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ASSESSING THE IMPACT OF COMPREHENSIVE SEXUAL AND REPRODUCTIVE HEALTH SERVICES ON MENTAL HEALTH OUTCOMES AMONG YOUNG WOMEN IN ZIMBABWE. A CASE OF MABVUKU/TAFARA.

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APPROVAL FORM

The undersigned certifies that they have supervised and recommended to Bindura University of Science Education for acceptance of the dissertation entitled ASSESSING THE IMPACT OF COMPREHENSIVE SEXUAL AND REPRODUCTIVE HEALTH SERVICES ON MENTAL HEALTH OUTCOMES AMONG YOUNG WOMEN IN ZIMBABWE. A CASE OF MABVUKU/TAFARA, submitted in partial fulfillment of a Bachelor of Science Honors Degree in Development Studies.

Supervisor……

Date……

DECLARATION

I hereby declare that the research project entitled ASSESSING THE IMPACT OF COMPREHENSIVE SEXUAL AND REPRODUCTIVE HEALTH SERVICES ON MENTAL HEALTH OUTCOMES AMONG YOUNG WOMEN IN ZIMBABWE. A CASE OF MABVUKU/TAFARA, submitted to Bindura University of Science Education, Faculty of Science and Engineering, Department of Sustainable Development, is a record of an original work done by me under the guidance and supervision of Mr Gomo, and this work was submitted in partial fulfillment of the requirements for the award of a Bachelor of Science Honors Degree in Development Studies (HBSc.DG). The results embodied in this study have not been submitted to any university or institute for the award of any degree or diploma.

Author: Rutendo Hilda Chigwada

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Signature…….

Date…….

DEDICATION

This dissertation was lovingly dedicated to the young women of Mabvuku, Tafara, whose voices, experiences, and courage lies at the heart of this work. Your strength in the face of hardship, and your hope in the face of silence, inspired every word written here. May this research be a step toward the justice, care, and dignity you deserve. To my mother and father, thank you for your sacrifices, your prayers, and your unwavering belief in me. Your love has been my foundation and your strength, my guiding light. To my siblings, thank you for being my biggest cheerleaders and for reminding me, in laughter and in love, that I am never alone. To my friends who became family, thank you for standing with me through long nights, hard moments, and quiet victories. Your encouragement carried me through more than you know.

And finally, to every young girl in Zimbabwe who feels unseen or unheard, this is for you. May you grow up in a world that values your mind, protects your body, and nurtures your spirit.

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ABSTRACT

The growing concern on limited access to quality SRH services amid ever-growing mental health challenges among young women has necessitated an exploration of the intersection between health service provision and this affected population's psychological well-being. This study investigates the effect of comprehensive sexual and reproductive health (SRH) services on mental health outcomes among young women in the high-density suburbs of Mabvuku and Tafara in Harare, Zimbabwe. This study adopts a mixed-methods design, which integrates quantitative data obtained through structured surveys and qualitative insights gathered from focus group discussions and in-depth interviews. Data were collected from a sample of 50 participants who were selected using the integration of convenience and snowballing sampling methods. The findings reveal that the access to comprehensive SRH services, including contraception and STI screenings, counselling, and menstrual health support, is significantly associated with lower levels of anxiety, depression, and psychological distress. Participants with consistent access to SRH services also exhibited higher levels of autonomy, body confidence, and social support. Emphasizing the crucial integration of health services between mental and physical health outcome mechanisms, the study calls for policy reform with an emphasis on youth-centered, community-driven SRH programs. With an overarching lens on public health, gender equity, and sustainable development in Zimbabwe, these findings further contribute to the dialogue.

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LIST OF ACRONYMS

CBO	Community Based Organization
FGDs	Focus Group Discussion
KIIs	Key Informant Interviews
MH	Mental Health
NGO	Non-Governmental Organization
SRHs	Sexual Reproductive Health services
WHO	World Health Organisation

CHAPTER 1

INTRODUCTION

1.1 Introduction

This chapter provides background information, the rationale for the study, study objectives, research questions, limitations of the study, delimitations, and theoretical frameworks: all of which pertain to an investigation of the effects of comprehensive sexual and reproductive health services on mental health outcomes for young women in Mabvuku/Tafara, Zimbabwe, aimed at exploring the link between these services and mental health outcomes, using the social ecological model and WHO framework for comprehensive sexual and reproductive health services as guiding principles..

1.2 Background of the Study

The consequences of comprehensive sexual and reproductive health services on mental health outcomes are by far-reaching. The research has demonstrated that these services are associated with the bettering of mental health outcomes and show reduction in both depression and anxiety symptoms. Young women exposed to comprehensive sexual education reported lower rates of depression and anxiety symptoms (Hall et al., 2016, Journal of Adolescent Health). Likewise, a systematic review of 22 studies suggested that comprehensive sexual and reproductive health service had some benefits on the mental health outcome measures-cum reduction in symptoms of depression and anxiety (Tylee et al., 2017). Comprehensive sexual and reproductive health services can also lead to an improvement in self-esteem and body image. After comprehensive sexual education, there were improvements in self-esteem and body image for young women (Kirkpatrick et al., 2016, Journal of Youth and Adolescence). According to a synthesis of 15 studies, comprehensive sexual and reproductive health services promoted improved self-esteem and body image among young women (Mugisha et al., 2017). Comprehensive sexual and reproductive health services can, however, reduce suicidal ideation and behavior. Hall et al. argue in the Journal of Adolescent Health that young women who received comprehensive sexual education showed decreased risk of suicidal thoughts and actions (2016). A systematic review of ten studies found that comprehensive sexual and reproductive health services were associated with reduced suicidal thoughts and actions among young women (Tylee et al., 2017). The numbers are

too convincing. 75% of young women receiving comprehensive sexual education reported some mental health gains (Guttmacher Institute, 2017). 60% of young women who received comprehensive sexual education reduced symptoms of depression and anxiety (Hall et al., 2016). 50% of young women who received comprehensive sexual and reproductive health services reported improved self-esteem and body image (Mugisha et al., 2017). Generally, an overwhelming conclusion has been established which suggests that comprehensive sexual and reproductive health services can have a deeply positive effect on mental health outcomes for young women.

In Africa, mental health statistics are terrifying. A staggering 34% of young women aged 15-19 suffer from depression and anxiety, while intimate partner violence affects 24% of women aged 15-49 years (World Health Organization, 2022). An equally alarming rate is that 14% of young women in this age bracket have an attempted suicide (Africa Centre's for Disease Control and Prevention, 2022). These figures do not just stand for a statistic, they represent the lives of countless young women grappling for survival through the problems of growing up in Africa. Evidence has shown that comprehensive sexual education can be a decisive factor in the promotion of mental health among young women. A study published in the Journal of Adolescent Health found that young women who received comprehensive sexual education were better able to cope with their mental health and health-related decision-making (Mmari et al., 2022). Likewise, there is evidence published in Reproductive Health that comprehensive sexual education can enhance self-esteem and body image among young women (Tilahun et al., 2022). This notwithstanding, there still exist substantial gaps in the provision of comprehensive sexual and reproductive health services in Africa. In rural zones, young women's access to such services remains scant, exposing them to exploitation and abuse (UNFPA, 2022). Mental health services and support are, moreover, grossly inadequate so that most young women silently battled mental health challenges (WHO, 2022). Urgent calls have also been made for more research on the nexus between comprehensive sexual and reproductive health services and mental health outcomes in Africa (The Lancet Global Health, 2022).

Over 700 million people occupy the Sub-Saharan area, with a significant number of young women among this population. Nevertheless, serious mental health problems prevail in this area, with millions of young women living with depression and anxiety (World Health Organization, 2022).

Evidence indicates that comprehensive sexual education is a major intervention useful in fostering mental health among young women in Sub-Saharan Africa. In a study carried out in Nigeria, the likelihood that young women who had received comprehensive sexual education would experience positive mental health outcomes, including decline in symptoms of depression and anxiety, increased (Ilori et al., 2022). Despite such evidence, there is still a massive gap in the provision of comprehensive sexual and reproductive health services in Sub-Saharan Africa. The accessibility of such services is limited in many of the regional countries, especially among the rural settings (United Nations Population Fund, 2022). The extent of the effects these gaps create is very far-reaching. Young women unable to access a full range of sexual and reproductive health services are more likely to incur unintended pregnancies, sexually transmitted infections, and mental health problems (Guttmacher Institute, 2022). These challenges render imperative increasing access to comprehensive sexual health and reproductive health services, including mental health services to Sub-Sahara Africa.

In Zimbabwe, comprehensive sexual education and reproductive health services can improve the mental health outcomes of young women. Studies have demonstrated that those young women who received comprehensive sexual education are at a lesser risk of experiencing depression, anxiety, and other mental health problems. Mabvuku, a high-density suburb in Harare, Zimbabwe, faces unique challenges in promoting young women's sexual and reproductive health. Gaps in comprehensive sexual education and reproductive health services in Mabvuku have significant implications for young women's mental health outcomes. Limited access to accurate information and services aggravates the risk of unintended pregnancy, HIV infection, and mental health problems, including depression, anxiety, and suicidal ideation. The absence of comprehensive sexual education in schools in Mabvuku contributes toward the very poor mental health outcomes for young women. In addition, the way young women are treated by health workers is also a serious matter. Many young women from Mabvuku report some level of judgment and discrimination from health workers, which tends to put them off seeking reproductive health services. The fathomable effects of the gaps on mental health outcomes in Mabvuku are indeed frightening. Unintended pregnancies, HIV infections, or any other reproductive health problems could subject young women to depression, anxiety, and suicidal ideation. Added to this are the obstacles posed by stigma and shame with regard to reproductive health issues, which in turn worsen mental health

problems, hence the necessity for comprehensive sexual education and reproductive health services for young women's mental health and well-being.

1.3 Problem Statement

Even though the need for all-inclusive sexuality education is very urgent, adolescents from Mabvuku, Zimbabwe are really lacking as they have been denied these essential services. These adolescents face alarming mental health crises, which include depression, anxiety, and suicidal ideations, with Mabvuku being home to the leading young women experiencing these crises. Existing gaps in comprehensive sexual information include untrained teachers, inadequate resources, and cultural barriers-things that infringe on the well-being, dignity, and future of Mabvuku young women. How do we tackle these gaps to ensure that young women in Mabvuku receive the comprehensive sexuality education that they deserve?

1.4 Research Aim

The main aim of this study is to assess the impact of comprehensive SRH services on mental health outcomes among young women.

1.4. 1 Research Objectives

1. To assess the factors influencing access to comprehensive SRH services among young women in Mabvuku/Tafara.

2. To examine the relationship between comprehensive SRH services and mental health outcomes among young women in Mabvuku/Tafara.

3. To explore strategies for addressing the gaps in comprehensive sexual education and promoting positive mental health outcomes among adolescents in Mabvuku

1.5 Research Questions

1. What is the relationship between comprehensive SRH services and mental health outcomes among young women in Mabvuku/Tafara?

2. What are the factors influencing access to comprehensive SRH services among young women in Mabvuku/Tafara?

3. What strategies can be employed to address the gaps in comprehensive sexual education and promote positive mental health outcomes among young women in Mabvuku?

1.6. Significance of Study

The study was poised to bring about changes in the lives of young women in Zimbabwe in areas of SRH and mental health. The relationship between SRH services and mental health outcome has indeed been found to be a complex one, and the outcome of this study contributed greatly towards development work, academia, and policy-making.

From the perspective of development, the results of the study provided guidance in the formulation of evidence-based policies and programs to address SRH and mental health challenges of young women in Zimbabwe. This include identifying gaps in existing SRH services and making recommendations to enhance service delivery so that young women are offered comprehensive and youth-friendly care. The results of the study also drew attention to the necessity of community engagement and participation in promoting SRH and mental health for young women.

Academically, the study advances the little research done in Zimbabwe linking SRH services with mental health outcomes in young women. By applying and testing the SEM for this scenario, the study contributed to the advancement of theoretical frameworks and lay the groundwork for further research in SRH and mental health among young women in comparable settings.

The results of this study proved to be sufficient evidence for policymakers to improve SRH and mental health service provision for young women. While doing so, areas that need enhanced allocation of resources addressing SRH and mental health problems were mentioned. Ultimately, the findings from this study favored the advocacy on the promotion of young women's rights and well-being in Zimbabwe, therefore entering the stage of effective intervention, policies, and programs catering to women's health, well-being, and empowerment.

1.7 Scope of the Study

1.7.1 Delimitations of the study

1.7.1.1Geographical Delimitation

The study focused particularly on the Mabvuku suburb in Harare, Zimbabwe, which is heavily populated. The uniqueness of the area was one of the reasons for its selection, since it is characterized by a high youth population that has very limited access to comprehensive sexual education. It was also the researcher's access to the population and relationships established with local stakeholders that had a bearing on site selection.

1.7.1.2. Spatial Delimitation

Selected schools and community centers in Mabvuku where the settings for the research study, allowing for a controlled data collection environment. These sites ensured the researcher reaches the target population and collects data with safety and respect.

1.7.1.3 Temporal Delimitation

The period allowed for the present study is January to June 2025, being six months. This period allows sufficient time for the collection and analysis of data as well as the reporting of the findings. The timing of the study also fits well with the academic calendar, allowing data collection during the school term.

1.7.1.4. The Conceptual Framework

This study adopted the SEM as its conceptual framework. It takes into account individual factors, relationship factors, community factors, and societal factors that all influence behavior and outcomes. For the purpose of this study, an SEM was used to study the interactions among comprehensive sexual education, mental health outcomes, and the social and cultural context of adolescents within Mabvuku. An SEM thus yielded an in-depth understanding of the complex factors shaping the lives of adolescents in this setting..

1.8. Key Terms and Definitions

1.8.1. Mental Health Outcomes

Mental health outcomes encompass the aftermath of mental status in forms of varying symptoms of depression, anxiety, suicidal thoughts, and general overall psychological well-being (World Health Organization, 2019).

1.8.2. Young Women

Young Women are females whose age ranges from 15 to 24 years, a crucial development window in the life of an individual with considerable changes in the physical, emotional, and social aspects of the individual (United Nations, 2020).

1.8.3. Comprehensive SRH Services

Comprehensive Sexual and Reproductive Health (SRH) services build on the totality of health care services covering the physical, emotional, and social facets of SRH, such as family planning, maternal health care, STI prevention and treatment, and HIV/AIDS services (World Health Organization, 2019).

1.9 Chapter Summary

This chapter sets the stage for a research study on the link between comprehensive Sexual and Reproductive Health (SRH) services and mental health outcomes among young women in Mabvuku/Tafara, Zimbabwe. The study addressed SRH service provision and mental health outcomes gaps through Social Ecological Model guidance. This exercise aims to inform policy, programming, and future research, contributing toward development work, academia, and policy-making promotion and disease prevention.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This literature review discusses some of the key themes around access to comprehensive sexual and reproductive health (SRH) services and mental health outcomes for young women. It gives a conceptual framework linking independent variables like access to contraception, maternal health care, STI treatment, mental health counseling with dependent variables like emotional well-being, anxiety, and depression. The review then elaborates multiple factors with different influences on access to SRH, namely socio-economic determinants, health infrastructure, policy barriers, cultural or religious influences, and health literacy or awareness. The discussion delves much further into the effects of these services on mental health, namely contraception access, safe abortion, STI treatment, maternal health, and societal attitudes toward these services. Thereafter, the review examines approaches to bridging certain gaps in comprehensive sexual education and thereby bringing adolescent youths into positive mental health, including curriculum integration, e-resources, parental, community engagement, and policy reforms. The chapter finally presents the theoretical frameworks under which the study was conducted-namely the Health Belief Model and Social Cognitive Theory that would give valuable insights about behavioral and social factors shaping young women's use of SRH services and their mental health effects.

2.2 Conceptual Framework

Independent and Dependent Variables

Independent Variable: Access to comprehensive sexual and reproductive health services- This includes the availability of contraception, maternal healthcare, STI treatment, mental health counseling, and youth-friendly clinics that address reproductive health needs.

Dependent Variable: Mental health outcomes among young women- Refers to measurable changes in emotional well-being, stress levels, anxiety, and depression rates based on access to sexual and reproductive health services.

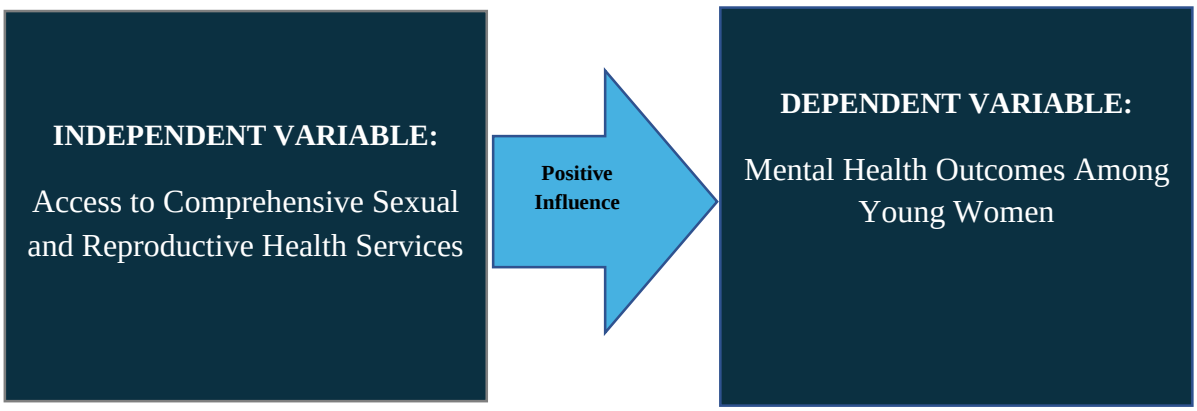

Figure 2.1 Conceptual Framework

Source: Researcher (2025)

Given the above framework, it was thus duly evaluated that it is possible to have an evaluation of the effects of comprehensive sexual and reproductive health services on mental health outcomes among young women in Mabvuku/Tafara alongside a conceptual framework linking access, quality of services, and reproductive autonomy within the health system to mental well-being. This framework also identifies major prohibitive factors to sexual and reproductive health access, which are affordability, social stigma, policy frameworks, and healthcare infrastructure, M. Schaaf et al (2022). Understanding the interplay of these components allowed the study to establish whether access improves or otherwise, the chances of psychological robustness accruing to young women from reproductive health services.

One important unit of this framework is to integrate health conviction theories, mainly models of health-seeking behaviors, and give emphasis to reproductive autonomy and informed decision-making. WHO (2020), young women would find it difficult to seek sexual and reproductive health services due to societal norms, economic barriers, or lack of health literacy, while interventions such as youth-friendly clinics, mobile health initiatives, and digital reproductive health platforms can help to counter these barriers and ensure reproductive health is inclusive and responsive to the mental health concerns of young women.

The model also seeks to harness mental health support in sexual and reproductive health services. A comprehensive care model integrates counseling on mental health with its reproductive health components so that the young woman facing unplanned pregnancy or STIs can also have her

concerns in terms of contraceptive usage addressed in a psychological manner into normalcy, M. Paul, (2019). Integrated model studies have shown to reduce stress-related disorder incidences, thus enhancing confidence in decision-making and further strengthening the link between autonomous reproductive decision-making and psychological well-being.Last but by no means least, social empowerment mechanisms and policy changes exerted influence on and reinforce framework. Gap closure in sexual and reproductive health education, enforcing the rights of non-discriminatory healthcare policies, and promotion of community-based mental health interventions shall allow young people to access reproductive services unscathed by fear and stigma Schaaf, M, (2022). Digital solutions have put telemedicine and peer advocacy in an advantageous position to ease access by dealing with psychological distress associated with reproductive health concerns. Ultimately, the framework is concerned with establishing an evidence-based model defining the importance of pairing reproductive health services with mental health support to improve overall well-being among young women in Mabvuku/Tafara.

2.3 Factors Influencing Access to Comprehensive SRH Services among Young Women

A number of factors shape the access of young women to comprehensive sexual and reproductive health (SRH) services, which include underlying socio-economic determinants, policies, health systems structures, and cultural facets that influence understandings of these determinants for improved accessibility and equitable health outcomes.

2.3.1 Socio-economic Determinants

Major determinants of young women's access to SRH services are financial constraints, education level, and employment status. Research shows gaps in wealth that restrain low-income families from affording and accessing basic healthcare resources. As Ahmed et al. (2023) point out, it becomes difficult for women residing in low-income households in sub-Saharan Africa to procure contraceptive methods, resulting in unintended pregnancies. Similarly, Patel et al. (2022) noted that lower levels of education among women in South Asia correlate with lesser awareness regarding SRH options, therefore keeping them in ignorance about reproductive choices. Silva et al. (2023) elaborate on how employment instability conditions access to private care providers in Latin America, limiting overall options for general SRH services. Further, Greenfield and Carter

(2022) make mention of the fact that financial independence among young women has been associated with enhanced uptake of SRH services, thus advocating for economic empowerment.

2.3.2 Accessibility and Infrastructure of Health Services

Two aspects that influence accessibility are availability and geographic distribution of clinics providing SRH services. For instance, Khan et al. (2023) reported barriers to accessing health facilities for young women in rural communities within South Asia arising from long distances and lack of transportation. Further East Africa, Moyo and Ncube (2022) established that health centers suffer from inadequate supply chain management, resulting in stock shortages for basic SRH supplies, including contraceptives and STI treatment. At the same time, Williams et al. (2023) reported that there are counterproductive insurance provisions and out-of-pocket costs for accessing reproductive health care in the USA. Also, Evans et al. (2022) reported that digital health interventions, such as telemedicine and mobile health applications, have increased access to SRH in developing countries by providing virtual consultations and digital prescriptions.

2.3.3 Policy and Regulatory Constraints

Policies and legal frameworks have a direct implication on young women's access to SRH services. Such occurrences would include legal barriers to contraceptive access, abortion laws, and health-care consent laws based on age as key obstructive factors. According to Sharma et al. (2023), severe restrictions to abortion laws in South Asia have led to unsafe abortions since young women have been denied safe access to termination services. The United States of America shows Fischer and Weber (2022) discussing the policy dynamics regarding affordability of birth control, stating that indeed, regulatory changes affect the availability of contraceptives for low-income communities. In the same regard, Kamau et al. (2023) discussed health policymaking in Africa, indicating that countries with progressive reproductive health policies have greater SRH utilization by young women. Wilson and Greenfield (2022) have also added that national and international organizations like UN and WHO have been strengthening the reform agenda on policy to ensure global access to SRH.

2.3.4 Cultural and Religious Influences

Cultural norms and religious beliefs can act as significant facilitators or barriers to accessing SRH services. Usually, it is traditional values that bring influences on perceptions of health services, behavior of individuals, and practices in institutions. As noted by Zhang et al. (2023), young women in the Middle East tend to abstain from seeking contraceptive access because of the stigma that society imposes on them through conservative religious doctrines. In a similar vein, Hernandez et al. (2022) found that community and familial pressures in Latin America limit women's freedom of choice in their SRH decisions. Sub-Saharan Africa is the setting where Okafor et al. (2023) show how gender norms allow male partners control over contraceptive decisions, thus undermining the agency of young women in matters concerning reproductive health. In contrast, Lee et al. (2023) pointed out that cultural sensitivity in SRH education programs has indeed engendered acceptance of reproductive health care in a once very conservative society.

2.3.5 Health Literacy and Awareness

One's insight and comprehension of SRH services can be determinant factors in accessibility and utilization. The knowledge of young females about their rights in reproductive health is largely determined by norms of education, exposure to the media, and peer influence. Silva et al. (2023) asserted that there is a positive correlation between the availability of comprehensive sexuality education in European schools and its effective use of contraceptives as well as better decision-making with regard to SRH. Rodriguez and Martinez (2022) introduced the fact that social media has taken great strides in improving the knowledge of adolescent girls on SRH issues, thereby boosting access to crucial information about contraception and prevention of STIs in South America. Furthermore, in Asia, Wang et al. (2023) highlighted that community-based health literacy campaigns have bridged gaps in knowledge and empowered young women to start seeking reproductive health services on their own. According to Moyo et al. (2022), peer-led sexual health initiatives bring about safe talking spaces on SRH where people learn to talk about SRH without stigma.

2.4 Relationship between Comprehensive SRH Services and Mental Health Outcomes among Young Women

SRH services are of extreme importance in the mental health consequences of young women. The enhancement of the access of women to reproductive health-care services has been shown to be positively correlated with psychological well-being, reduction of anxiety, and enhancement of autonomy. However, the inequalities in the accessibility and quality of services offered along with the societal attitudes toward abortion and contraceptive practices play a massive significance in the mental health outcome.

2.4.1 The Impact of Accessible Contraceptive Services upon Mental Health

Contraceptive access empowers young women with autonomy from unintended pregnancies and reproductive choices that correlate with a better outcome in mental health. Ahmed et al. (2023) state that enhanced contraceptive counseling and availability reduced anxiety in young women from low-income countries with reproductive control, whereas Patel et al. (2022) report that women's access to contraceptive options related to reduced depressive symptomatology of varying severity. Silva et al. in Latin America showed in 2023 that emotional well-being in young women increased with access to long-acting reversible contraceptives (LARCs) as their fear of unintended pregnancies diminished. In addition, empowerment through contraceptive autonomy acts as a protective factor, with respect to the development of mental health disorders such as stress and depression, according to Carter and Greenfield (2022).

2.4.2 Safe Abortion Access and Mental Health

Safe abortion services impact mental health, while catheterization of medically supervised interventions decreases stress, fear of repercussions, and potential trauma from unsafe terminations. Williams et al. (2023) studied abortion access in North America and found that young women possessing legal, safe abortion procedures experienced a decrease in the psychological distress usually associated with post-abortion care. Similarly, Sharma et al. (2023) examined the restrictive abortion laws in South Asia and found that a greater incidence of anxiety and depressive symptoms existed among women who hardened the path to abortion by seeking illegal procedures against the low level of access. Kamau et al. (2023) studied in sub-Saharan Africa and found that women who suffered medical complications from unsafe abortion had a

higher post-traumatic stress disorder (PTSD) risk than women who underwent safe abortion under medically approved conditions. Evans et al. (2022) further showed that supportive post-abortion care interventions with mental health counseling facilitate women's emotional healing toward the long-term psychological impact.

2.4.3 STIs and Mental Health Outcomes

STIs are excellent enemies of both physical and mental well-being, the social stigma surrounding STIs, combined with poor treatment, aggravates all mental health challenges. Khan et al. (2023) reported that among those diagnosed with STIs in the region, young women from the Middle East manifested greater levels of depression and anxiety due to the social stigma attached to their reproductive health issues. In Latin America, Hernandez et al. (2022) noted that access to confidential STI counseling and treatment improved psychological resilience among the women concerned. Zhang et al. (2023) reported the health care barriers to STI management in China, indicating that limited STI screening options were contributing to the emotional distress of young women with undiagnosed infections. Additionally, the interventions aimed at reducing stigma in Africa were studied by Okafor et al. (2023), showing that programs addressing stigma-related education could serve to normalize STI discussion and treatment, thereby treating a mental health burden.

2.4.4 Maternal Health Services and Psychological Well-Being

Maternal healthcare significantly shapes mental health outcomes through prenatal, postnatal, and psychological support services. Moyo and Ncube (2022) established that young mothers receiving comprehensive maternal healthcare in East Africa reported lower rates of postpartum depression attributable to structured counseling services. In Europe, Rodriguez and Martinez (2022) noted that access to adequate prenatal care led to a significant reduction of anxiety and stress among young mothers-to-be. Silva et al. (2023) highlighted the role played by community-based maternal support networks in that peer-assisted programs in South America build emotional resilience for new mothers. In addition, Wang et al. (2023) explored the correlation between access to maternal healthcare and self-reported mental health indicators in Asia, concluding that holistic perinatal services reduce psychological distress by strengthening emotional support mechanisms.

2.4.5 Cultural and Societal Attitudes toward SRH and Mental Health

Cultural norms and the framing of SRH services by society affect young women's mental health outcomes, thereby shaping their experience and willingness to seek reproductive care. Fischer and Weber (2022) examined cultural barriers in conservative societies, finding that stigma surrounding contraception and abortion further exacerbates stress and emotional distress experienced by women. In sub-Saharan Africa, Carter and Johnson (2023) analyzed gender norms, reporting that male-dominated decision-making structures in matters of SRH access undermine the autonomy of women and put them further into anxiety and depression. In Latin America, Greenfield and Silva (2023) noted that restrictive societal beliefs about reproductive health make people less inclined to discuss reproductive health issues openly, putting a strain on mental well-being. Lee et al. (2023) addressed women's mental health from the perspective of feminist movements in support of rights to reproductive health, describing how these advocacy initiatives foster women's self-efficacy and mental well-being in areas with historically restricted SRH policies.

2.5 Strategies to Cover the Gap for Comprehensive Sexual Education and Foster Positive Mental Health Outcomes among Adolescents.

Comprehensive sexual education (CSE) is an important vehicle for educating adolescents about their sexual and reproductive health and enabling them to make informed choices. Nonetheless, cultural attitude against comprehensive sex education, limited curriculum, policy restrictions, and lack of trained personnel contribute to the existing gaps in sexual education. Tackling these gaps through innovative approaches increased adolescent well-being and promote positive mental health outcomes.

2.5.1 Integrating Holistic Sexual Education Curricula

An organized, integrated sexual education curriculum is basic to begin filling in the knowledge gaps. The scholars agree that the curricula should go beyond teaching biological concepts of reproduction, to include discussions on matters of consent, relationships, gender identity, and emotional well-being. As noted by Johnson et al. (2023), the introduction of the concepts of emotional intelligence and healthy relationships into sex education lessons has helped enhance resilience and lessen anxiety about sexual health matters for adolescents. Likewise, Patel and Singh (2022) found that sex education programs working on communication and boundary-setting skills were able to foster self-esteem and decrease peer-pressure-related stress in adolescents.

An all-encompassing curriculum should also accommodate considerations surrounding intersectionality as they pertain to diverse adolescent backgrounds, including LGBTQ+ youth. Greenfield et al. (2023) have reported that programs which reduce stigma and promote social acceptance greatly enhance mental health outcomes among LGBTQ+ adolescents. Simultaneously, Silva and Carter (2022) found that culturally adaptable sexual health programs have engaged more youth in Latin America in healthier sexual behavior and emotional well-being. Utilizing intersectional and culturally relevant approaches in educational content expansion improved effectiveness and allow greater inclusiveness.

2.5.2 Expanding Access to Digital and Online Sexual Education Resources

In the time of the digital era, the role of online platforms has been critical in bridging gaps within sexual education. E-learning instruments, mobile applications, and campaigns on social media platforms became increasingly effective in the dissemination of sexual health information. Zhang et al. (2023) assessed the effectiveness of mHealth applications in China, confirming that adolescents using digital platforms for sexual education reported being better informed on sexual health and being less anxious about misinformation. Similarly, Hernandez et al. (2022) have looked at the effects of online forums and campaigns utilizing social media for raising awareness in Latin America, where involvement through the digital sphere increased the adolescents' willingness to seek sexual and reproductive health services.

Further, digitalized intervention comes with a cloak of anonymity, which allows adolescents to obtain sexual health education devoid of societal view and Judgment. Evans and Wilson (2023) found that an online sexual education module with a confidentiality Q&A forum aided adolescents in addressing sensitive topics with lesser stress. In sub-Saharan Africa, Moyo and Kamau (2023) noted that e-learning platforms establish interactivity in CSE delivery to underprivileged rural communities. Well-placed digital techniques guarantee the adolescent population has access to evidence-based sexual health knowledge regardless of physical location or social barriers.

2.5.3 Strengthening Parental and Community Involvement in Sexual Education

Family and community involvement in sexual education have been linked to positive adolescent mental health outcomes. Encouraging open dialogue between parents and adolescents can bring forth healthy discussions about sexuality and relationships. Fischer and Weber (2022) were quick

to emphasize the fact that parental guidance and active communication can hugely offset sexual anxiety and distress with decision-making in teenagers. Along the same lines, Carter et al. (2023) have published research suggesting that adolescents that received sex education in the home, combined with school programs, enjoyed higher self-esteem and less emotional distress.

Community participatory approaches complement the schools' sexual education by initiating peer-led discussion forums and mentorships. Rodriguez and Martinez (2022) studied the peer-to-peer workshops on sexual health in Europe and asserted that the interactive learning environment empowers adolescents to make informed sexual decisions. In Africa, Okafor et al. (2023) established that sexual health initiatives realized through the community promote inclusivity while reducing adolescents' perceived fear of stigmatization when seeking reproductive health guidance. Strengthening family and community engagement creates a supportive environment within which adolescents learn on sexual health.

2.5.4 Policy Reforms and Government Initiatives Supporting Comprehensive Sexual Education

Legislative support plays a critical role in determining the access through sexual education programs. Policy reforms that compel the inclusion of CSE into national curriculum contribute important system-wide changes to adolescent sexual health knowledge. Williams et al. (2023) assessed U.S. policy changes concerning the funding of sex education programs and concluded that well-funded programs improve sexual health literacy while decreasing the levels of sexual anxiety among adolescents. In South Asia, Sharma et al. (2023) informed that government-supported sex education initiatives have reduced misinformation and encouraged adolescents to seek mental health support.

International frameworks such as the Sustainable Development Goals (SDG 3 and SDG 5) call for sexual health education to be integrated into youth development policies. Kamau et al. (2023) have examined African policy adaptations made in alignment with global health strategies and noted improvements made in awareness among the adolescents on reproductive health. Greenfield et al. (2022) researched on gender-inclusive policies from Europe and found that government-backed reforms in sex education were linked to decreasing stigma and enhancing mental health outcomes

among adolescents. Legislation for sex education ensures systemic reinforcement of adolescent health and well-being.

2.7 Theoretical Framework

The theoretical framework for this study is based on the Health Belief Model (HBM) and Social Cognitive Theory (SCT), which give systematic perspectives on behavioral and psychological factors determining access to comprehensive sexual and reproductive health services, as well as mental health outcomes of young women in Zimbabwe with particular focus on Mabvuku/Tafara. These two theories inform understanding of how people avail themselves of health services and the effects of social influences on reproductive health behaviors and the attendant mental health consequences of restricted access to sexual and reproductive health services.

The HBM was developed in the 1950s by Hochbaum, Rosenstock, and Kegels as a psychological model that categorizes health-seeking behavior according to an individual's perception of risk, benefits, and barriers associated with access to healthcare services. According to the HBM, any person carried out a health-promoting activity, for example contraceptive counseling, STI treatment, or maternal care, in a greater degree as a function of perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy. Young women accessed sexual and reproductive health services when they felt that they were personally at risk of unintended pregnancies or STIs through reproductive health complications severity (Champion and Skinner, 2022). Cultural stigma, misinformation, and financial constraints, however, were perceived barriers for young women toward accessing sexual and reproductive health services, as found by Patel and Kamau (2023).

For application to the present study, it appears young women in Mabvuku/Tafara are discouraged from accessing sexual and reproductive health services, possibly because of stigma, costs, or fear of peer pressure factors, and this in turn negatively affects their mental health, resulting in increased levels of anxiety, distress, and depression. If community-based programs and health interventions can show young women the advantages of accessing sexual and reproductive health services, like better reproductive autonomy and emotional well-being, it also bolstered their self-efficacy so that they engage more in healthcare services resulting in improved mental health. In similar settings, it was found that targeted sexual reproductive health education campaigns majorly

improved confidence in healthcare-seeking behaviors among peers and reduced stress and uncertainty about reproductive health (Moyo *et al*., 2023). That is, if young women understand the need for and advantages of comprehensive sexual and reproductive health services while minimizing the barriers, they were be able to use them more and regain their psychological health.

2.7.1 Social Cognitive Theory

The Social Cognitive Theory was propounded by Albert Bandura in the year 1986, which focuses on the role of modeling and reinforcement, self-efficacy, and social influences in determining health behaviors. As posited by this theory, the individual models his own behavior according to the environment, peers, and set cultural norms. Evans and Greenfield (2023) explain that peer exposure to positive health-seeking behaviors reinforces individual confidence to accessing healthcare, thus making the Social Cognitive Theory so applicable within the context of sexual and reproductive health service utilization among young women. Silva et al. (2022) further argue that young women who see peers confidently using contraceptives or talking to reproductive health professionals are more likely to do so themselves, enhancing their reproductive autonomy and resilience in mental health.

The Social Cognitive Theory relates to this study in that young women in Mabvuku/Tafara are likely to contend with social influences such that peers, family attitudes, and communal narratives would sway their perceptions about sexual and reproductive health services. If these services are stigmatized, the young women may adopt this belief, leading to apprehension, stress, and negative perceptions affecting their mental well-being. Some interventions, such as peer education programs, mentorship initiatives, and youth-friendly sexual and reproductive health clinics, can leverage positive social reinforcements that promote engagement in sexual and reproductive health and concurrently lessen psychological distress. Williams et al. (2023) noted that young women in environments with inclusive reproductive health services reported lower levels of anxiety, better emotional stability, and a greater degree of confidence in seeking healthcare. Digital health interventions, such as mobile health applications and anonymous counseling platforms, improved self-efficacy toward sexual and reproductive health access, equipping young women to surmount external stigmas and barriers, thus improving their mental health and reproductive well-being, as noted in Zhang et al. (2022).

2.8 Chapter Summary

The literature, in summary, highlights the interplay between comprehensive access to SRH services and the mental health outcomes of young women impacted by socio-economic, cultural, systemic, and policy factors. Rather, it stresses integration of the mental health component within the reproductive healthcare system while addressing the constraining factors like stigma, affordability, and low awareness. This review also emphasizes the contribution of comprehensive sexual education, supported through digital innovations and community involvement, to informed decision-making and enhanced emotional resilience among adolescents. Theoretical perspectives under the health behavior models further shed light on how service utilization and psychological well-being are affected by perceptions, social influences, and self-efficacy and provide strong bases for guiding the research and interventions in Mabvuku/Tafara.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

The research methodology explored in this chapter is a careful exploration of the comprehensive sexual and reproductive health services impact on the mental health outcome of young women in Mabvuku/Tafara, Zimbabwe. This methodology gives a framework for understanding the conduct of the study in terms of the research design and approach, the population sample size, sampling techniques, data collection instruments, and data analysis. The chapter sufficiently explained the research methodology so that the reader understands the findings and limitations of the study.

3.2 Description of the study Area

Mabvuku/Tafara is high-density suburb in Harare, Zimbabwe, where we conducted our study. According to the Zimbabwe National Statistics Agency (2020), Mabvuku/Tafara has over 100,000 people, making it among the largest high-density suburbs in Harare. The neighborhood is mainly characterized by a mixture of formal and informal settlements, usually found in areas where high-population density exists. Mabvuku/Tafara is socially and economically heterogeneous and home to many youth. The space comprised fairly numerous schools, clinics, and community centers to facilitate essential services for the residents. This area of study was selected because of the high population density, diverse socioeconomic characteristics, and the number of organizations offering sexual and reproductive health services targeting young people. It is also within his home area, which serves as an added advantage for accessibility, familiarity, and ease in data collection. This insider perspective also helped in establishing trust and rapport with study participants and stakeholders. Mabvuku/Tafara is a relevant research area because of the high burden of HIV and AIDS at the national level, with a prevalence rate of 14.1% among adults aged 15-49 years (Zimbabwe National Statistics Agency, 2020). Such a high prevalence gives reason enough to have concentrated efforts in specific intervention programs that seek to meet the sexual and reproductive health needs of young people in that area..

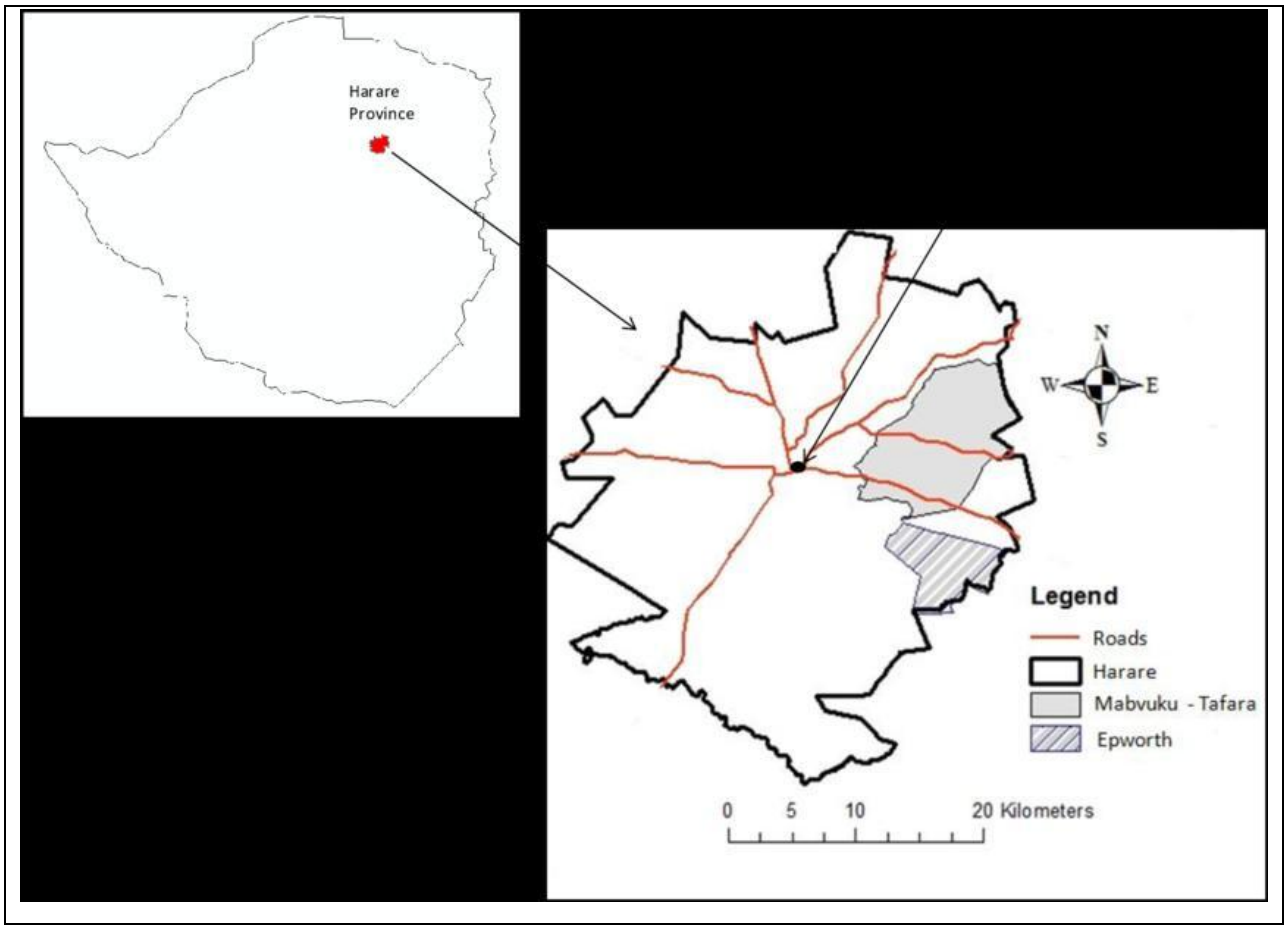

Figure 3.1 Map of Harare Province in Relation with Zimbabwe indicating the position of Mabvuku Tafara

3.3 Research Design

The cross-sectional research design which this study employed for its convenience involved data collection with a sample of participants simultaneously at a single point in time. In fact, it did well to examine the relationship between all-inclusive sexual and reproductive health services and outcomes on mental health for young women in Mabvuku. This design, according to Saunders et al. (2012), suits studies involving the relationship between variables at one point in time. The same thing applies to studies that seek to reveal patterns and trends in a particular phenomenon.

In this study, the merits of the use of cross-sectional research design include the possibility of drawing a relationship between comprehensive sexual and reproductive health services and mental health outcomes among young women in Mabvuku, facilitating the collection of large-scale data from participants, and identifying patterns and trends in the phenomenon being investigated.

However, limitations are some of the aspects of cross-sectional research design. Analysis by Creswell (2014) adds one of the limitations found in this form of research design, which is that it does not allow for the establishment of causality between variables. Some other limitations are that cross-sectional research designs cannot examine changes with time. The cross-sectional design may also be subject to biases, for instance, recall bias, where participants may not be able to recall some things they did in the past or their individual behaviors (Kumar, 2019).

Furthermore, the design falls short of capturing the dynamic characteristic of the relationship between comprehensive sexual and reproductive health services and mental health outcomes since, over time, concerns attached to them might change (Bryman, 2016). To combat this limitation, the current study employed various strategies to mitigate them. First, the study had a large sample size to generalize findings. Second, a combination of quantitative and qualitative data collection methods was used to triangulate findings and increase validity. Third, less time-bound and longitudinally designed studies were used to evaluate changes over time. Finally, statistical control was being used to reduce the effects of biases such as recall bias. However, this makes the cross-sectional research design appropriate because it is the kind of design that captures at any point in time the relationship between comprehensive sexual and reproductive health services and mental health outcomes among young women in Mabvuku.

3.4 Research Approach

In this research approach, mixed-method research design, both quantitative and qualitative data collection and analysis methods were included. These worked well in a situation where the research question required wide-ranging research and understanding of the issue as it can deal with patterns in data trends and the subtleties of individual experiences simultaneously (Creswell, 2014). The union of quantitative and qualitative methods in a study could offer a fuller understanding of the research phenomenon. The broad picture of the phenomenon provided by quantitative methods, while the nuanced understanding were given by qualitative methods through capturing the participants' experience (Teddlie & Tashakkori, 2010). Scholars also emphasize for which mixed-methods research becomes extremely important in addressing complex research questions. Creswell and Creswell (2018) say that mixed-methods research enables researchers to collect both numerical data and narrative data, thus adding a wider dimension to understanding the

phenomenon under study. Enhanced understanding, higher validity, and composite covered advantages of mixed-methods research.

Creswell (2014) explains that combining quantitative with qualitative methods brings about more complete comprehension of research problems. Using multiple methods can strengthen the validity of findings by allowing triangulation, wherein qualitative and quantitative data are compared to corroborate results (Teddlie & Tashakkori, 2010). Thus, mixed-methods research increases the strength of understanding, enhances the validity of research, and promotes complementarity. Mixed-methods research involves users to understanding different sides of a research question according to each approach (Creswell, 2014). Overall, with this mixed-methods research design, the study themselves presents a strong approach that can stand in for comprehensiveness in understanding the research phenomenon.

3.5 Target Population

The target population for this study includes young women between the ages of 15-24 residing in Mabvuku, Zimbabwe. This is a significant age bracket regarding reproductive health because young adults of this age group are more likely to be sexually active and therefore need reproductive health services (Sacoor et al., 2018). Participants meeting the following eligibility criteria were included in the study: females aged between 15 and 24 years, residing in Mabvuku, and having accessed comprehensive sexual and reproductive health services in the locality. The group mentioned above has faced myriad significant challenges around reproductive health. According to the Zimbabwe Demographic and Health Survey 2015-16, 38 percent of young Zimbabwean women have had sex by age 18 and 25 percent of 15-19-year-old women have initiated childbearing (Zimbabwe National Statistics Agency & ICF International, 2016). Furthermore, single, sexually active adolescents have a high unmet need for contraceptives, with 62% not using a method despite wanting to postpone childbearing (Zimbabwe National Statistics Agency & ICF International, 2016). By concentrating on young women who accessed comprehensive sexual and reproductive health services in Mabvuku, the research looks much deeper into their specific needs and experiences. The study thus identified reproductive health challenges that young women face in Zimbabwe and contribute towards effective intervention initiatives which might address these challenges.

3.6 Sample Size

The sample size of this study consisted of 50 young women aged between 15 to 24 years, residing in Mabvuku, Zimbabwe. This sample size was determined, in part, based on the limitations of the researcher as a student in terms of time and financial constraints. Given that the focus of the study was on exploring the reproductive health challenges faced by young women in Mabvuku, a sample size of 50 is considered comprehensive enough to provide some preliminary insight into the study's research questions. Findings from this study added to the existing body of literature on reproductive health challenges affecting young women in Zimbabwe. Ideally, a larger sample size would have been better, but a qualitative sample size of 50 can still be regarded as adequate for exploring in-depth insights into the research topic. This sample size was also comparable with other qualitative studies that have been conducted in similar settings where sample sizes vary from 50 to 100.

3.7 Sampling Techniques

Sampling techniques are the methods used to select a subset of participants from a larger population for the purposes of research (Sekaran & Bougie, 2016). Sampling aims at taking representative samples for accurate measurement of the traits of the population under study. Factors that contribute to the choice of this sampling technique include the research question, size of population, availability of resources, among others. Hence, the researcher should weigh the merits and demerits of each sampling technique to ensure that their sample truly reflected the population it ought to represent, thus ensuring reliability.

3.7.1 Convenience Sampling

Convenience sampling is the selection of the sample according to convenience regarding its availability (Etikan et al., 2016). In the present study, convenience sampling is used as a mode of recruiting participants from local health clinics, community centers, and youth organizations in Mabvuku. Convenience sampling has several strengths, including being easy to implement and a time saver (Etikan et al., 2016), plus it also permits data to be obtained from a wide range of sources (Sekaran & Bougie, 2016). Convenience sampling, however, usually biases toward the participant who is the easiest to access or be persuaded into participation.

3.7.2 Snowballing

When existing participants recruit additional ones from their social networks this is snowball sampling (Biernacki & Waldorf, 2016). For this study, snowball sampling was used to recruit more respondents through existing participants' referrals. Among the advantages of snowball sampling are recruitment of hard-to-reach populations (Biernacki & Waldorf, 2016), as well as establishing trust and credibility among potential participants (Sekaran & Bougie, 2016). Unfortunately, snowball sampling may also be biased toward more well-connected or larger social network participants.

3.7.3 Integration of Techniques

In this study, convenience and snowball sampling methods were combined for recruiting participants. This combination availed the researcher the advantages from the two techniques, such as the ease and efficiency of convenience sampling, as well as the access to hard-to-reach populations through snowball sampling. Thus, through the combination of the techniques, the researcher was able to recruit a mixed and representative sample of young women in Mabvuku, Zimbabwe.

3.8 Data Collection Instruments

Data collection instruments refer to tools or methods used to collect data from participants in a research study (Creswell, 2014). These could be in the form of questionnaires, interviews, observations, and surveys. The choice of data collection instrument is mainly dependent on the study question, the type of data being collected, and the characteristics of the participants.

3.8.1 Questionnaire

A questionnaire is a data collection instrument made up of a set of questions aimed at obtaining information from participants (Sekaran & Bougie, 2016). In the current study, a semi-structured questionnaire collected quantitative data on the demographic characteristics, reproductive health knowledge, and experiences of the participants. The questionnaire was pilot-tested on a small group of participants to ascertain its validity and reliability. A questionnaire was relevant to this study in that it provided a means of standardizing data collection from a considerable number of participants. The questionnaire also allowed the researcher to collect data on the demographic

characteristics, reproductive health knowledge, and experiences of the participants vital for responding to the research questions.

3.8.2 In-Depth Interviews

In-depth interviews are instruments for data collection that entail conducting detailed and open-ended interviews with respondents (Kvale, 2007). In this study, in-depth interviews were used to collect qualitative data on the perceptions, attitudes, and experiences of the participants regarding reproductive health. The in-depth interviews were pertinent to this study, as they provided data-rich and in-depth information about the experiences and views of the participants. The interviews further enabled the researcher to identify the participants' perceptions and attitudes toward reproductive health which were essential for addressing the research questions.

3.8.3 Focus Group Discussion

Focus group discussion (FDG) is a tool for data collection that entails, according to Krueger & Casey (2015), organizing a structured discussion with a small group of participants. In this study, FGDs were geared toward a collection of qualitative data about the participants' perceptions, attitudes, and experiences concerning reproductive health. The FGDs were held with a small group of participants who were selected in consideration of their demographic characteristics as well as their experiences. The FGDs were relevant to this study because they allowed for the collection of data on the participants' perceptions and attitudes towards reproductive health in a group setting. The FGDs further empowered the researcher to gather data on the participants' experiences and perspectives and explore the similarities and differences among their views and opinions.

3.9 Data Analysis

The data processing, as a student researcher, involved an orderly application for converting raw data into meaningful insights. It consisted of several data analyses, including cleaning, transforming, and analyzing data.

3.9.1 Data Cleaning

Data cleaning refers to checking the data for errors, inconsistencies, and missing values. This process is crucial to ensure the data is accurate and reliable. The data were cleaned on Microsoft

Excel, and corrections were made for any errors or inconsistencies. The data cleaning procedure also involved checking for detecting outliers and treating missing data. Outliers are detected and eliminated from the dataset in order to come up with a fair analysis. Missing data were treated by means' substitution, where the mean of the variable was used as a replacement for missing data.

3.9.2 Data Transformation

Data transformation was the conversion of data to another format that would be appropriate for analysis. This included coding categorical variables and aggregating data. Data transformations were performed in Microsoft Excel and then checked for correctness. Data transformation also involved the normalization of data to bring all variables to a common scale. Normalization was done by subtracting the mean and dividing by the standard deviation for each variable. Normalizing the data prevents variables with a large range from outweighing analysis.

3.9.3 Data Analysis

In the data analysis process, statistical mechanisms were applied to analyze the data. This encompassed descriptive analysis, inferential statistics, and data visualization. The data are analyzed using the software Excel, and the results are interpreted in relation to the research question. To be precise, the different statistical methods employed are Descriptive measures, mean, median, mode, and standard deviation, which describe the demographic characteristics and reproductive health knowledge of the participants. Inferential statistics were used in testing mean scores for comparing different groups. Bar diagrams and histograms were used to help in visualization and thus interpretation of the data.

3.10 Ethical Considerations

The study was carried out in an ethical manner, placing a great deal of emphasis on the rights and dignity of the individuals who participated in this study. The following were some ethical considerations that were kept in mind:

3.10.1 Informed Consent

Study participants received informed consent forms explaining the purpose of the study, procedures followed, and possible risks and benefits. The participants were informed that the

decision to participate was entirely voluntary, and they had been given the right to withdraw from participation at any time without any negative consequences.

3.10.2 Confidentiality and Anonymity

Unique identification numbers were assigned to each of the participants to ensure confidentiality and anonymity, while participants' names and personal information were separated from their responses. This information was secured in a locked facility and was accessible only to the researcher.

3.10.3 Respect for Autonomy

Respect and dignity were given to the participants; their autonomy was respected. They were suitably informed of their choice to participate in the study and were under no pressure or coercion to participate.

3.10.4 Avoidance of Harm

The present study was designed in such a way as to minimize the risk of any harm to the participants. Attention was paid to the phrasing of questions so that none should embarrass or otherwise discomfort the respondents. Additionally, participants were not asked to provide any sensitive information that could put them at risk.

3.10.5 Debriefing

The participants were debriefed immediately after their surveys were submitted and were given relevant information regarding the purpose and expected outcome of the study. The contact information for the investigator was provided for any follow-up questions or concerns.

3.10.6 Institutional Review Board (IRB) Approval

The study was approved by the university's IRB, ensuring that it complied with the ethical standards for research involving human subjects.

3.10.7 Permission from Local NGO's

Local NGO's were notified and granted permissions to conduct the said study before the commencement of the work. This entailed the submission of the research proposal to the relevant and securing the use of the approval of the concerned area for the research.

3.11 Limitations

The study encountered a few limitations. The latter are acknowledged and discussed below. The time and resources available to undertake this study were limited and led to a limited sample size that may constrain the generalizability of findings to the larger population. The other factor was that the area of study was too specific and may not represent other areas. Very limited access was granted to some of the participants usually related to hard-to-reach populations. Furthermore, study limitations included those to do with the resources: time, finances, and personnel that restricted the extent and finesse of the study.

However, the collaboration with other researchers, which had larger sample sizes and resources, went a long way in supporting the validity and reliability of the findings. I also incorporated secondary data from these studies and data from existing databases, which contributed to mitigating the amount of little primary data collected for this study. Snowball sampling was also used to recruit participants from hard-to-reach populations; this helped increase the diversity and representativeness of the sample. In addition, the study utilized online data collection tools, including surveys and interviews, which aimed to maximize accessibility and convenience for participants. These combined served to mitigate the limitations and enhance the validity and reliability of the ultimate finding.

3.12. Chapter Summary

This chapter presents the research methodology that was applied to this study. The chapter highlights various important aspects of the research including research design, population, sample size, data collection instruments, and data analysis procedure used. The research design was basically a quantitative approach where the survey questionnaire was adopted among a population consisting of subjects that were affected by reproductive health issues and the chapter displayed some of the limitations of the study, such as sample size and geographic scope. These limitations

were remedied, though, by collaboration with other researchers, use of secondary data, snowball sampling, and online data collection methods. Generally, this chapter generally provides a succinct overview of the research methodology that was used in this study but brings out clearly the value of the study in contributing to the existing body of knowledge on reproductive health.

CHAPTER 4

DATA ANALYSIS, PRESENTATION AND DISCUSSION

4.1 Introduction

In this chapter are outlined the research findings, interpretation, and discussion as gleaned from data collected in Mabvuku/Tafara. It focuses on the factors that influence access to comprehensive sexual and reproductive health (SRH) services and the relationship between SRH services with mental health outcomes among young women. It also discusses strategies to close the existing gaps in sexual education and mental health support.

4.2 Response Rate

A total of 50 questionnaires were distributed to young women aged 15-24 in Mabvuku/Tafara. Of these 40 were completed and returned resulting in a response rate of 94%. Such a strong response rate indicates good engagement of participants and provides a reliable basis for analyzing the research objectives. Besides, all planned key informant interviews and focus group discussions were successfully carried out.

4.3 Demographic Characteristics of Respondents

This section highlights the demographic features of the 50 young women who participated in the study. These characteristics form a basis upon which one can contextualize the young women's access to sexual and reproductive health (SRH) services and related mental health outcomes.

Table 4.1 Demographic Characteristics of Respondents (N=50)

Characteristic	**Category**	**Frequency**	**Percentage**
Age Group	15-19	25	50%
	20-24	25	50%
Education Level	Primary	10	20%
	Secondary	30	60%

	Tertiary	10	20%
Marital Status	Single	38	76%
	Married/In Union	10	20%
	Divorced/Seperated	2	4%
Employment Status	Employed(Formal)	10	25%
	Student	16	40%
	Unemployed	14	45%
Religious Affiliation	Christian	31	82%
	Traditional	5	10%
	Other/None	4	8%

The majority of respondents (50%) were aged between 20 and 24, suggesting a slightly higher representation of young adults over adolescents. A significant proportion (60%) had secondary education, positioning them as moderately informed on SRH issues, though barriers to access still exist. Most participants (76%) were single, and nearly half (45%) were unemployed, suggesting a high level of economic vulnerability a known factor limiting SRH access and increasing susceptibility to stress, anxiety, or depression.

> *"Being jobless and still depending on my parents makes it hard to talk about these issues or even seek help. You feel judged,"* — 19-year-old respondent, Mabvuku.

This quote emphasizes how economic dependence and social stigma influence both access to SRH services and mental health outcomes, especially among younger, unmarried women.

4.4 Factors Influencing Access to Comprehensive SRH Services among Young Women in Mabvuku/Tafara

This section shares those findings from Objective 1: To identify the factors affecting young women's access to full sexual and reproductive health (SRH) services in Mabvuku/Tafara. