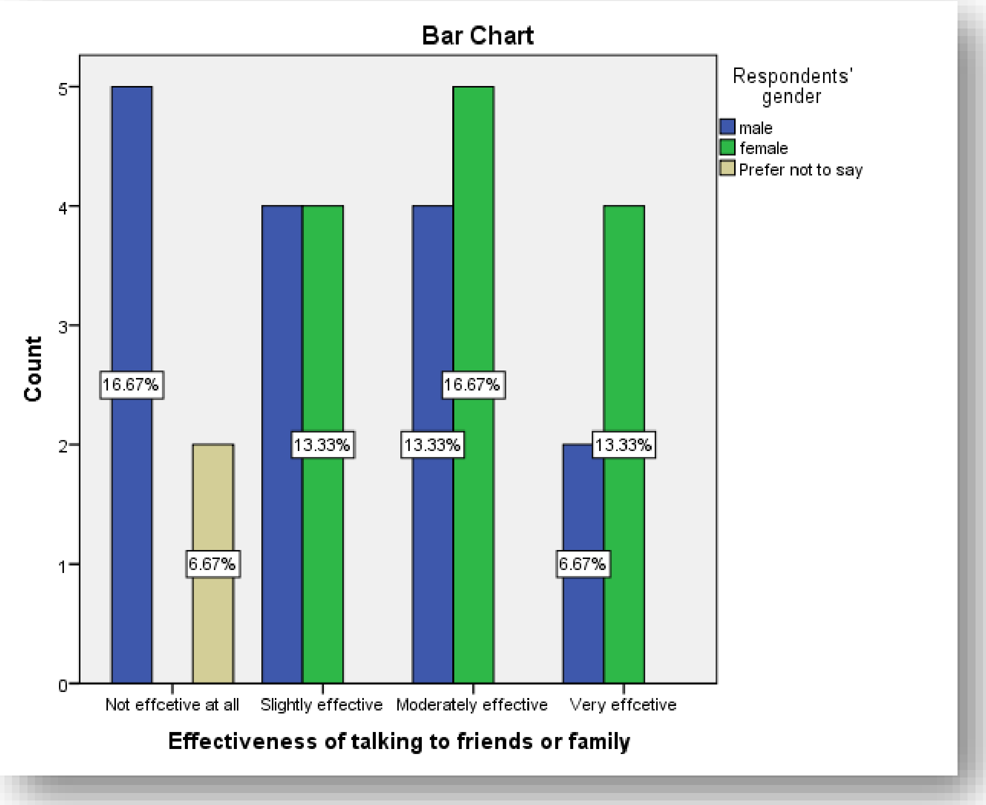

Figure 6: Effectiveness of talking to friends or family in dealing with mental health challenges

Table 5 and Figure 7 below show that participants (73.3%) viewed their school's mental health support as inadequate. Only 26.7% of the participants agreed that the support is available but needs improvement.

Table 5: Adequacy of support that addresses mental health challenges

	Frequency	**Percent**	**Cumulative Percent**
Yes, but could be improved	8	26.7	26.7
No, not enough support	19	63.3	90
No support available	3	10	100
Total	30	100	

