

Substance Abuse, Psychosocial Functioning and Support Systems among Youths in Mbare High-Density Suburb, Harare, Zimbabwe

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ABSTRACT

Drug and substance abuse among youths in Mbare high-density suburb, Harare, Zimbabwe, has reached alarming levels, with serious consequences for psychological well-being and social functioning. Despite the scale of the problem, there is a severe shortage of localized, empirical evidence that systematically examines the psychosocial functioning effects of substance abuse and the role of support systems within this specific community context. This study therefore seeks to assess the psychosocial functioning effects of drug and substance abuse among youths aged 15–24 in Mbare and to evaluate the accessibility and effectiveness of existing support systems. Specifically, the study aims to identify the types, patterns and prevalence of substances abused; to assess the prevalence and severity of depression and anxiety among substance-using youths; to examine the relationship between substance abuse and social functioning across family, educational and community domains; and to evaluate formal and informal support systems available to affected youths. The study adopts a mixed-methods research design, combining quantitative and qualitative approaches to capture both statistical patterns and lived experiences. A sample of youths aged 15–24 residing in Mbare will be selected through stratified random and purposive sampling techniques. Data will be collected using structured questionnaires, the Patient Health Questionnaire (PHQ-9), the Generalized Anxiety Disorder scale (GAD-7) and semi-structured interview guides. Quantitative data will be analysed using descriptive statistics, correlation and regression analysis, while qualitative data will be analysed thematically. The expected contribution of the study is a localized, evidence-based framework that informs policymakers, mental health practitioners and community organizations in designing integrated, context-sensitive interventions for substance-abusing youths in urban high-density settings in Zimbabwe.

Keywords: substance abuse, psychosocial functioning, youths, support systems, Mbare

INTRODUCTION

Overview

This chapter introduces the research study on drug and substance abuse and its psychosocial functioning effects among youths in Mbare high-density suburb, Harare, Zimbabwe. It establishes the foundation of the study by providing the background context that situates the research within the broader social and academic landscape, followed by a clearly articulated statement of the research problem. The chapter further presents the purpose of the study, specific objectives, and research questions that guide the investigation. It also outlines the research hypotheses, rationale, and delimitations of the study. The theoretical and conceptual frameworks underpinning the research are introduced, followed by a description of the study location and definitions of key terms used throughout the proposal. The chapter concludes with a brief summary linking its content to the chapters that follow.

Background

The phenomenon of drug and substance abuse among youths in Zimbabwe is deeply embedded within a complex interplay of historical, economic, social and structural factors. Since the early 2000s, Zimbabwe has experienced prolonged economic instability characterised by hyperinflation, currency collapse, industrial

decline, and a dramatic contraction of formal employment opportunities. These macro-economic shocks have had a disproportionate impact on urban youths, particularly those residing in high-density suburbs such as Mbare, where poverty, overcrowding and limited access to social services remain persistent challenges (ZIMSTAT, 2021; Nhengo, 2019). As a result, many young people have grown up in contexts marked by uncertainty, insecurity and constrained life chances.

Historically, Mbare emerged as a migrant labour settlement during the colonial period, designed to house African workers employed in urban industries. This historical legacy has contributed to long-standing structural inequalities, including inadequate housing, under-resourced health and educational facilities, and fragile social support networks. Over time, these conditions have been compounded by rural–urban migration, population growth, and the weakening of extended family systems that traditionally provided emotional and material support to young people. The impact of the HIV/AIDS pandemic further disrupted caregiving structures, leaving many youths orphaned or raised in child-headed households, thereby increasing vulnerability to psychosocial distress and risky behaviours (Makanza & Chibanda, 2019; Matsika, 2020).

Within this socio-economic milieu, drug and substance use among youths has gradually shifted from sporadic or experimental behaviour to an entrenched coping mechanism for managing daily hardships. The Zimbabwe Republic Police (2022) reports indicate a steep rise in drug-related arrests involving individuals under the age of 25, with substances such as mutoriro, a highly addictive methamphetamine derivative, becoming increasingly common in high-density urban communities. This rise reflects not only increased availability but also the growing normalisation of drug use within youth peer networks. The widespread consumption of alcohol, cannabis and synthetic or pharmaceutical substances has become embedded in everyday social life, particularly among unemployed and out-of-school youths who experience prolonged idleness and social exclusion (Chikwariro, 2021).

Concurrently, the non-medical consumption of codeine-based cough syrups, commonly referred to as brongo or broncleer, has surged among young people in urban Zimbabwe. Studies suggest that these substances are frequently used for their sedative and euphoric effects, often as a form of self-medication for untreated psychological distress, including anxiety, depression and trauma-related symptoms (WHO, 2021; Matsika, 2020). The affordability and accessibility of such substances, combined with weak regulatory enforcement, have further accelerated their misuse. Importantly, this pattern highlights the blurred boundaries between mental health challenges and substance abuse, underscoring the need for integrated psycho-social approaches rather than isolated punitive responses.

Scholars argue that the proliferation of drug and substance abuse among youths in Zimbabwe should not be viewed solely through a criminal justice lens. Chikwariro (2021) contends that the current crisis reflects deeper societal failures, including limited mental health literacy, inadequate youth-friendly recreational and psychosocial services, and the absence of meaningful economic opportunities. Similarly, Pearlin's (1989) Social Stress Theory suggests that chronic exposure to structural stressors such as poverty, unemployment, and social marginalisation overwhelms individual coping capacities, increasing the likelihood of maladaptive coping strategies such as substance abuse. In high-density suburbs like Mbare, these stressors are persistent and cumulative, making youths particularly susceptible to both psychological distress and impaired social functioning.

Despite the growing scale of the problem, institutional responses remain insufficient. The Constitution of Zimbabwe (2013), under Section 76, guarantees every citizen the right to health, including mental health care. In addition, the National Drug Strategy (2020–2025) promotes a balanced approach that integrates prevention, treatment, rehabilitation and social reintegration. However, in practice, these policy commitments have not translated into effective community-level interventions in high-density suburbs. Public health facilities in areas such as Mbare are often under-resourced, with limited capacity to provide specialised mental health or substance abuse services. As a result, many youths remain undiagnosed, untreated, and excluded from formal support systems (Government of Zimbabwe, 2020; Duri & Chikwanha, 2021).

Informal support systems, including families, religious institutions, peer groups and community-based organisations, attempt to fill this gap but frequently lack the expertise, resources, and coordination required to address the complex psycho-social needs associated with substance abuse. Family relationships are often strained by economic hardship and substance-related conflict, reducing their effectiveness as protective environments. Consequently, many youths cycle between substance use, psychological distress, social dysfunction and marginalisation, with limited opportunities for recovery or reintegration.

Against this background, understanding drug and substance abuse among youths in Mbare requires an approach that goes beyond prevalence estimates to examine its psycho-social functioning effects and the role of available support systems. There remains a critical need for localized, empirical evidence that captures how substance abuse affects youths' mental health, family relations, educational engagement and community participation within specific urban contexts. This study is therefore grounded in the recognition that drug and substance abuse among youths in Mbare is both a manifestation and a driver of deeper psychological and social challenges, necessitating integrated, context-sensitive responses informed by robust research.

Purpose of the Study

The purpose of this study is to assess the psychosocial functioning effects of drug and substance abuse among youths aged 15–24 in Mbare high-density suburb, Harare, Zimbabwe, and to evaluate the role, availability and effectiveness of both formal and informal support systems in addressing these challenges. The study seeks to generate empirically grounded, context-specific evidence that explains how substance abuse influences mental health outcomes, particularly depression and anxiety, as well as social functioning across family, educational and community domains. In addition, the study aims to provide a deeper understanding of the lived experiences of substance-abusing youths and the structural factors that shape their behaviour, including poverty, unemployment and social marginalisation. By integrating quantitative measurement using standardised tools such as the Patient Health Questionnaire (PHQ-9) and the Generalized Anxiety Disorder scale (GAD-7) with qualitative insights from participant narratives, the study intends to produce comprehensive findings that are both analytically robust and socially meaningful. Ultimately, the purpose of this research is to inform the development of integrated, youth-centred mental health and social support interventions, and to contribute to policy and practice aimed at reducing the psychosocial burden of substance abuse in high-density urban communities in Zimbabwe (Creswell & Plano Clark, 2017; World Health Organization, 2021).

Research Problem

Ideally, young people residing in urban communities should have access to adequate mental health services, functional social support systems and economic opportunities that protect their psychological well-being and enable meaningful social participation. Policy frameworks such as the Constitution of Zimbabwe (2013) and the National Drug Strategy (2020–2025) affirm these rights and commit the government to providing integrated health and rehabilitation services for vulnerable youth populations. However, the reality in Mbare high-density suburb, Harare, is far removed from this ideal. Drug and substance abuse among youths in this community has reached alarming levels, driven by persistent poverty, high unemployment, overcrowded living conditions and the widespread availability of highly addictive substances such as mutoriro and brongo. Formal mental health and rehabilitation services in Mbare remain severely under-resourced, inaccessible and largely absent from the daily lives of affected youth. Informal support systems, including families and community organisations, are similarly stretched beyond their capacity, leaving many young people without any meaningful intervention or care.

The consequences of this gap between policy intent and lived reality are severe. Many youths in Mbare remain trapped in cycles of addiction, deteriorating psychological health, family breakdown, school dropout and social marginalisation. Depression, anxiety and impaired social functioning go largely undiagnosed and untreated, compounding the long-term developmental costs for both individuals and the broader community. Despite the visible scale of this crisis, there is a critical empirical gap in the existing body of knowledge. Few studies have investigated the psychosocial functioning effects of substance abuse specifically within Mbare or comparable

high-density urban communities in Zimbabwe. Most available evidence is national or regional in scope and fails to capture the community-level dynamics, lived experiences and specific psychological burden faced by youths in this particular context. Furthermore, existing studies rely predominantly on descriptive approaches and do not employ standardised psychological assessment instruments such as the PHQ-9 and GAD-7 to systematically measure the mental health consequences of substance abuse or to examine the relationship between substance use patterns and social functioning outcomes. This methodological gap means that policymakers, health practitioners and community organisations currently lack the precise, evidence-based data needed to design targeted and effective interventions. This study therefore seeks to address both gaps by generating localised, empirically grounded evidence on the psychosocial functioning effects of drug and substance abuse among youths in Mbare, using validated instruments and a rigorous mixed-methods research design.

Aims and Objectives

Aims

The overarching aim of this research is to comprehensively assess the psychological and social functioning effects of drug and substance abuse among youths aged 15–24 in Mbare high-density suburb, Harare, in order to generate actionable evidence for the development of integrated mental health and social support interventions.

Specific Objectives

1. The first objective is to identify and document the types, patterns and prevalence of drugs and substances most commonly abused by youths in Mbare. This will be measured using the adapted World Health Organization Alcohol, Smoking and Substance Involvement Screening Test (WHO ASSIST) administered through a structured questionnaire to 150 youth participants. Types of substances will be documented through a checklist of locally relevant substances including mutiro, brongo, cannabis and alcohol. Patterns of use, including frequency, duration and age of initiation, will be captured through categorical and ordinal response items. Prevalence will be calculated as the percentage of the sample reporting use of each substance within the 12 months preceding data collection.
2. The second objective is to assess the prevalence and severity of depression and anxiety among youths engaged in substance abuse in Mbare, using the Patient Health Questionnaire-9 (PHQ-9) and the Generalized Anxiety Disorder-7 (GAD-7) scale. The PHQ-9 consists of nine items scored on a four-point scale from zero to three, producing a total score ranging from zero to twenty-seven. Severity is interpreted as follows: scores of zero to four indicate minimal depression, five to nine indicate mild depression, ten to fourteen indicate moderate depression, fifteen to nineteen indicate moderately severe depression, and twenty to twenty-seven indicate severe depression. The GAD-7 consists of seven items scored similarly, with a total score of zero to twenty-one. Scores of zero to four indicate minimal anxiety, five to nine indicate mild anxiety, ten to fourteen indicate moderate anxiety, and fifteen to twenty-one indicate severe anxiety. Both instruments have demonstrated strong reliability and validity in Zimbabwean and Southern African contexts and will be translated into Shona through a rigorous back-translation process and pilot tested prior to administration. Scores at or above ten on the PHQ-9 and at or above ten on the GAD-7 will trigger referral to available counselling services.
3. The third objective is to examine the relationship between the duration and frequency of substance abuse and the level of social functioning among youths in Mbare. Social functioning will be measured using a culturally adapted scale covering four domains, namely family relationships, educational or occupational engagement, peer relationships and community participation. Each domain will be assessed through Likert-scale items drawn from the Social Functioning Questionnaire and the WHO Disability Assessment Schedule 2.0, adapted for the Mbare context through expert input and pilot testing. The relationship between substance use variables and social functioning scores will be examined using Pearson correlation and simple linear regression analysis, enabling the study to determine both the direction and strength of the

association and to identify which substance use characteristics are the strongest predictors of impaired social functioning.

4. The fourth objective is to evaluate the availability, accessibility and perceived effectiveness of existing formal and informal support systems for youths affected by substance abuse in Mbare. Availability will be assessed by identifying and documenting which formal services such as clinics, NGOs and rehabilitation programmes and informal supports such as family, religious institutions and community groups currently exist in or near Mbare. This will be measured through a structured questionnaire item asking participants to indicate which services they are aware of, complemented by key informant interviews with service providers. Accessibility will be assessed through questionnaire items examining physical proximity, cost, waiting times and awareness of services among youth participants. Perceived effectiveness will be measured through Likert-scale items asking participants to rate the helpfulness of services they have used, as well as through in-depth interviews exploring their subjective experiences of support. Qualitative data from youth interviews and key informant interviews will be analysed thematically to provide deeper insight into barriers, enablers and gaps across all three dimensions.

Research Questions

1. What types of drugs and substances are most commonly abused by youths in Mbare, and what are the patterns and prevalence of their use?
2. What is the prevalence and severity of depression and anxiety among substance-abusing youths in Mbare as measured by the PHQ-9 and GAD-7?
3. What is the nature and strength of the relationship between the duration and frequency of substance abuse and the level of social functioning among youths in Mbare?
4. How available and accessible are existing support systems to substance-abusing youths in Mbare, and how effective do those youths perceive them to be?

Research Hypotheses

Null Hypotheses (H_0)

H₀₁: There is no significant relationship between the duration of substance abuse and the severity of depressive symptoms among youths in Mbare.

H₀₂: There is no significant relationship between the duration of substance abuse and the severity of anxiety symptoms among youths in Mbare.

True Hypotheses

H₁₁: There is a significant positive relationship between the duration of substance abuse and the severity of depressive symptoms among youths in Mbare, as measured using the Patient Health Questionnaire (PHQ-9).

H₁₂: There is a significant positive relationship between the duration of substance abuse and the severity of anxiety symptoms among youths in Mbare, as measured using the Generalized Anxiety Disorder scale (GAD-7).

Rationale

The justification for this study is multidimensional, addressing academic, policy, practical and communal imperatives. Academically while there is a growing body of literature on substance abuse in Zimbabwe, few studies have combined quantitative psychological assessment with qualitative lived-experience analysis within a specific, high-density urban context like Mbare. This research will therefore contribute original data to the fields of public health psychology, social work and African urban studies. From a policy perspective, findings will provide empirical evidence to critique and strengthen the implementation of the National Drug Strategy (2020–2025) and mental health policies, advocating for a shift from punitive to rehabilitative approaches.

Practically, the study will equip health authorities, NGOs, and community workers with a deeper understanding of the co-occurring mental health needs of young substance users, facilitating the design of targeted psychosocial interventions. At the community level, the research process itself may raise awareness and empower local stakeholders to advocate for better-resourced youth services. Ultimately, by centering the voices and experiences of affected youths, the study aligns with the constitutional right to health and dignity, promoting a more humane and effective response to a crisis that undermines the future of Zimbabwe's youth.

Delimitation

This study is deliberately focused in scope to ensure depth and feasibility. Geographically, it is confined to Mbare high-density suburb in Harare, Zimbabwe. The target population is limited to youths aged 15–24 who have engaged in drug or substance abuse within the 12 months preceding data collection. The study focuses on two specific psychological conditions, namely depression and anxiety, measured using the PHQ-9 and GAD-7 respectively, and assesses social functioning across the domains of family relationships, educational engagement, peer relationships and community participation. It does not attempt a comprehensive diagnostic assessment of all possible mental health disorders, nor does it explore the neurobiological or pharmacological dimensions of addiction. Findings are specific to Mbare and are not intended to be directly generalised to other high-density suburbs or rural communities in Zimbabwe without further research.

Limitations

The primary limitation of this study relates to its sampling approach. Although respondent-driven sampling is the most appropriate method for reaching hidden populations such as substance-using youth, it carries the risk of recruiting participants predominantly from a single peer network if seed selection is not carefully managed. To mitigate this, seeds will be purposively selected to ensure diversity across key characteristics including age, gender, location within Mbare and primary substance used. A minimum of six seeds will be recruited from different social networks and geographic zones within the suburb to maximise the breadth of recruitment chains. Despite these safeguards, the possibility of network clustering cannot be entirely eliminated and may affect the representativeness of the sample. Additionally, self-reported data on sensitive topics such as substance use and psychological symptoms may be subject to social desirability bias, as participants may underreport behaviours they perceive as stigmatised or illegal. Finally, the cross-sectional nature of the study means that causal relationships between substance abuse and psychosocial outcomes cannot be conclusively established, only associations.

CONCEPTUAL AND THEORETICAL FRAMEWORK

Theoretical Framework

This study is grounded in two complementary theoretical perspectives, namely Social Stress Theory and the Biopsychosocial Model. These theories were selected because they directly explain the relationships between the key variables of this study, which are poverty, stress, substance use, mental health, social functioning and support systems, and they will guide the analysis and interpretation of findings throughout the research.

Social Stress Theory, as advanced by Pearlin (1989), provides the foundational explanation for why youths in Mbare are particularly vulnerable to substance abuse. The theory argues that chronic exposure to structural stressors such as poverty, unemployment, family instability and social marginalisation overwhelms individual coping capacities, increasing the likelihood of maladaptive coping behaviours. In this study, poverty and unemployment in Mbare are treated as the primary structural stressors that generate chronic psychological stress among youths. This stress, when left unaddressed by adequate support systems, drives substance use as a coping mechanism. Social Stress Theory therefore directly guides the analysis of Objective One, which examines substance use patterns, and Objective Three, which examines the relationship between substance use and social functioning. It also informs the analysis of Objective Four by explaining why the absence or weakness of support systems intensifies stress and worsens outcomes for affected youths.

The Biopsychosocial Model, originally proposed by Engel (1977), complements Social Stress Theory by explaining the mechanisms through which substance use damages mental health and social functioning. The model holds that substance abuse and its consequences are the product of interacting biological, psychological and social factors rather than any single cause. In this study, the biological dimension refers to the neurochemical changes caused by repeated substance use that heighten vulnerability to depression and anxiety. The psychological dimension refers to the pre-existing conditions such as trauma, low self-esteem and poor coping strategies that both precede and are worsened by substance abuse. The social dimension refers to the role of peer influence, family dysfunction and community norms in shaping and sustaining substance use behaviour. This model directly guides the analysis of Objective Two, which measures the severity of depression and anxiety using the PHQ-9 and GAD-7, by framing these psychological conditions as outcomes of the interaction between biological vulnerability and social stress rather than isolated symptoms.

When applied together, the two theories create a coherent analytical chain that runs through the entire study. Structural poverty and unemployment generate chronic stress, which overwhelms coping capacity and drives substance use. Sustained substance use then interacts with biological and psychological vulnerabilities to produce measurable mental health consequences, particularly depression and anxiety. These psychological consequences in turn impair social functioning across the domains of family relationships, educational engagement, peer relationships and community participation. Support systems, both formal and informal, act as mediating factors at every stage of this chain, either buffering the effects of stress and substance use or, where absent or inadequate, allowing the cycle to continue unchecked. This theoretical chain will guide the interpretation of all four objectives and will ensure that statistical findings are understood within the broader social and psychological context of Mbare rather than treated as isolated data points.

Conceptual Framework

The conceptual framework of this study maps the relationships between the key variables that guide the research. It identifies the independent variables, the dependent variables and the moderating role of support systems in shaping psychosocial outcomes among substance-abusing youths in Mbare.

The independent variables in this study are substance use characteristics and social context factors. Substance use characteristics include the type of substance used, the frequency of use and the duration of use. Social context factors include economic stress arising from poverty and unemployment and peer influence operating within the social networks of Mbare. These two sets of independent variables work together to initiate and sustain patterns of drug and substance abuse among youths in the community.

The dependent variables are psychological functioning and social functioning. Psychological functioning is operationalised as the prevalence and severity of depression and anxiety, measured using the PHQ-9 and GAD-7 respectively. Social functioning is operationalised across four domains, namely family relationships, educational or occupational engagement, peer relationships and community participation. The independent variables are expected to directly and negatively influence both dependent variables, meaning that heavier, longer and more frequent substance use combined with greater social stress is expected to produce worse psychological and social functioning outcomes among youths.

Support systems constitute the moderating variable in this framework. Both formal support systems, including clinics, NGOs, rehabilitation programmes and schools, and informal support systems, including family networks, religious institutions, peer support groups and community organisations, are positioned as buffers that can reduce the strength of the relationship between the independent variables and the dependent variables. Where effective support systems are present and accessible, the negative psychosocial effects of substance abuse are expected to be reduced. Where support systems are absent, inadequate or inaccessible, the harmful effects are expected to be more severe and more persistent.

The framework therefore illustrates a pathway that moves from structural poverty and peer influence through substance use to impaired psychological and social functioning, with support systems intervening at multiple points along this pathway to either strengthen or weaken the eventual outcomes. This conceptual structure

directly aligns with and organises the four objectives of the study, and it will guide both the data collection process and the interpretation of findings throughout the research.

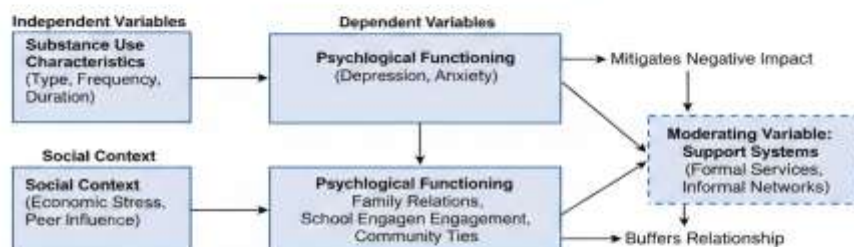


Figure 1: Conceptual Framework Illustrating the Relationship Between Substance Use, Psychological Functioning, Social Context and Support Systems Among Youths in Mbare

The conceptual framework illustrates the relationships between independent variables, dependent variables, and a moderating variable in the study of drug and substance abuse among youths in Mbare. The independent variables comprise substance use characteristics, including type, frequency, and duration of substance use, as well as social context factors, such as economic stress and peer influence.

These independent variables directly influence the dependent variables, which are psychological functioning specifically depression and anxiety and social functioning, including family relationships, school engagement, and community ties. The arrows indicate the direction of influence from substance use characteristics and social context to psychological and social outcomes. The framework further incorporates support systems both formal services and informal networks as a moderating variable. Support systems are shown to mitigate the negative psychological effects of substance abuse and buffer the relationship between substance use and social functioning. This suggests that effective support mechanisms can reduce the severity of adverse psychological and social consequences associated with drug and substance abuse among youths.

Location of the Study

Mbare is one of the oldest and most densely populated high-density suburbs in Harare, Zimbabwe. Originally established as a township for migrant workers, it is characterised by a mix of old hostel accommodations, crowded housing, informal trading markets, and limited public amenities. The area faces significant challenges including high unemployment, under-resourced schools and clinics and inadequate sanitation. It is also historically known for vibrant informal economies and cultural sites, but in recent years, has gained notoriety for high levels of crime and substance abuse. Its specific socio-demographic profile, marked by concentrated poverty and a large youth population, makes it a critical and representative site for investigating the nexus of substance abuse, mental health, and social functioning in urban Zimbabwe.

Definition of Terms

Drug and Substance Abuse: The harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs, leading to dependence, health damage or impaired social functioning (WHO, 2021).

Youths: In this study, individuals aged between 15 and 24 years, aligning with definitions used by the Zimbabwe National Youth Policy and UN agencies.

Psychological Functioning: Refers to an individual's mental health status, operationalised in this study as levels of depression and anxiety measured by the Patient Health Questionnaire (PHQ-9) and Generalised Anxiety Disorder scale (GAD-7).

Social Functioning: The ability of an individual to perform their expected roles in society, assessed here through domains such as family relationships, educational participation, peer interactions and avoidance of criminal activity.

Mutoriro: A local street name in Zimbabwe for crystal methamphetamine, a highly addictive stimulant drug.

Brongo/Broncleer: Refers to the non-prescription misuse of codeine-based cough syrup, commonly used for its sedative and euphoric effects.

SUMMARY

This chapter lays a comprehensive foundation for the study by addressing the critical issue of drug and substance abuse among youths in Mbare, a high-density suburb of Harare, Zimbabwe. It presents the background context, defines the research problem, and outlines the aims, objectives, and research questions guiding the investigation. Additionally, the chapter explains the rationale and scope of the study, introduces the theoretical framework, specifies the study location, and provides key definitions, concluding with a summary that highlights the importance and direction of the research. This introductory chapter has established the significant and multifaceted problem of youth drug and substance abuse in Mbare, Harare. It has outlined the socio-economic background that fuels this crisis, articulated a clear research problem centred on the lack of localized psychological evidence, and set forth specific aims, objectives and hypotheses. The rationale underscores the study's potential contributions to knowledge, policy and practice. Guided by an integrated social stress and biopsychosocial framework, the research will be conducted within the specific context of Mbare, with key terms carefully defined to ensure conceptual clarity. The subsequent chapters will provide a detailed review of existing literature and outline the methodological approach for generating the necessary empirical data to address the identified gaps.

LITERATURE REVIEW

Overview

This chapter reviews existing literature relevant to the study of drug and substance abuse and its psychosocial functioning effects among youths in Mbare, Harare, Zimbabwe. The review draws on peer-reviewed journals, academic books, government reports and policy documents from local, regional and international sources, with particular emphasis on urban African and Zimbabwean contexts. The chapter opens with the conceptual framework that guides the study, followed by literature organised around the four research objectives. The first theme examines the prevalence, types and patterns of drug and substance abuse among youths. The second theme explores the psychological effects of substance abuse, focusing on depression and anxiety. The third theme reviews the relationship between substance abuse and social functioning across the domains of family, education, peer relationships and community participation. The fourth theme evaluates the availability, accessibility and effectiveness of formal and informal support systems for substance-abusing youths. The

chapter concludes with a summary that identifies key gaps in the existing literature and links the reviewed evidence to the research questions guiding this study.

ANTECEDENTS (Risk Factors)	PROCESS (Drug & Substance Abuse)	OUTCOMES (Effects)
Poverty & unemployment Peer pressure Family dysfunction Urban marginalisation Trauma & stress	Alcohol abuse Cannabis (mbanje) Crystal meth (mutoriro) Prescription drug misuse Polydrug use	Depression & anxiety Psychosis Cognitive decline Social withdrawal Academic failure Criminal behaviour
Moderating Factors: Mental Health Services Policy Interventions Community Support Cultural Norms		

Table 2.2 : Conceptual Framework for the Study of Drug and Substance Abuse Among Youths and Its Psychological and Social Effects (Adapted from various sources)

THEORETICAL FRAMEWORK

This study is grounded in two complementary theoretical perspectives, namely Social Stress Theory and the Biopsychosocial Model. These theories are used to explain the relationships between the key variables of the study, including poverty, stress, substance use, mental health, social functioning and support systems, and to guide the interpretation of findings. Social Stress Theory, as advanced by Pearlin (1989), provides a foundational explanation for the vulnerability of youths in high-density urban communities such as Mbare to substance abuse. The theory argues that prolonged exposure to structural stressors such as poverty, unemployment, family instability and social marginalisation increases psychological strain and weakens individual coping capacity. In such contexts, substance use may emerge as a maladaptive coping mechanism. This perspective is particularly relevant to this study as it explains how socioeconomic conditions in Mbare contribute to patterns of drug and substance abuse among youths.

The Biopsychosocial Model, originally proposed by Engel (1977), complements Social Stress Theory by explaining the interaction between biological, psychological and social factors in shaping substance use behaviour and its consequences. The biological dimension relates to neurochemical changes associated with substance use, the psychological dimension includes factors such as trauma and coping strategies, while the social dimension reflects the influence of peer networks, family environment and community context. This model is useful in understanding how substance abuse leads to mental health outcomes such as depression and anxiety, as well as impaired social functioning. When applied together, these two theoretical perspectives provide a comprehensive framework for analysing the pathways through which structural stressors lead to substance use, and how substance use in turn affects psychological and social functioning. They also highlight the role of support systems as moderating factors that can either reduce or reinforce the negative effects of substance abuse (Engel, 1977; Pearlin, 1989).

Sub-theme 1: Defining Drug and Substance Abuse

Before examining the prevalence and patterns of drug and substance abuse among youths in Mbare, it is important to establish clear and consistent definitions of the key concepts used throughout this study. The World Health Organisation (WHO, 2019) defines substance abuse as the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs, in ways that cause damage to health or impair social functioning. This definition is broad and inclusive, covering a spectrum of behaviours ranging from recreational use that causes individual harm to chronic dependence that significantly disrupts daily life. The American Psychiatric Association (APA, 2013), through the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5), uses the term substance use disorder to describe a cluster of cognitive, behavioural and physiological symptoms indicating that an individual continues using a substance despite significant substance-related problems.

While both definitions are widely applied in the literature, they differ in important ways. The WHO definition is more appropriate for community-level research and public health studies because it captures a broader range of harmful use without requiring a formal clinical diagnosis, whereas the DSM-5 definition is better suited to clinical settings where diagnostic precision is required. For the purposes of this study, the WHO definition is adopted because the research is community-based and relies on self-reported data rather than clinical assessment.

In the African context, and specifically within Zimbabwe, substance abuse is commonly understood to include the misuse of alcohol, cannabis known locally as mbanje, crystal methamphetamine known as mutoriro, codeine-based cough syrups referred to as brongo or broncleer, prescription drugs and inhalants (Chadwick, 2020; Ministry of Health and Child Care Zimbabwe, 2021). It is worth noting that most definitions used in the global literature were developed in high-income, Western contexts and may not fully capture the social meanings, cultural norms and locally specific substances that characterise substance use in urban Zimbabwean communities. For instance, the classification of brongo as a substance of abuse is a relatively recent development in Zimbabwean policy discourse, and its inclusion in international diagnostic frameworks remains inconsistent. This limitation means that studies relying solely on internationally standardised instruments may undercount or misclassify patterns of substance use in communities like Mbare, a methodological gap that this study addresses by adapting the WHO ASSIST instrument to include locally relevant substances by name.

The term youth, as used in this study, refers to individuals aged between 15 and 24 years, consistent with the definitions used by the United Nations, the African Union and Zimbabwe's National Youth Policy (Government of Zimbabwe, 2013). It is important to note that some studies reviewed in this chapter, particularly those drawing on the African Union definition, apply a broader age range of 15 to 35 years. Where such studies are cited, their findings are interpreted cautiously and their age range is noted, as the older end of this spectrum may reflect different social circumstances, life stages and substance use motivations compared to the 15 to 24 age group that is the focus of this research. This definitional inconsistency across the literature is itself a limitation that complicates direct comparisons between studies and highlights the need for greater standardisation in youth substance abuse research in the African context.

A further gap in the existing definitional literature is the limited attention given to the gendered dimensions of substance abuse definitions and measurement. Most standardised instruments and diagnostic criteria were developed and validated primarily with male participants, and their applicability to the experiences of young women in high-density urban communities in Zimbabwe has not been sufficiently examined. This gap is relevant to the present study and will be taken into account during data collection and interpretation, particularly in relation to the experiences of female youth participants in Mbare.

Sub-theme 2: Theoretical Frameworks

Several theoretical frameworks are relevant to understanding why youths engage in drug and substance abuse and the consequences that follow. This study is primarily grounded in the Biopsychosocial Model, the Social Learning Theory, and the Ecological Systems Theory.

The Biopsychosocial Model, originally proposed by Engel (1977) and later applied extensively to addiction research (McLellan, 2017), argues that substance abuse and its effects cannot be explained by any single factor. Rather, they are the product of an interaction between biological, psychological and social variables. Biologically, genetic predisposition and neurochemical changes in the brain's reward pathways make some individuals more vulnerable to addiction than others (Koob & Volkow, 2016). Psychologically, factors such as trauma, unresolved grief, low self-esteem and poor coping strategies increase the risk of substance use. Socially, poverty, unemployment, peer pressure and family dysfunction create an environment that both encourages drug use and makes recovery more difficult.

Table 2.3 : The Biopsychosocial Model Applied to Drug and Substance Abuse (Adapted from McLellan, 2017)

BIOLOGICAL	PSYCHOLOGICAL	SOCIAL
Genetic predisposition Neurochemical changes Brain reward pathways Tolerance & withdrawal	Trauma & PTSD Low self-esteem Impulsivity Mood disorders Coping strategies	Peer influence Family breakdown Poverty Unemployment Cultural norms

Social Learning Theory, developed by Bandura (1977), provides another lens through which to understand youth substance abuse. This theory posits that behaviour, including drug use, is learned through observation, imitation and reinforcement. Young people who grow up in environments where drug use is normalised whether in the home, among peers or in the broader community are more likely to adopt these behaviours themselves. In the context of Mbare, where substance use is reportedly visible in public spaces and where many young people lack positive role models, Social Learning Theory offers a compelling explanation for the patterns of drug use observed in the area (Kaminer, 2019; UNICEF Zimbabwe, 2020).

Ecological Systems Theory, put forward by Bronfenbrenner (1979), highlights the layered nature of human development and behaviour. According to this theory, an individual's behaviour is shaped by a series of nested systems from the immediate family and peer environment (microsystem), to the school and neighbourhood context (mesosystem), to broader social institutions and policies (exosystem and macrosystem). This framework is particularly useful for this study because it encourages a multi-level analysis of how substance abuse emerges and what consequences it has across different domains of a young person's life in Mbare, Harare.

Together, these three theoretical frameworks provide a comprehensive foundation for understanding the complexity of drug and substance abuse among youths and guide the interpretation of findings throughout this study.

Theme 2: Prevalence of Substance Abuse

Understanding the scale and nature of drug and substance abuse among youths is fundamental to appreciating the mental health and social consequences that follow. This section reviews the literature on the types of substances commonly used by young people, as well as the trends and patterns that have been documented across sub-Saharan Africa and Zimbabwe specifically.

Sub-theme 1: Types of Substances Commonly Abused by Youths

The range of substances used by young people is varied and continues to evolve in response to availability, cost, social trends and enforcement patterns. Globally, alcohol remains the most widely used substance among adolescents and young adults, with the WHO (2018) reporting that alcohol use contributes to over 200 disease and injury conditions. Cannabis is the second most widely used substance, particularly in sub-Saharan Africa, where it is often culturally embedded and relatively inexpensive (UNODC, 2021). In urban Zimbabwe, cannabis (mbanje) has long been associated with youth social networks and is frequently described in local studies as the 'gateway' drug through which young people first encounter substance use (Mayeya et al., 2004; Chadwick, 2020).

In recent years, the emergence of crystal methamphetamine known locally in Zimbabwe as mutoriro has significantly changed the landscape of substance abuse in high-density urban areas such as Mbare (ZNCADA, 2021). Mutoriro is cheap, easily accessible and extremely addictive, and its use has been linked to severe psychiatric consequences including paranoia, aggression and psychosis (Kessler et al., 2014; Rusenga, 2021). Prescription drug misuse, particularly of benzodiazepines and opioid painkillers, is also increasingly reported among urban youths in Zimbabwe, often facilitated by informal drug markets and over-the-counter availability (Ministry of Health and Child Care Zimbabwe, 2021).

Inhalant abuse involving substances such as glue, petrol or paint thinners is particularly prevalent among the youngest and most economically deprived youth, including street children and school dropouts in urban centres (Dube et al., 2019). Although heroin and other opioids remain less prevalent compared to other regions, there is growing evidence of their use in Zimbabwean cities, often linked to drug trafficking networks that have expanded following regional geopolitical changes (UNODC, 2021).

Table 3: Common Substances Abused by Youths in Urban Zimbabwe, Age of Onset and Primary Effects (Compiled from ZNCADA, 2021; UNODC, 2021; Ministry of Health and Child Care Zimbabwe, 2021)

Substance	Age Range	Prevalence Among Youth	Primary Psychological/Health Effects
Alcohol	15–35 years	High	Depression, liver disease, violence
Cannabis (Mbanje)	14–25 years	Very High	Psychosis, cognitive decline, anxiety
Crystal Meth (Mutoriro)	16–30 years	Rising	Paranoia, psychosis, aggression
Prescription drugs	18–35 years	Moderate	Dependency, overdose, mood instability
Glue/solvents (inhalants)	10–20 years	Moderate	Brain damage, hallucinations
Heroin/opioids	20–35 years	Low but growing	Addiction, overdose, HIV risk

Sub-theme 2: Prevalence Trends in Sub-Saharan Africa and Zimbabwe

Substance abuse among youths in sub-Saharan Africa has been described as a 'growing public health crisis' by several international health bodies (WHO, 2019; UNODC, 2021). The United Nations Office on Drugs and Crime (UNODC, 2021) reports that Africa has some of the highest rates of cannabis use in the world, with youth populations disproportionately affected. Studies from South Africa (Peltzer & Pengpid, 2018), Nigeria (Obot, 2013) and Kenya (Odek, 2015) consistently show that substance use initiation typically occurs in adolescence, between the ages of 12 and 18 years, and that prevalence rates are significantly higher in urban slum communities compared to rural or suburban settings.

Within Zimbabwe, the Zimbabwe National Statistics Agency (ZIMSTAT, 2019) reported that approximately 30% of young people aged 15–35 in urban areas had used an illicit substance at least once in their lifetime, with Harare's high-density suburbs recording the highest rates. The Zimbabwe National Commission Against Drug Abuse (ZNCADA, 2021) similarly documented a sharp rise in substance-related arrests and hospital admissions among individuals under the age of 30 between 2015 and 2020. Mbare, as one of the oldest and most densely populated high-density suburbs in Harare, has been consistently identified in these reports as a hotspot for drug distribution and use (ZNCADA, 2021; Rusenga, 2021).

Chadwick (2020) notes that the COVID-19 pandemic exacerbated substance use trends in Zimbabwe, as lockdowns, loss of income, increased stress and the disruption of social support systems drove many young people toward substance use as a coping mechanism. This observation is consistent with broader global literature which documents a surge in substance use disorders during periods of social and economic crisis (WHO, 2020; Dube et al., 2021).

It is important to note that official prevalence data in Zimbabwe likely underestimates the true extent of substance abuse, given that many users do not seek treatment, and community-level use often goes unreported due to stigma and fear of legal consequences (Ministry of Health and Child Care Zimbabwe, 2021). This gap between official statistics and actual prevalence further underscores the need for community-based research such as this study, which seeks to capture lived experiences at the grassroots level in Mbare.

Theme 3: Psychological Effects of Drug and Substance Abuse on Mental Health

One of the most extensively documented consequences of drug and substance abuse is the damage it causes to the psychological wellbeing of users. The relationship between substance abuse and mental health is complex and bidirectional substance use can cause or worsen mental health disorders, and pre-existing mental health conditions can increase the risk of substance abuse (Kessler et al., 2005; WHO, 2019). This section reviews the evidence on the major psychological effects of substance abuse, including mood disorders, psychosis and cognitive impairment.

Sub-theme 1: Depression, Anxiety and Mood Disorders

Among the most commonly reported psychological consequences of substance abuse are depression and anxiety. Multiple longitudinal studies have established a strong causal relationship between heavy substance use and the development of depressive disorders. Volkow et al. (2016) found that prolonged use of alcohol and cannabis significantly disrupts serotonin and dopamine regulation in the brain, leading to persistent low mood, hopelessness and anhedonia the inability to feel pleasure which are hallmark symptoms of major depressive disorder. This neurochemical disruption is not merely a short-term effect of intoxication but can persist for months or years after the individual stops using the substance.

Anxiety disorders are also commonly co-occurring with substance use disorders. Studies by Peltzer and Pengpid (2018) in South Africa and Odek (2015) in Kenya found that young substance users in urban settings reported significantly higher levels of generalised anxiety, social phobia and panic attacks compared to non-users. The relationship between anxiety and substance use is often cyclical young people use substances to manage anxiety, but withdrawal and the consequences of substance use (such as debt, family conflict and health problems) generate new sources of anxiety, driving further use (Kaplan & Sadock, 2015).

In the Zimbabwean context, a study by Dube et al. (2019) on youth mental health in Harare found that depression and anxiety were significantly more prevalent among young people who reported substance use, with cannabis and alcohol use being the strongest predictors of mood disorders. The study also found that many young people in high-density suburbs used substances as a way of self-medicating for pre-existing psychological distress, suggesting that mental health services and substance abuse interventions need to be integrated rather than treated as separate systems (Dube et al., 2019).

Post-Traumatic Stress Disorder (PTSD) is another mental health condition frequently linked to substance abuse, particularly among urban youth who have been exposed to violence, crime, sexual abuse or poverty-related trauma. Kaminer (2019) argues that in contexts of chronic community violence and social deprivation such as those found in Mbare PTSD and substance use disorders frequently co-occur and reinforce each other in ways that make standard mental health treatment less effective without addressing both conditions simultaneously.

Sub-theme 2: Psychosis, Cognitive Impairment and Behavioural Changes

Beyond mood disorders, substance abuse is associated with more severe psychiatric conditions including psychosis and significant cognitive impairment. The relationship between cannabis use and psychosis has been one of the most researched areas in addiction psychiatry over the past two decades. A landmark study by Murray et al. (2017) demonstrated that regular use of high-potency cannabis (such as the strains commonly available in urban African markets) substantially increases the risk of developing psychotic disorders, including schizophrenia, particularly when use begins in adolescence. This finding is especially relevant to the Zimbabwean context, where cannabis use is widespread among teenagers and young adults in communities like Mbare.

Crystal methamphetamine (mutoriro) has emerged as a particularly dangerous substance in terms of its psychiatric consequences. Kessler et al. (2014) document that methamphetamine use can trigger acute psychotic episodes characterised by auditory and visual hallucinations, paranoid delusions and extreme

aggression, even after relatively short periods of use. In chronic users, these symptoms can persist as a form of methamphetamine-induced psychosis that is clinically indistinguishable from paranoid schizophrenia (Rusenga, 2021). Given the rapid rise of mutoriro use in Mbare and other parts of Harare, there is growing concern among mental health practitioners and community leaders about the psychiatric burden this substance is creating (ZNCADA, 2021; Ministry of Health and Child Care Zimbabwe, 2021).

Cognitive impairment is another well-documented consequence of chronic substance use. Studies consistently show that prolonged use of alcohol, cannabis and stimulants is associated with deficits in memory, attention, executive functioning and processing speed (Parsons, 2014; Squeglia et al., 2014). In adolescents, whose brains are still developing, the damage is often more severe and more enduring than in adult users. Squeglia et al. (2014) found in a longitudinal study of adolescent substance users that those who began drinking heavily in their early teenage years showed measurable deficits in verbal memory and spatial working memory by the time they reached their early twenties, even after controlling for other factors. These cognitive deficits have direct implications for academic performance, vocational training and social decision-making.

Behavioural changes associated with substance abuse include increased aggression and impulsivity, risk-taking behaviour, and disregard for social norms and obligations. These changes are partly neurological substance abuse alters functioning in the prefrontal cortex, the part of the brain responsible for impulse control and decision-making (Koob & Volkow, 2016) and partly social, as the substance use lifestyle often draws individuals into environments characterised by conflict, criminality and instability. For young people in Mbare, these behavioural changes can have severe consequences, including involvement in crime, victimisation and social exclusion, which in turn perpetuate a cycle of substance use and psychological harm (Chadwick, 2020; Rusenga, 2021).

Theme 4: Drug and Substance Abuse and Social Functioning Among Youths

The social consequences of drug and substance abuse are as profound as the psychological ones, and in many cases, the two are inseparable. Substance abuse affects how young people relate to their families, how they perform in educational and occupational settings, and how they participate in community life. This theme examines the evidence on the social functioning implications of substance abuse, drawing on studies from Zimbabwe and comparable African urban settings.

Sub-theme 1: Family Relationships and Peer Influence

The family is the primary social unit in which a young person's identity, values and behavioural patterns are formed, and it is often the first social institution to bear the weight of the consequences of substance abuse. Substance-abusing youth frequently experience deteriorating relationships with parents and siblings, as their behaviour becomes erratic, their responsibilities go unfulfilled and their moods become unpredictable (Kaminer, 2019). In many cases, family members respond with a combination of denial, enabling behaviour and outright conflict, which can deepen the cycle of abuse (Kaufman & Yoshioka, 2004).

In Zimbabwe, where extended family networks play a central role in the social fabric and where parents often depend on young adult children for economic support, the impact of substance abuse on family functioning can be especially severe. A study by Dube et al. (2019) found that substance-abusing youth in Harare were more likely to steal from family members, fail to contribute to household expenses, be absent for long periods and engage in domestic violence, all of which placed enormous strain on family relationships. In female youth, substance abuse was associated with increased vulnerability to sexual exploitation and early pregnancy, further complicating family dynamics (UNICEF Zimbabwe, 2020).

Peer influence is widely recognised as one of the most powerful predictors of youth substance use initiation and continuation. Social Learning Theory (Bandura, 1977) explains this through the mechanism of social modelling young people observe, admire and emulate the behaviour of their peers, including drug use, particularly when peer groups are central to their social identity and sense of belonging. In high-density urban

areas like Mbare, where formal recreational spaces are limited and youth unemployment is high, peer groups and street gangs often become the primary social environment for many young people (Rusenga, 2021).

Research consistently shows that having close friends who use substances is one of the strongest risk factors for substance use initiation (Hawkins et al., 1992; Kaminer, 2019). In a study of urban youth in Zimbabwe, Chadwick (2020) found that over 65% of young substance users reported that they had been introduced to their primary substance by a peer or close friend, and that peer approval remained a key motivator for continued use even when users were aware of the health consequences. This finding highlights the importance of peer-based interventions in prevention programming.

Sub-theme 2: Academic Performance, Employment and Community Integration

The negative relationship between substance abuse and academic performance is one of the most consistently documented findings in the literature. Substance use is associated with absenteeism, dropout, poor concentration, reduced motivation and underachievement across all levels of education (Peltzer & Pengpid, 2018; Odek, 2015; UNODC, 2021). The cognitive effects of substances, particularly the impairment of memory and executive function, directly undermine the cognitive skills that academic success requires. At the same time, the social world of substance use – late nights, peer pressure to skip school, involvement in drug-related activities – creates structural barriers to regular school attendance and engagement.

In Zimbabwe, a report by the Ministry of Primary and Secondary Education (2020) identified substance abuse as one of the leading contributors to school dropout in urban schools, particularly in high-density suburbs. Young people who drop out of school due to substance abuse are subsequently placed at a significant disadvantage in the labour market, as educational qualifications remain the primary gateway to formal employment in Zimbabwe (ZIMSTAT, 2019). This creates a self-reinforcing cycle – substance abuse leads to academic failure, which leads to unemployment, which in turn creates the conditions of boredom, financial desperation and hopelessness that drive further substance use (Chadwick, 2020).

Employment and economic productivity are also significantly impaired by substance abuse. Young adults who are addicted to substances typically struggle to maintain regular employment due to absenteeism, unreliable performance, conflicts with colleagues and employers, and, in many cases, criminal records acquired as a result of drug-related offences (Kaplan & Sadock, 2015). In Mbare, where formal employment is already scarce and competition for available jobs is intense, substance-abusing youth face compounded disadvantages that often push them further into the informal economy, petty crime or street-based survival strategies (Rusenga, 2021; ZNCADA, 2021).

Community integration, which refers to the extent to which an individual participates meaningfully in social, civic and communal activities, is also adversely affected by substance abuse. Substance-abusing youth are frequently described as socially withdrawn, unreliable and disruptive, leading to their marginalisation from community structures such as churches, sports clubs, burial societies and neighbourhood associations (Dube et al., 2019). This social marginalisation not only deprives young people of important support networks but also reinforces the stigma attached to substance abuse and mental illness, making it harder for affected individuals to seek help (Thornicroft, 2006; Ministry of Health and Child Care Zimbabwe, 2021).

Theme 5: Socioeconomic and Contextual Factors Driving Youth Substance Abuse in Urban Zimbabwe

Substance abuse does not occur in a vacuum. It is deeply embedded in the social, economic and environmental conditions in which young people live. Understanding these contextual factors is essential for designing effective interventions and for interpreting the experiences of youth in Mbare. This theme reviews the literature on the socioeconomic and contextual drivers of youth substance abuse in urban African settings, with particular attention to the specific circumstances of Mbare, Harare.

Sub-theme 1: Urban Poverty, Unemployment and Marginalisation

Poverty is widely regarded as the single most powerful structural driver of substance abuse in urban African communities. The relationship between poverty and drug use is mediated by several pathways, including the stress and hopelessness that accompany chronic deprivation, the limited availability of healthy recreational alternatives, the normalisation of substance use within impoverished social environments, and the economic incentives of the drug trade (UNODC, 2021; Chadwick, 2020). Young people from poor backgrounds are not only more likely to use substances but are also more likely to suffer severe and long-lasting consequences because they have fewer resources economic, social and institutional with which to recover.

Mbare is one of the most economically deprived areas of Harare, characterised by high population density, limited formal employment opportunities, poor housing conditions, inadequate sanitation and limited access to quality health and education services (City of Harare, 2019; ZIMSTAT, 2019). The unemployment rate among young people in Mbare is estimated to be over 60%, and many of those who are 'employed' work in the informal sector under precarious conditions (ZIMSTAT, 2019). This economic reality creates what Rusenga (2021) describes as a 'landscape of hopelessness' in which substance use becomes a way of managing psychological pain, filling idle time and, in some cases, generating income through drug dealing.

Youth unemployment, in particular, has been extensively linked to substance abuse in the literature. The absence of meaningful occupation and purpose, combined with the availability of cheap substances and the social pressure of peers who are similarly disengaged, creates conditions that are highly conducive to substance use initiation and escalation (Hawkins et al., 1992; Odek, 2015). Studies by Kaminer (2019) and the WHO (2019) both identify unemployment as one of the top five modifiable risk factors for substance use disorders among young men in low and middle-income countries.

Sub-theme 2: Community Environment, Cultural Norms and Peer Networks in Mbare

Beyond economic factors, the physical and social environment of a community plays a powerful role in shaping substance use behaviours. Mbare's unique social ecology characterised by its long history as a migrants' hub, its dense and diverse population, its vibrant but sometimes volatile street culture, and its proximity to the Mbare Musika bus terminus and market creates a particular kind of social environment in which substance use is highly visible and relatively normalised (Chadwick, 2020; Rusenga, 2021). The presence of established drug distribution networks, the availability of cheap substances at the musika and in local drinking establishments (shebeens), and the existence of social spaces where substance use is accepted all lower the barriers to use for young people living in the area.

Cultural norms and attitudes towards substance use are also important contextual factors. In some urban Zimbabwean communities, moderate alcohol use is embedded in social and ceremonial life, and the line between social drinking and problematic drinking can be culturally ambiguous (Dube et al., 2019). The traditional use of certain substances for medicinal or spiritual purposes, combined with contemporary peer norms that glorify substance use as a sign of maturity, toughness or social belonging, creates a cultural environment in which young people receive mixed messages about the acceptability of drug use (Kaminer, 2019; Chadwick, 2020). This cultural complexity presents a challenge for public health messaging and intervention, as approaches that ignore cultural context are often rejected or rendered ineffective by communities.

The role of trauma in driving substance use deserves specific attention in the Mbare context. Historical factors including urban migration, the economic crises of the 2000s and the associated social disruption have left many families in Mbare carrying unresolved collective and individual trauma (Ministry of Health and Child Care Zimbabwe, 2021). Young people who have grown up in households affected by poverty, violence, family breakdown and loss are particularly vulnerable to substance use as a coping mechanism for unresolved trauma (van der Kolk, 2014; Dube et al., 2019). This trauma-substance use nexus is a critical area of focus for mental health practitioners working in communities like Mbare, and it is one that the present study seeks to explore in depth.

Gender is another dimension of the contextual analysis that the literature highlights. While substance abuse among young males in urban Zimbabwe is more visible and more commonly reported, female youth are not exempt. Studies by UNICEF Zimbabwe (2020) and Dube et al. (2019) document rising rates of alcohol and prescription drug use among young women in Harare's high-density suburbs, often connected to sexual coercion, gender-based violence and economic exploitation. The gendered dimensions of substance abuse in Mbare require specific attention in both research and intervention to ensure that the experiences and needs of young women are not overlooked.

Theme 6: Interventions and Implications for Mental Health Policy

The foregoing themes establish clearly that drug and substance abuse among youths in urban Zimbabwe is a complex, multi-dimensional problem with serious psychological and social consequences. This final thematic section examines what the literature says about how this problem has been and should be addressed, focusing on intervention strategies and the policy environment in Zimbabwe.

Sub-theme 1: Treatment and Rehabilitation Approaches

A range of treatment and rehabilitation approaches have been documented in the literature, spanning biological, psychological and social interventions. Medically assisted detoxification is often the first step in treating severe substance dependence, particularly for alcohol and opioid addiction, and involves the use of pharmacological agents to manage withdrawal symptoms safely (McLellan, 2017; Kaplan & Sadock, 2015). However, detoxification alone is not sufficient for sustained recovery and must be followed by comprehensive psychological and social support to address the underlying causes of substance use and build recovery skills.

Cognitive Behavioural Therapy (CBT) is one of the most empirically supported psychological treatments for substance use disorders. CBT helps individuals identify the thoughts, emotions and situations that trigger substance use, and teaches practical skills for managing cravings, resisting peer pressure and developing healthier coping strategies (Carroll & Onken, 2005; WHO, 2019). In resource-limited settings like Zimbabwe, group-based CBT delivered by trained community health workers has shown promising results as a cost-effective and scalable approach (Abas et al., 2016). Motivational Interviewing (MI), another evidence-based psychological approach, is particularly useful in engaging young people who are ambivalent about treatment, as it is non-confrontational and respects the individual's autonomy (Miller & Rollnick, 2013).

Community-based rehabilitation (CBR) and social reintegration programmes are critically important for addressing the social dimensions of recovery. These programmes focus on rebuilding social skills, restoring family relationships, supporting educational re-entry or vocational training, and facilitating meaningful community participation (WHO, 2019; Dube et al., 2019). In Zimbabwe, organisations such as Freeth Hospital, Chikurubi Psychiatric Unit and a small number of NGOs including Zimbabwe Lawyers for Human Rights and the Counselling Services Unit provide some form of substance abuse treatment and rehabilitation, but capacity is severely limited relative to the scale of need (Ministry of Health and Child Care Zimbabwe, 2021).

Prevention programmes are equally important as treatment and are generally more cost-effective. School-based drug education programmes, peer resistance training and community awareness campaigns all have evidence of effectiveness in reducing substance use initiation among adolescents (UNODC, 2021; Kaminer, 2019). However, in Zimbabwe, the reach and quality of these programmes are inconsistent, with high-density suburbs like Mbare often receiving less attention and fewer resources than more affluent areas.

Level	Key Strategies	Purpose
Primary Prevention	School-based education, peer resistance training, community awareness campaigns	Reducing initiation of drug use among young people
Secondary Prevention	Early screening, brief interventions, counselling in community health	Identifying and assisting at-risk youth before addiction develops

	centres	
Tertiary Prevention	Rehabilitation centres, detoxification, psychiatric treatment, aftercare support	Treating existing addiction and preventing relapse
Policy-Level Interventions	National drug control policies, Mental Health Act, ZIMHAF, ZNCADA programmes	Creating an enabling legislative and institutional environment

Table 4: Levels of Intervention for Drug and Substance Abuse Among Youths (Adapted from WHO, 2019; UNODC, 2021)

Sub-theme 2: Mental Health Policy and Social Support Frameworks in Zimbabwe

The policy environment is a critical determinant of the availability and quality of mental health and substance

abuse services, and understanding it is essential for evaluating the formal support systems available to youths in Mbare. Zimbabwe's Mental Health Act (Chapter 15:12) provides the primary legislative framework for mental health care in the country, including provisions for the compulsory treatment of individuals with severe mental illness. However, the Act has been widely criticised in the literature for being outdated, institutionally oriented and inadequate in addressing substance use disorders as a distinct and pressing category of mental health need (Ministry of Health and Child Care Zimbabwe, 2021; WHO Zimbabwe, 2018). Duri and Chikwanha (2021) argue that the Act's emphasis on hospital-based, custodial care reflects a colonial-era mental health model that was never designed to serve the community-level, preventive and rehabilitative needs of substance-abusing youth in high-density urban settings. This critique is well founded, but it is important to note that Duri and Chikwanha's study relied primarily on interviews with NGO officials rather than service users, which means that the perspectives of affected youths themselves are largely absent from their analysis. This methodological limitation reduces the applicability of their findings to the lived realities of young people in communities like Mbare.

Zimbabwe's National Mental Health Policy (2014–2020) acknowledged the growing burden of substance abuse and called for the integration of substance abuse services into primary health care. While this represented a meaningful step at the policy level, evidence of implementation at the community level remains thin. WHO Zimbabwe (2018) reported that the country had fewer than twenty psychiatrists and approximately two hundred psychiatric nurses serving a population of over fifteen million people, leaving the vast majority of individuals with substance use disorders without access to specialised professional care. Matsika (2020) similarly documents that community health workers in high-density suburbs, including Mbare, are rarely trained in substance abuse screening or psychosocial intervention, despite being the first point of contact for many affected youth. A significant contradiction emerges here between the policy commitments outlined in the National Mental Health Policy and the resource realities documented by WHO Zimbabwe and Matsika. The policy calls for integration and accessibility, yet the human resource data reveals a system that is structurally incapable of delivering on these commitments at the community level. This contradiction is rarely addressed directly in the literature, with most studies either analysing policy documents or documenting service gaps without explicitly examining the relationship between the two.

The Zimbabwe National Commission Against Drug Abuse (ZNCADA), established under the Dangerous Drugs Act, is the primary government body responsible for coordinating drug abuse prevention and control efforts. ZNCADA has conducted awareness campaigns, school-based programmes and community outreach activities, particularly in high-density suburbs (ZNCADA, 2021). However, critics including Rusenga (2021) and Chadwick (2020) argue that ZNCADA's work has been insufficiently funded, poorly coordinated with health and social welfare departments and excessively focused on law enforcement rather than public health approaches. While these critiques are compelling, it is worth noting that both Rusenga and Chadwick rely heavily on document analysis and secondary sources rather than primary data from communities or service users. Their conclusions, while analytically sound, do not capture how youth in specific communities such as

Mbare actually experience or perceive ZNCADA's interventions, or whether the organisation's activities have had any measurable impact on substance use patterns or mental health outcomes at the local level. This gap between policy-level analysis and community-level evidence is a recurring weakness in the Zimbabwean literature on substance abuse governance.

Regional and international frameworks also provide important guidance for Zimbabwe's response to youth substance abuse. The African Union's Agenda 2063 and the United Nations Sustainable Development Goals, particularly SDG 3 on good health and wellbeing and SDG 10 on reduced inequalities, call on member states to invest meaningfully in mental health services and to address the structural determinants of substance abuse (African Union, 2015; UN, 2015). Government of Zimbabwe (2020) acknowledges these frameworks in the National Drug Strategy 2020–2025 and commits to aligning national policy with their principles. However, the literature offers little evidence of how these international commitments have translated into concrete, funded programmes at the community level in high-density suburbs. Gomba (2022) notes that international frameworks tend to influence national policy language without necessarily changing resource allocation or service delivery patterns on the ground, a finding that is consistent with the broader literature on policy implementation in low and middle-income countries. This observation points to a critical disconnect between Zimbabwe's international policy commitments and the actual support system landscape experienced by youths in Mbare.

A significant gap exists in the literature on mental health policy and social support frameworks in Zimbabwe. While studies consistently document the inadequacy of formal services and the policy-implementation gap, very few have investigated how these systemic failures are experienced at the individual and community level by the young people they are supposed to serve. Most existing studies adopt a top-down analytical perspective, examining policies, institutions and organisational mandates rather than the accessibility, availability and perceived effectiveness of services from the perspective of service users. Furthermore, the informal support systems that many youths in Mbare rely on in the absence of adequate formal services, including family networks, religious institutions and community-based organisations, are underrepresented in the policy literature and have received limited empirical attention. This gap directly motivates Objective Four of the present study, which seeks to evaluate both formal and informal support systems from the perspective of affected youths themselves, thereby generating the community-level, user-centred evidence that the existing literature lacks.

SUMMARY

This chapter has reviewed existing literature relevant to the four objectives guiding this study on drug and substance abuse and its psychosocial functioning effects among youths in Mbare, Harare, Zimbabwe. The review drew on peer-reviewed journals, government reports, policy documents and academic books from local, regional and international sources, with particular emphasis on urban African and Zimbabwean contexts.

In relation to Objective One, the literature confirms that drug and substance abuse among youths in sub-Saharan Africa is widespread and escalating, with alcohol, cannabis, crystal methamphetamine and codeine-based cough syrups being the most commonly abused substances in urban Zimbabwean settings. However, most prevalence studies rely on national or regional data that obscures community-level variations. Official statistics consistently underestimate the true extent of substance abuse due to stigma, fear of legal consequences and the hidden nature of the population. Furthermore, definitions of youth across the literature are inconsistent, with some studies applying the African Union range of 15 to 35 years rather than the UN range of 15 to 24 years used in this study, making direct comparisons between studies difficult and highlighting the need for definitional standardisation in future research.

In relation to Objective Two, the literature establishes a strong and well-documented relationship between substance abuse and psychological harm, particularly depression, anxiety, psychosis and cognitive impairment. Studies from Zimbabwe and the broader Southern African region consistently demonstrate that substance-abusing youths carry a significantly higher mental health burden than non-users. However, a critical limitation of most existing studies is their reliance on broad urban or national samples rather than community-specific

populations. Few studies have employed standardised instruments such as the PHQ-9 and GAD-7 to systematically measure the severity and prevalence of depression and anxiety within specific high-density suburbs, meaning that the psychological burden in communities like Mbare remains largely unquantified and poorly understood at the local level.

In relation to Objective Three, the literature consistently demonstrates that substance abuse severely undermines social functioning across the domains of family relationships, educational engagement, employment and community participation. The evidence from Zimbabwe and comparable African contexts shows that substance-abusing youths are significantly more likely to experience family breakdown, school dropout, unemployment and social marginalisation than their non-using peers. However, most studies examining social functioning rely on qualitative or descriptive approaches and do not statistically test the strength or direction of the relationship between specific substance use variables and social functioning outcomes. The absence of correlation and regression analyses in the existing Zimbabwean literature means that the predictive relationship between substance use characteristics and social functioning impairment has not been empirically established at the community level, which this study seeks to address directly.

In relation to Objective Four, the literature reveals a consistent and deeply concerning gap between policy commitments and service delivery realities. While national frameworks such as the National Drug Strategy (2020–2025) and the National Mental Health Policy (2014–2020) advocate for integrated, accessible and rehabilitative responses to youth substance abuse, the evidence consistently shows that formal services in high-density suburbs remain severely under-resourced, inaccessible and inadequately staffed. Informal support systems, including family networks and religious institutions, attempt to fill these gaps but are themselves constrained by economic hardship, limited capacity and insufficient coordination with formal services. Critically, most existing studies on support systems adopt a top-down analytical perspective, examining institutional mandates and policy documents rather than the lived experiences of affected youths. The accessibility, availability and perceived effectiveness of both formal and informal support systems from the perspective of youth service users in Mbare has received virtually no empirical attention, representing a significant gap in the literature.

Taken together, the gaps identified across all four thematic areas point to a common and overarching deficiency in the existing body of knowledge. There is a critical shortage of localised, empirically grounded, community-specific research that captures the full scope of substance abuse, its psychosocial consequences and the role of support systems as experienced by youths within the specific social and economic context of Mbare. Most studies reviewed were either too broad in scope, too limited in methodology or too removed from the perspectives of affected youth to provide the kind of targeted, actionable evidence needed to inform effective intervention. This consolidated gap directly justifies the present study and confirms that its four objectives, mixed-methods design and community-based approach are both necessary and well positioned to make a meaningful contribution to knowledge, policy and practice in this field. Chapter Three outlines the research methodology adopted to address these gaps systematically and rigorously.

METHODOLOGY

Overview of Approach

This chapter provides a comprehensive and detailed exposition of the methodological approach that will guide the entire research process. It moves beyond mere description of techniques to engage in a thorough justification of the philosophical underpinnings, design choices and procedural frameworks that will ensure the study's rigor, validity and ethical integrity. The chapter is structured to systematically address each component of the research process, beginning with the foundational research philosophy that informs how knowledge is understood and created within this study. It then proceeds to elaborate the specific research design selected to answer the study's questions, followed by detailed discussions of population definition, sampling strategies, data collection instruments and procedures, plans for data analysis and finally the ethical framework that will govern all interactions with participants and communities. The methodology presented here is not merely a technical blueprint but a coherent argument for how best to investigate the complex and sensitive phenomenon

of psycho-social functioning among substance-using youth in Mbare. It reflects careful consideration of the unique challenges posed by the research context, including the hidden nature of the population, the sensitivity of the topic, and the need to produce findings that are both scientifically credible and practically useful for policy and intervention development. Each methodological choice is explicitly linked to the study's aims and objectives, ensuring alignment between what the research seeks to understand and how it plans to achieve that understanding.

Research Philosophy

Research Paradigm

This study is guided by a pragmatic research paradigm. Pragmatism, as articulated by Morgan (2014) and Creswell and Plano Clark (2017), prioritises the research question above rigid adherence to any single philosophical position and holds that the value of knowledge lies in its practical utility for solving real-world problems. This paradigm is the most appropriate foundation for the present study because the research problem demands both quantitative measurement and qualitative exploration, and pragmatism provides the philosophical justification for combining these two approaches within a single coherent design.

Ontologically, this study adopts a position that acknowledges substance abuse, psychological distress and social dysfunction as real phenomena with measurable consequences in the lives of youths in Mbare. At the same time, it recognises that how these phenomena are experienced, understood and reported by participants is shaped by the specific social, economic and cultural context of the community. This balanced ontological position supports the use of standardised instruments such as the PHQ-9 and GAD-7 to capture objective measurements of psychological outcomes while simultaneously using in-depth interviews to explore the subjective meanings and lived experiences behind those measurements.

Epistemologically, knowledge in this study is understood as arising from the interaction between the researcher, the participants and the research context. This means that the structured questionnaire generates reliable, comparable data across all 150 participants, while the qualitative interviews generate deep, contextually grounded understanding from a purposively selected sub-sample. Neither form of knowledge is treated as superior to the other. Instead, both are valued for what they uniquely contribute to answering the research questions.

Axiologically, this study is guided by a commitment to research that is ethically responsible, respectful of participant dignity and practically useful for the Mbare community. Given that the study involves a sensitive topic and a vulnerable population that includes minors aged 15 to 17, every methodological decision has been made with the well-being of participants as a central consideration. This value orientation is reflected in the ethical framework, the choice of safe interview settings, the inclusion of referral pathways for participants in distress and the commitment to returning findings to the community in accessible formats.

Together, these philosophical positions directly support and justify the explanatory sequential mixed-methods design adopted in this study. The pragmatic paradigm provides the flexibility to use whatever methods best answer each research question, the ontological position supports the integration of quantitative and qualitative data, the epistemological stance justifies the two-phase sequential approach, and the axiological commitment ensures that the research is conducted responsibly within the sensitive context of youth substance abuse in an urban high-density community.

Philosophical Underpinnings

Epistemological Orientation

The epistemological stance, or theory of knowledge, flowing from this pragmatic-critical realist position is one of interactionism and contextualism. Knowledge is seen as arising from the interaction between the researcher and the researched within a specific context, rather than being discovered in a purely objective fashion. The

researcher's background, theoretical commitments, and relationship with the community inevitably shape the knowledge produced. Rather than attempting to eliminate this influence, which many pragmatists argue is impossible, the methodology seeks to manage it reflexively. This is achieved through transparency about the researcher's positionality, the use of multiple methods to triangulate findings, and the active engagement with participants' own interpretations of their experiences. The epistemology thus values both the verifiable evidence produced through systematic measurement and the deep understanding generated through empathetic interpretation.

Axiological Position

Axiology, the study of values and ethics, constitutes the third crucial pillar of the research philosophy and is of paramount importance in a study of this nature. Pragmatism inherently carries an axiological commitment to research that is morally engaged and socially responsible. As Dewey argued, inquiry should not be a dispassionate observation of the world but a means for improving it. The axiological position of this study is explicitly emancipatory and transformative. It is guided by the belief that research should not merely describe the suffering of marginalized youth but should be conducted in a way that respects their dignity, amplifies their voices, and contributes to tangible improvements in their lives and communities. This value orientation influences every aspect of the methodology, from the selection of collaborative and non-exploitative sampling techniques to the commitment to reciprocal dissemination of findings. It means that ethical considerations are not an add-on or a hurdle to be cleared but are central to the definition of what constitutes valid and worthwhile knowledge. The study is deeply informed by African ethical frameworks, particularly the concept of Ubuntu, which emphasizes interconnectedness, community, and the fundamental dignity of all persons. Scholars like Murove (2009) and Nussbaum (2003) in the African context argue for research ethics rooted in relationality and care, principles that will guide interactions with participants, ensuring the research process itself does not replicate the marginalization it seeks to document. This axiological commitment necessitates a participatory ethos where possible, ensuring that the research questions and methods remain relevant to the community's own concerns and that findings are returned to the community in accessible formats.

Ontological Orientation

This study is grounded in critical realism as its ontological orientation. Critical realism holds that reality exists independently of human awareness, while also recognising that knowledge of this reality is always shaped by social, cultural, and historical contexts. Within this study, this perspective makes it possible to acknowledge that phenomena such as drug and substance abuse, psychological distress, and social dysfunction are real and have concrete effects on the lives of youths in Mbare. At the same time, it recognises that how these realities are experienced, understood, and expressed is influenced by the specific socio-economic and cultural conditions of the Mbare community.

This ontological position moves beyond naïve realism, which assumes direct and objective access to reality, and strong constructivism, which treats reality as entirely socially constructed. Instead, critical realism proposes a stratified view of reality made up of three interconnected domains.

The real domain refers to the underlying structures, mechanisms, and causal powers that give rise to observable events. In this study, these include factors such as economic hardship, historical marginalisation, social inequalities, and psychological or neurobiological processes that contribute to substance abuse and related challenges.

The actual domain consists of events that occur regardless of whether they are directly observed. Examples include the use of drugs and substances, episodes of psychological distress, and incidents of family or social conflict among youths. The empirical domain comprises events as they are experienced, perceived, and reported by individuals. This includes youths' self-reported experiences of anxiety or stress, family narratives of breakdown, and community stakeholders' accounts of service limitations or support gaps. This layered understanding of reality informs the study's mixed-methods approach. The quantitative component focuses on identifying patterns within the actual and empirical domains by measuring prevalence, intensity, and

relationships between key variables. The qualitative component, on the other hand, explores the empirical and real domains by examining lived experiences, meanings, and the underlying social and psychological mechanisms that shape observed outcomes. Through this ontological stance, the study seeks to generate knowledge that is both empirically grounded in the lived realities of Mbare youths and critically sensitive to the contextual forces that shape those realities.

Research Design

This study adopts an explanatory sequential mixed-methods design in which the quantitative phase is conducted first, followed by the qualitative phase. The purpose of this approach is to use qualitative data to explain and provide deeper insight into the quantitative results. In Phase One, quantitative data will be collected using structured questionnaires to assess patterns of substance use, levels of depression and anxiety, and social functioning among youths in Mbare. The results from this phase will be analysed using descriptive and inferential statistical techniques, including correlation and regression analysis, to identify key trends and relationships.

In Phase Two, qualitative data will be collected through in-depth interviews with a purposively selected sub-sample of participants drawn from the quantitative phase. Selection will be guided by the quantitative findings, for example participants who report high levels of substance use, elevated psychological distress, or significantly impaired social functioning. The qualitative phase will therefore focus on explaining the patterns observed in the quantitative data by exploring participants' lived experiences, perceptions of substance use, and interactions with support systems. The integration of findings will occur at the interpretation stage, where qualitative insights will be used to explain, support and expand upon the quantitative results. This approach enhances the validity of the study by providing both measurable evidence and contextual understanding of the psychosocial functioning effects of substance abuse among youths in Mbare (Creswell & Plano Clark, 2017).

Population Target

The target population for this study is precisely defined to ensure clarity and focus while encompassing the group central to the research problem. It consists of all youths aged between 15 and 24 years who are bona fide residents of the Mbare high-density suburb in Harare, Zimbabwe, and who have engaged in the use of any illicit drug or the misuse of any psychoactive substance for non-medical purposes at least once within the 12 months preceding data collection. This definition requires careful unpacking. The age range of 15-24 aligns with standard definitions of youth used by the United Nations, the African Union, and Zimbabwe's own National Youth Policy (Government of Zimbabwe, 2013). This range captures the developmental period from mid-adolescence to early adulthood, a critical window where patterns of substance use often become established and where psycho-social impacts can have long-term consequences.

Residency in Mbare is a key criterion, anchoring the study in the specific geographical and social context that is the focus of the investigation. This excludes youths who may come into Mbare to purchase or use substances but live elsewhere, ensuring that the findings reflect the experiences of those embedded in the suburb's unique socio-economic ecosystem. The substance use criterion is intentionally broad yet specific. It includes the use of internationally recognized illicit drugs such as cannabis and methamphetamine (mutoriro). Crucially, it also includes the misuse of psychoactive substances that may have licit medical purposes but are used here for intoxication, such as codeine-based cough syrups (brongo/broncleer) and the hazardous or harmful use of alcohol beyond culturally accepted norms. The specification of "non-medical purposes" is important to distinguish recreational or dependence-forming use from medically supervised treatment. The 12-month timeframe, a common benchmark in epidemiological research such as that guided by the World Health Organization's (2021) substance use disorder criteria, ensures that participants have recent experience with substance use, making their accounts and assessments of current psycho-social functioning more reliable and relevant.

This population is inherently a hidden and hard-to-reach population. There is no official roster or sampling frame listing all youth in Mbare who use substances. Many engage in behaviours that are stigmatized and

illegal, leading to purposeful concealment. Furthermore, the chaotic lifestyles often associated with problematic substance use can make individuals geographically and temporally unstable. Defining this population thus immediately foregrounds the significant methodological challenges of access and sampling, which are addressed in the following sections. The study acknowledges that its operational definition may exclude some very marginalized individuals, such as those who are homeless and completely detached from any social networks, or those whose substance use is so severe they cannot meaningfully participate. These limitations are acknowledged as part of the delimitation of the study.

Sample Size Determination

Quantitative Sample Size Determination

Determining appropriate sample sizes for both the quantitative and qualitative components of this mixed-methods study requires separate but related rationales, each grounded in methodological literature and practical considerations. For the quantitative phase, a target sample size of 150 youth participants has been established. This number is derived from considerations of statistical power, feasibility, and the principles of survey research with hidden populations. Statistical power analysis, using software like G-Power and following conventions established by Cohen (1988), provides a formal justification. To detect a moderate correlation ($r = 0.30$) between key variables, such as duration of substance use and depression score, with a power of 0.80 and an alpha level of 0.05, a minimum sample of approximately 85 participants is required. To detect smaller but still meaningful effects, or to allow for more complex multivariate analyses and subgroup comparisons (for example, by gender or primary substance used), a larger sample is prudent. A sample of 150 provides a comfortable buffer above the minimum, enhancing the robustness of the findings. Furthermore, in survey research, particularly in heterogeneous populations, larger samples reduce sampling error and provide more precise estimates of population parameters. From a feasibility standpoint, given the hidden nature of the population and the need for time-intensive, face-to-face administration of questionnaires, 150 represents a challenging but achievable target that balances scientific rigor with practical constraints on time and resources. This figure is consistent with sample sizes used in similar community-based studies on substance use in Southern Africa, such as the work of Peltzer and Phaswana-Mafuya (2018) in South Africa, which surveyed 150-200 participants in localized studies.

Qualitative Sample Size Determination

For the qualitative phase, sample size is determined not by statistical power but by the principle of information power or saturation. Saturation, a concept central to qualitative research methodology, refers to the point where additional interviews yield no new substantive themes or insights relevant to the research questions (Guest, Bunce, & Johnson, 2006). Based on extensive methodological research, particularly the work of Hennink, Kaiser, and Marconi (2017) who conducted empirical studies on saturation in qualitative research, a sample of 15 to 20 in-depth interviews is typically sufficient to reach thematic saturation in studies with a relatively homogeneous population and a well-defined focus. Given that the qualitative participants will be purposively selected from the quantitative sample to represent maximum variation in terms of gender, substance type, and severity of psychological scores, this range is deemed appropriate to capture a wide spectrum of experiences while remaining manageable for deep, analytical work. The selection of 15 to 20 participants is standard practice in phenomenological and exploratory studies within public health, as evidenced in the work of Makanza and Chibanda (2019) in Zimbabwe, who conducted 18 in-depth interviews for their study on trauma and substance use.

In addition to youth participants, the study will include key informant interviews to provide contextual and systemic perspectives. A sample of 8 to 10 key informants is planned, encompassing parents or guardians of substance-using youth, community health workers operating in Mbare, officials from non-governmental organizations addressing youth or substance abuse issues, and religious leaders. This number aligns with recommendations for key informant interviews in community-based research, which suggest that between 5 and 12 well-chosen informants can provide comprehensive insights into institutional and community-level dynamics (Tremblay, 1957). The specific range of 8 to 10 allows for the inclusion of at least two

representatives from each stakeholder category, ensuring diverse perspectives while maintaining depth. This approach is supported by the work of Duri and Chikwanha (2021) in their analysis of NGO roles in Harare, which utilized key informant interviews with 10 organizational representatives to reach a point of informational redundancy on policy and service delivery issues.

Sampling Techniques

Quantitative Sampling Techniques

Given the absence of a formal sampling frame for the hidden population of substance-using youth in Mbare, this study will employ non-probability sampling techniques, specifically chosen for their appropriateness and effectiveness in reaching this marginalized group. The primary technique for the quantitative phase will be respondent-driven sampling (RDS), an advanced form of chain-referral or snowball sampling that incorporates methodological adjustments to mitigate some of the biases inherent in conventional snowball approaches. RDS, formally developed by Heckathorn (1997, 2002), is considered a best-practice method for sampling hidden populations such as people who use drugs, sex workers, and undocumented migrants. The process begins with the purposive selection of a small number of initial participants, or "seeds," who are well-connected within the substance-using networks of Mbare. These seeds will be identified in collaboration with trusted community-based organizations, such as local churches or youth advocacy groups, that have existing rapport and legitimacy in the community.

Each seed participant will complete the quantitative survey and will then be given a limited number (typically 3) of uniquely coded referral coupons to distribute to other eligible youths within their personal networks. These recruits then participate and receive coupons for further recruitment, creating successive waves of referral. RDS assumes that as recruitment waves progress, the sample composition becomes less dependent on the initial seeds and begins to better reflect the broader social network structure of the population. Analytical techniques, including the use of specialized RDS analysis software like RDSAT, will later be applied to generate population estimates that adjust for the non-random sampling method based on participants' network size and recruitment patterns. While RDS does not produce truly probabilistic samples, it represents a rigorous improvement over basic snowball sampling and is widely used and accepted in epidemiological research on hard-to-reach groups, including in African contexts as demonstrated in the work of Hakim and colleagues (2020) in studies of key populations in East Africa.

Qualitative Sampling Techniques

For the qualitative phase, purposive sampling will be employed to select 15-20 participants from the quantitative pool. This selection will strive for maximum variation sampling, a strategy explicitly designed to capture a wide range of perspectives and experiences relevant to the phenomenon under study (Patton, 2015). Participants will be chosen to ensure diversity across several key dimensions that the literature and the quantitative findings suggest are important. These dimensions include gender (aiming for a balance between male and female participants), primary type of substance used (e.g. mutoriro, brongo, cannabis, alcohol), severity of psychological distress scores (selecting participants with both high and low PHQ-9/GAD-7 scores), and levels of social functioning (including those still engaged with family/school and those who are largely detached). This strategy ensures that the qualitative findings are rich and reflect the heterogeneity of the population, allowing for the exploration of how experiences differ across these salient categories. The selection of key informants will also follow a purposive strategy, specifically criterion sampling. Potential informants will be identified based on their pre-defined role or position (e.g. "community health worker in Mbare clinic," "director of an NGO working on youth substance abuse in Harare") and their presumed knowledge of the issues. Their recruitment will involve formal letters of invitation and snowballing within professional networks to identify the most knowledgeable individuals.

It is crucial to acknowledge the limitations of these sampling approaches. Despite the strengths of RDS, the final sample may still underrepresent the most isolated members of the population who are disconnected from any peer networks. The success of the method relies on sufficient network connectivity and recruitment chain

length, which cannot be guaranteed. The purposive sampling for the qualitative phase, while yielding information-rich cases, makes no claim to statistical representativeness. These limitations will be explicitly addressed in the interpretation of findings, with conclusions carefully framed in light of the sampling methods used.

Data Collection

Quantitative Data Collection

Data collection will be a carefully orchestrated, multi-stage process involving distinct but complementary instruments and procedures for the quantitative and qualitative phases, all conducted with meticulous attention to ethical and cultural sensitivity. Quantitative Data Collection will be carried out through structured, interviewer-administered questionnaires. This method is preferred over self-administration given variable literacy levels and the complexity of some standardized instruments. The questionnaire will comprise several integrated sections. The first section will collect essential socio-demographic data including age, gender, education level, current living situation, employment status, and household composition. The second section will focus on substance use patterns, utilizing a modified version of the World Health Organization's Alcohol, Smoking and Substance Involvement Screening Test (WHO ASSIST) (Humeniuk et al., 2010), which has been validated in multiple cultural settings. This section will gather detailed information on the types of substances used, age of initiation, frequency of use in the past 3 months, methods of use, and perceived impact on life. It will be carefully adapted to include locally relevant substances like mutiro and brongo by name.

The third section will measure psychological functioning using two gold-standard, brief diagnostic tools. Depression symptoms will be assessed using the Patient Health Questionnaire-9 (PHQ-9), a nine-item instrument where each item corresponds to one of the DSM-5 diagnostic criteria for major depressive disorder (Kroenke, Spitzer, & Williams, 2001). Anxiety symptoms will be measured using the Generalized Anxiety Disorder-7 (GAD-7) scale, a seven-item tool that effectively screens for anxiety disorders (Spitzer et al., 2006). Both instruments have been used in numerous studies in Zimbabwe and South Africa, demonstrating good reliability and validity in these contexts, as shown in work by Chibanda et al. (2016) in Zimbabwe. The fourth section will assess social functioning. This will involve a culturally adapted scale drawing on items from established instruments like the Social Functioning Questionnaire (SFQ) (Tyrer et al., 2005) and the World Health Organization Disability Assessment Schedule (WHODAS 2.0), but significantly contextualized through input from local experts and pilot testing. It will include Likert-scale and categorical questions covering functioning in the past month across domains of family relationships (e.g. conflict, support), educational/occupational engagement (e.g. attendance, performance), peer relationships, and community participation. The entire questionnaire will be translated into Shona, the predominant local language in Mbare, using a rigorous back-translation process to ensure conceptual equivalence, and will be pilot-tested with a small group of similar youth to check for comprehension and cultural appropriateness.

Qualitative Data Collection

Qualitative Data Collection will occur through semi-structured in-depth interviews (IDIs) and key informant interviews (KIIs). The interview guides will be flexible frameworks rather than rigid questionnaires, allowing the conversation to flow naturally while ensuring all key topics are covered. The youth IDI guide will explore several thematic areas in depth. It will begin with a narrative section inviting participants to tell the story of their substance use journey, including initiation, turning points, and current patterns. It will then probe deeply into the psychological and emotional experiences related to substance use, using prompts from their quantitative scores (e.g. "Your survey indicated you often feel down and hopeless; can you tell me more about what that feels like for you?"). A major focus will be on social functioning, exploring specific incidents and dynamics within families, with friends, and in educational or work settings. Finally, it will explore experiences with and perceptions of all forms of support, from family and friends to formal health services and traditional healers, investigating barriers to access and ideas for improvement.

The key informant interview guides will be tailored to the specific role of the informant but will generally focus on understanding the community and systemic context. Topics will include observed trends in youth substance abuse in Mbare, perceived root causes and consequences, descriptions of existing formal and informal support systems and their perceived strengths and weaknesses, major barriers to effective intervention, and recommendations for policy and practice. All interviews will be conducted in the participant's preferred language (Shona or English) by trained research assistants fluent in both. They will take place in private, safe, and neutral locations agreed upon with participants, such as quiet rooms in community centres or churches. With explicit, documented consent, all interviews will be audio-recorded to ensure accurate capture of data. Extensive field notes will also be taken to capture non-verbal cues and contextual observations. Interviews are anticipated to last between 45 and 90 minutes.

Secondary Data Collection will complement primary data. This will involve a systematic review of relevant documents, including Zimbabwe Republic Police annual crime reports for the Harare region, Ministry of Health and Child Care policy documents and any available program reports, reports from NGOs operating in Mbare, and relevant academic literature. This data will help triangulate findings, provide historical and policy context, and enrich the understanding of the service landscape.

Data Analysis

Quantitative Data Analysis

Quantitative data will be analysed using the Statistical Package for the Social Sciences (SPSS), version 27. Descriptive statistics will be used to summarise demographic characteristics, substance use patterns, and levels of psychological distress and social functioning. Inferential statistical techniques, including correlation analysis, chi-square tests and comparisons of means, will be applied to examine relationships between substance abuse variables and psychological and social outcomes. These analyses will directly address the study's research questions and test the stated hypotheses.

Qualitative Data Analysis

Qualitative data will be analysed using thematic analysis, following a systematic process of familiarisation, coding, theme development, and interpretation. This approach allows for the identification of recurring patterns and meanings within participants' narratives while remaining grounded in their lived experiences. Qualitative findings will be used to explain and contextualise quantitative results, particularly where statistical relationships require deeper interpretation. Integration of the two datasets will occur during the discussion phase, ensuring that numerical trends are supported and illuminated by rich, contextual evidence from the field.

Interpretation of Results

Results will be interpreted through the dual lenses of the Social Stress Theory and the Biopsychosocial Model. Statistical relationships will be discussed not merely as numerical associations but as manifestations of underlying social stressors and psychological processes. Qualitative themes will be used to give human depth to the numbers, ensuring that the interpretation remains grounded in the lived reality of Mbare youths. Discrepancies between quantitative and qualitative findings will be explored as valuable insights into the complexity of the issue.

Ethical Considerations

This study involves human participants, including youths aged between 15 and 24, and addresses sensitive issues related to drug and substance abuse and mental health. For this reason, strict ethical standards will be adhered to throughout the research process to ensure the protection, dignity and well-being of all participants. Ethical approval will be obtained from the relevant institutional review board prior to data collection, and permission will also be sought from local authorities and community leaders in Mbare.

Informed Consent

Participation in this study will be entirely voluntary. All participants will be provided with clear and detailed information about the purpose of the study, the procedures involved, the type of questions to be asked, and their rights as participants. Written informed consent will be obtained before participation. For participants aged 18 years and above, consent will be obtained directly from the individual. For participants aged between 15 and 17 years, both parental or guardian consent and participant assent will be obtained prior to inclusion in the study. Participants will also be informed that they have the right to withdraw from the study at any stage without any negative consequences.

Confidentiality and Anonymity

Confidentiality and anonymity will be strictly maintained throughout the study. No personally identifiable information such as names or exact addresses will be recorded on questionnaires or interview transcripts. Instead, unique identification codes will be assigned to each participant. All data collected will be stored securely in password-protected digital files and locked storage for hard copies. Access to the data will be limited to the researcher only. Findings will be reported in aggregate form, and any quotations used in the study will not include information that could identify individual participants.

Protection from Harm and Psychological Distress

Given the sensitive nature of the study, there is a possibility that some participants may experience emotional discomfort when discussing substance use or mental health experiences. To minimise this risk, data collection will be conducted in a respectful and non-judgmental manner, and participants will not be forced to answer any questions they are uncomfortable with. Participants will be informed in advance about the nature of the questions, and they will have the right to skip any question or withdraw from the study at any point.

Distress Protocol and Referral Mechanisms

This study includes the use of standardised mental health screening tools, namely the Patient Health Questionnaire (PHQ-9) and the Generalized Anxiety Disorder scale (GAD-7). Participants who score 10 or above on either scale, indicating moderate to severe symptoms of depression or anxiety, will be sensitively informed and referred to appropriate support services. Referral pathways will include local clinics, counselling services, and relevant non-governmental organisations operating within or near Mbare. Where necessary, the researcher will provide information on available mental health resources and encourage participants to seek professional support. This ensures that the study does not only identify distress but also contributes to participant well-being.

Privacy and Data Protection

Interviews will be conducted in private settings to ensure participants feel safe and comfortable when sharing their experiences. All electronic data will be encrypted and stored securely, while physical documents will be kept in locked storage. Data will be retained only for the period required by institutional guidelines and will be securely destroyed thereafter.

Ethical Responsibility and Integrity

The researcher will conduct the study with honesty, transparency and respect for participants at all times. No form of coercion, deception or undue influence will be used to recruit participants. The study will adhere to established ethical guidelines for social science research and will ensure that the rights and welfare of participants are prioritised throughout the research process (World Health Organization, 2021; Creswell & Creswell, 2018).

SUMMARY

This chapter has presented a comprehensive and coherent account of the research methodology adopted for this study. Guided by a pragmatic philosophical orientation and grounded in critical realism, the study employs an explanatory sequential mixed-methods design that combines the strengths of both quantitative measurement and qualitative exploration. This approach was deliberately chosen because the complex and sensitive nature of psycho-social functioning among substance-using youth in Mbare cannot be adequately captured through any single methodological lens. The quantitative phase, using a structured questionnaire administered to 150 youth participants through respondent-driven sampling, provides statistically analysable data on the prevalence, patterns and correlates of substance abuse and its psychological and social effects. The qualitative phase, involving in-depth interviews with 15 to 20 purposively selected youth and 8 to 10 key informants, enables a deeper exploration of the lived experiences, meanings and social dynamics that underpin the statistical findings.

The chapter has also detailed the philosophical underpinnings that inform the study, including its pragmatic paradigm, critical realist ontology, interactionist epistemology, and emancipatory axiological stance rooted in African ethical frameworks such as Ubuntu. These philosophical foundations ensure that the research is not merely technically rigorous but also ethically grounded and socially responsive. The target population is precisely defined as youth aged 15 to 24 who are residents of Mbare and have engaged in substance use within the past 12 months, a population that is inherently hidden and hard to reach. The use of respondent-driven sampling for the quantitative phase and purposive maximum variation sampling for the qualitative phase reflects careful attention to the methodological challenges posed by this population, while the planned use of validated instruments such as the PHQ-9 and GAD-7 ensures scientific credibility in the measurement of psychological outcomes.

Throughout this chapter, each methodological decision has been explicitly linked to the study's aims, objectives and research questions, ensuring coherence and transparency across the entire research design. The data analysis plan, involving SPSS for quantitative data and thematic analysis for qualitative data, is well suited to the mixed-methods framework and will enable integration of findings at the discussion stage. Most importantly, the ethical framework outlined in this chapter, covering informed consent, confidentiality, minimisation of harm, and respect for participant dignity, ensures that the research is conducted responsibly and in a manner that upholds the rights and well-being of all participants. The methodology presented here provides a solid foundation for generating empirically grounded, contextually relevant and practically useful evidence on the psycho-social effects of drug and substance abuse among youths in Mbare, which will be presented and discussed in the subsequent chapters.

In conclusion, Chapter Three has laid out a methodological framework that is philosophically informed, scientifically rigorous, and ethically sound. By aligning the research design, sampling strategy, data collection instruments, and analytical approaches with the specific aims and context of this study, the chapter demonstrates a coherent and well-justified path toward generating meaningful evidence on youth substance abuse and psycho-social functioning in Mbare. The methodology positions the study to make a valuable contribution to both academic scholarship and practical intervention in the field of youth mental health and social welfare in urban Zimbabwe.

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APPENDICES

Appendix One: Ethical Clearance

[To be obtained from the Africa Research University Institutional Review Board and relevant local authorities in Mbare prior to commencement of data collection.]

Appendix Two: Recommendation Letters

[Letters of recommendation and introduction from the Africa Research University and relevant community or institutional gatekeepers to be attached here.]

Appendix Three: Data Collection Tools

Tool A: Structured Questionnaire (Quantitative Survey)

Section 1: Socio-Demographic Information

1. Unique Participant Code: _____
2. Date of Interview: // _____
3. Age: _____ years
4. Gender: ☐ Male ☐ Female ☐ Other
5. Current living situation: ☐ With parents ☐ With relatives ☐ Alone ☐ With friends ☐ Homeless
6. Highest education level completed: ☐ None ☐ Primary ☐ Secondary ☐ Tertiary
7. Current main activity: ☐ In school ☐ Employed formal ☐ Employed informal ☐ Unemployed ☐ Other
8. Average monthly personal income (ZWL): _____

Section 2: Substance Use Patterns (Adapted WHO ASSIST)

1. Which of the following substances have you used in the past 3 months? (Mark all that apply)

- Mutoriro (crystal meth)
- Brongo/Broncleer (cough syrup)
- Cannabis (mbanje)
- Alcohol
- Prescription pills (without prescription)
- Other: _____

2. For your main substance, at what age did you first use? _____ years

3. In the past 3 months, how often have you used your main substance?

- Daily or almost daily
- Weekly
- Monthly
- Less than monthly

4. Has your substance use caused you any health, social, legal or financial problems? ☐ Yes ☐ No

Section 3: Psychological Functioning

PHQ-9 (Patient Health Questionnaire-9)

Over the last 2 weeks, how often have you been bothered by:

1. Little interest or pleasure in doing things

- Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

2. Feeling down, depressed, or hopeless

- Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

(Continue with remaining 7 PHQ-9 items) GAD-7 (Generalized Anxiety Disorder-7)

Over the last 2 weeks, how often have you been bothered by:

1. Feeling nervous, anxious or on edge

- Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

(Continue with remaining 6 GAD-7 items)

Section 4: Social Functioning Assessment

1. In the past month, how would you describe your relationships with family members?

- Very good ☐ Good ☐ Fair ☐ Poor ☐ Very poor

2. Have you had serious conflicts with family in the past month? ☐ Yes ☐ No

3. Are you currently attending school/training? ☐ Yes ☐ No

4. If yes, how many days did you miss in the past month? _____ days

5. How many close friends do you have who do NOT use substances? _____

6. Have you been involved in any criminal activity in the past 6 months? ☐ Yes ☐ No

Tool B: In-Depth Interview Guide (Youth Participants)

Opening: Thank you for agreeing to speak with me. This conversation will help us understand the experiences of young people in Mbare better. There are no right or wrong answers. You can skip any question or stop at any time.

Themes

1. Personal Journey with Substances

- Can you tell me about how you first started using [substance]?
- What does a typical day involving substance use look like for you?

2. Psychological and Emotional Experiences

- How would you describe your general mood or feelings lately?
- What do you do when you feel stressed, sad, or anxious?

3. Family and Social Relationships

- How have your relationships with family members changed since you started using substances?
- Can you describe a recent interaction with your family?

4. Education and Future Aspirations

- What are your current activities during the day?
- What are your hopes for the future?

5. Support and Services

- Where do you turn when you need help or someone to talk to?
- What kind of support do you wish existed in Mbare for young people like you?

Closing: Is there anything important about your experience that we haven't discussed?

Tool C: Key Informant Interview Guide

Opening: Thank you for your time. Your perspective as someone working with youth in Mbare is valuable for understanding how to better support young people.

Themes

1. Community Context

- From your perspective, what are the main factors driving substance abuse among youth in Mbare?
- How has the situation changed over the past few years?

2. Available Services and Resources

- What formal or informal support systems exist for youth who use substances?
- What are the biggest gaps in services?

3. Challenges and Barriers

- What are the main challenges in addressing youth substance abuse in Mbare?
- How do families typically respond when a youth is using substances?

4. Recommendations

- What practical interventions would make the biggest difference?
- How can community organizations better collaborate?

Appendix Two: Research Timeline (3 Months)

Month 1: Preparation and Ethical Clearance

Week 1-2: Finalize research tools, translations, and pilot testing

Week 3: Submit for ethical approval, recruit and train research assistants

Week 4: Community entry and engagement, identify initial "seed" participants

Month 2: Data Collection

Week 1-3: Quantitative survey administration (target: 150 participants)

Week 4: Preliminary quantitative analysis to inform qualitative sampling

Week 4: Begin qualitative interviews with youth and key informants

Month 3: Data Analysis and Reporting

Week 1-2: Complete qualitative interviews, transcription, and translation

Week 3: Comprehensive quantitative analysis and thematic qualitative analysis

Week 4: Integration of findings, draft report writing, and community feedback session

Appendix Three: Estimated Budget (400 USD)

I. Personnel Costs (250 USD)

- Research assistant stipends (2 assistants $\times$ 8 weeks $\times$ 15 USD/week): 240 USD
- Transcription services (partial): 10 USD

II. Data Collection Materials (50 USD)

- Printed questionnaires and consent forms: 20 USD
- Audio recording equipment (2 basic digital recorders): 30 USD

III. Participant Reimbursements (80 USD)

- Transport reimbursement for survey participants (150×0.50 USD): 75 USD
- Refreshments for interview participants: 5 USD

IV. Operational Costs (20 USD)

- Local transport for researcher: 15 USD
- Communication (airtime/data): 5 USD

V. Contingency (20 USD)

- Unforeseen expenses: 20 USD

Total Estimated Budget: 400 USD

Appendix Six: Consent Letter

Dear Participant,

You are being invited to participate in a research study titled “Assessment of the Psycho-Social Functioning Effects of Drug and Substance Abuse Among Youths and Support Systems in Mbare High-Density Suburb, Harare, Zimbabwe.” This study is being conducted by Terrence Madziva, a Master of Philosophy student at the Africa Research University, under academic supervision. The purpose of the study is to understand how drug and substance abuse affects the psychological well-being and social functioning of young people in Mbare, and to assess the support systems available to them. Your participation is entirely voluntary. You may choose not to

answer any question or to withdraw from the study at any time without penalty. All information you provide will be kept strictly confidential. Your name will not appear in any report or publication arising from this research. Data will be stored securely and only accessed by the research team. If you agree to take part, you will be asked to complete a questionnaire and, if selected, participate in an in-depth interview. Participation will take approximately 30 to 90 minutes of your time. There are no known risks associated with participation. However, if you feel distressed at any point, you may stop and you will be provided with referral information for free counselling services. By signing below, you confirm that you have read and understood this information, that you voluntarily agree to participate, and that you are 18 years of age or older (or have parental/guardian consent if aged 15–17).

Participant Signature: _____ Date: _____

Researcher Signature: _____ Date: _____

Appendix Seven: Map of Study Area (Mbare, Harare)

[A map showing the geographical location of Mbare within Harare, Zimbabwe, indicating the study site boundaries and key landmarks referenced in the research, to be inserted here.]

Note: All costs are estimated in USD equivalent. Budget assumes use of existing institutional resources for printing, workspace, and supervision. Community partnerships will facilitate venue access without cost.