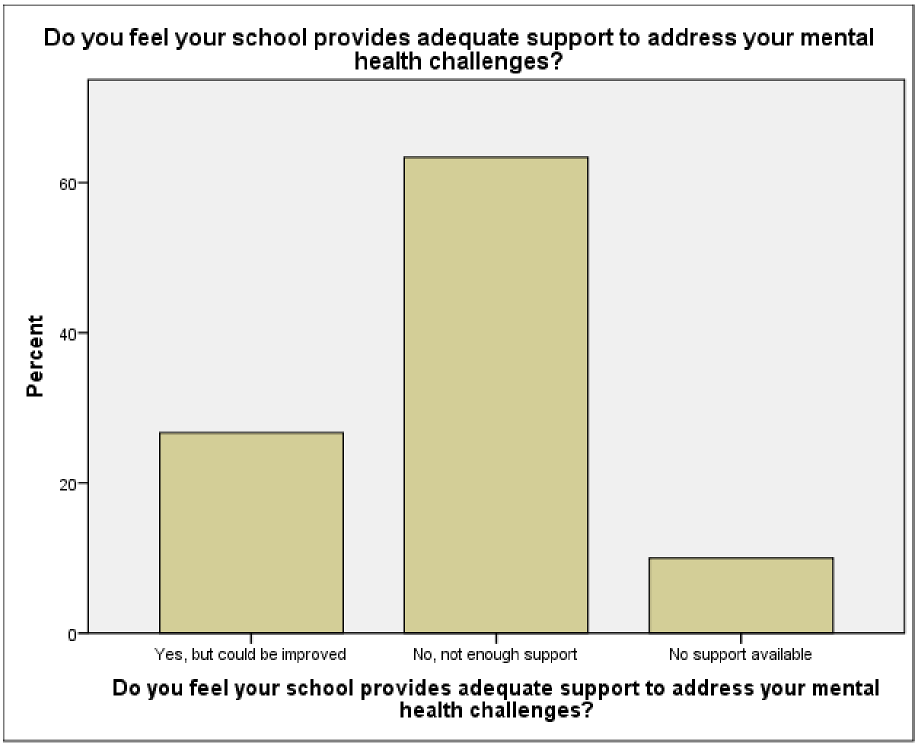

Figure 7: Adequacy of support provided by the school

Feedback on how to improve mental health guidance and counselling at the school

Many Form 4 students highlighted that they needed more help in dealing with academic pressure, anxiety and stress, especially towards the examinations period. They expressed desire to receive mental health support from psychologists rather than guidance and counselling teachers.

Some participants proposed raising of awareness at the school to demystify mental health and get rid of the stigma associated with seeking mental health services. Participant 12 commented:

> We need more awareness campaigns so that people get educated. Currently, there is stigma associated with seeking mental health services.

Most participants expressed concern over having guidance and guidance teachers, instead of psychologists, to provide mental health services. Students emphasised the need for a school psychologist for effective management of mental health issues. In addition, they highlighted the need for mental health lessons to equip both teachers and students.

> Having more mental health seminars would be helpful. Teachers also need awareness and, in the meantime, we need psychologists at our school until teachers are well-equipped to deal with mental health issues (Participant 16).

> We need professionals who are trained to deal with mental health issues, not teachers. The school should hire psychologists (Participant 7).
>
> The school is not allocating enough time for mental health lessons (Participant 5).
>
> We do not want our teachers as counsellors. We need psychologists to come and teach us about mental health issues (Participant 20).

Some participants also proposed students' active involvement and participation in mental health programmes so that their views and contributions would inform intervention strategies. They wanted to feel understood and heard. Participant 3 highlighted:

> They need to know what we are going through and what we need. They should come up with programmes that address our needs, hence it would be helpful if they involved us in mental health programmes.

Participants agreed that the current guidance and counselling programmes that promote mental health at the school were not adequate and there is still room for improvement.

Discussion

The findings from this study offer a detailed snapshot of mental health awareness and support among students at a high school in Bulawayo, Zimbabwe. The mixed-methods approach, integrating quantitative survey data with qualitative feedback, allowed for a nuanced understanding of both the strengths and limitations of the current mental health guidance and counselling programmes. These results are compared with those of other scholars to better contextualise the findings within the broader research landscape.

Level of mental health awareness

The survey results revealed that, while a substantial proportion of students were aware of mental health resources, with 80% acknowledging having received information about available services (Table 3), there remained significant variability in the depth of their knowledge. Only 3.3% of participants considered themselves extremely knowledgeable, with the majority falling into the "very knowledgeable" (33.3%) or "moderately knowledgeable" (26.7%) categories (Table 2). This disparity suggests that, while information dissemination has been successful to an extent, there is a need for a more structured and consistent approach to ensure comprehensive knowledge across all students. Enhanced efforts, such as regular workshops and interactive guidance and counselling sessions, could bridge this knowledge gap and ensure that all students are equally informed about mental health resources and support options. These findings resonate with similar research in South Africa, where studies by Pillay and Louw (2019) highlighted gaps in students' understanding despite extensive awareness programmes, suggesting that greater emphasis is needed on depth and consistency of mental health education.

Perceptions of stigma and support

The persistent stigma associated with mental health services, as highlighted by 50% of participants (Figure 2), points to a significant barrier in accessing support. This stigma, coupled with the discomfort felt by 43% of students in discussing mental health issues with school counsellors (Figure 3), underscores a critical issue in the current support structure. Research consistently shows that stigma not only discourages help-seeking behaviours, but also exacerbates mental health challenges (Corrigan & Watson, 2022). This aligns with findings from Kenya, where Omondi et al. (2017) observed that stigma remains a substantial barrier to accessing mental health support in schools, often preventing students from seeking help despite awareness of available services. In this context, the discomfort reported by students might be indicative of a lack of trust in or rapport with the existing counsellors or could reflect broader societal and institutional stigma, as observed by Mwangi and Kamau (2020). To address this, schools might consider implementing stigma-reduction programmes, similar to those proposed by Pescosolido et al. (2018), and fostering an environment where mental health is openly discussed and normalised.

Effectiveness of guidance and counselling programmes

The data revealed a general dissatisfaction with the effectiveness of existing mental health programmes, with 56.7% of participants rating them as only slightly effective (Figure 5). This sentiment is supported by the finding that 54% of students believed mental health issues were not taken seriously at their school (Figure 4). This perception of ineffectiveness could stem from several factors, including insufficient programme integration into the curriculum, lack of engaging content, or inadequate follow-up and support. Effective mental health programmes should be integrated into the school's regular activities and tailored to address the specific needs and concerns of students. The results here echo those found by Durlak et al. (2020), who highlighted that integrating mental health programmes into regular school curricula, involving students in the design process, and ensuring follow-up support can significantly increase programme effectiveness. Similarly, research by Kutcher et al. (2021) suggests that programmes should be designed with regular feedback mechanisms to ensure they remain relevant and effective.

Mental health challenges

The prevalence of mental health challenges among students, including excessive worry, persistent sadness, and social withdrawal, is consistent with broader research on adolescent mental health (Fazel, Von Hoebel, & Luntamo, 2019). The high rates of anxiety and depressive symptoms highlight an urgent need for targeted interventions. The significant number of students who reported that talking to friends and family was less effective in managing these challenges (Figure 6) suggests that existing support systems outside the school setting may also be inadequate. This finding is in line with studies in other African countries, such as South Africa, where Herman et al. (2020) found that adolescents often experience limited support from family and peers, thus underscoring the necessity of professional mental health interventions in schools. These results further reinforce the need for the school to provide more robust and professional mental health support to complement external resources.

Support adequacy and recommendations

The overwhelming majority of students (73.3%) rated the school’s mental health support as inadequate (Table 5 and Figure 7). This perception is particularly concerning given the reported need for more effective support mechanisms. The students' feedback emphasises a clear demand for professional psychologists rather than reliance on guidance counsellors. Many students also called for more awareness campaigns to reduce stigma and increase the visibility of mental health issues. This feedback aligns with the recommendations in the literature, which advocate for the integration of mental health professionals into school settings and the implementation of comprehensive mental health guidance and counselling programmes (Gonzalez & Tavares, 2021; Kutcher, Wei, & Coniglio, 2021). These findings echo research by Karcher et al. (2018), who emphasised the necessity of enhancing school-based mental health programmes with the support of trained professionals and more frequent mental health literacy campaigns to better address the needs of students.

Conclusion

The study provides critical insights into mental health awareness and support at a high school in Bulawayo, Zimbabwe, revealing both progress and significant challenges. The data demonstrates that while most students had some knowledge of mental health resources, their understanding was not uniformly deep or comprehensive. The prevalent stigma associated with seeking mental health support remains a formidable barrier, impacting students' willingness to seek help and affecting their overall mental well-being. The reported discomfort with school counsellors suggests that existing support mechanisms were insufficient and highlights a need for a more empathetic and professional approach to mental health services.

The effectiveness of current guidance and counselling programmes was notably lacking, with a substantial portion of students rating them as only slightly effective or ineffective. This dissatisfaction was compounded by students' requests for more specialised support and a stronger emphasis on practical mental health guidance and counselling. Persistent mental health challenges, including high levels of anxiety and depression, further underscored the inadequacy of existing interventions. The results suggest that the current system did not fully address the complex and varied needs of students, emphasising the need for a robust, multi-faceted approach to mental health support in schools.

Recommendations

i) **Revise and expand mental health curriculum:** Schools should undertake a comprehensive review and revision of their mental health curriculum. This curriculum should not only provide foundational knowledge, but also incorporate advanced topics and skills, such as coping mechanisms, emotional regulation, and resilience building. The curriculum should be dynamic, incorporating student feedback to remain relevant and engaging. Collaborative efforts with mental health professionals can ensure the inclusion of evidence-based practices and strategies that resonate with students.

ii) **Combat stigma through continuous engagement:** To effectively combat stigma, schools should implement ongoing engagement strategies, including workshops, peer-led discussions, and community events that promote mental health awareness. These initiatives should aim to normalise mental health issues and encourage open dialogue. Schools might also consider integrating mental health guidance and counselling into existing subjects to ensure that it becomes a regular part of students' learning experiences.

iii) **Integrate specialised mental health professionals:** The employment of trained mental health professionals, such as psychologists and counsellors with specialised expertise is crucial. These professionals can offer tailored support and interventions that are more effective in addressing complex mental health issues than general guidance counsellors. Schools should explore partnerships with local mental health organisations or agencies to provide access to these specialists, ensuring that students receive high-quality, professional support.

iv) **Enhance student involvement in programme design:** To create more effective mental health programs, schools should actively involve students in their design and implementation. This can be achieved through focus groups, surveys, and student advisory boards that provide ongoing input. Engaging students in this way ensures that programmes are aligned with their needs and preferences, fostering a greater sense of ownership and engagement.

v) **Strengthen support systems and resources:** Schools should conduct a thorough evaluation of their current mental health support systems and resources. This evaluation should assess the adequacy, accessibility, and effectiveness of the available support services. Based on these assessments, schools should make necessary improvements, such as increasing funding for mental health initiatives, expanding the availability of support services, and ensuring that these services are easily accessible and confidential.

vi) **Implement comprehensive training for educators:** Professional development for educators is essential in equipping them with the skills and knowledge to recognise and address mental health issues effectively. Training programmes should focus on mental health literacy, intervention techniques, and strategies for creating a supportive classroom environment. This would enable teachers to better support students and contribute to a more holistic approach to mental health in schools.

vii) **Promote parental and community involvement:** Engaging parents and the wider community in mental health initiatives can enhance the overall effectiveness of school-based programs. Schools should develop strategies to educate parents about mental health issues and involve them in supporting their children's mental health. Community partnerships can also provide additional resources and support, contributing to a more comprehensive network of care.

By addressing these recommendations, schools can create a more inclusive and effective mental health support system that better meets the needs of their students. Implementing these changes would not only improve mental health outcomes, but also foster a supportive and understanding environment that promotes the overall well-being of the school community.

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Guide for authors

The *Zimbabwe Journal of Health Sciences* (*ZJHS*) will consider for publication articles relating to all forms of human psychological services as well as human health and social services issues.

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- All submissions should be written in English.
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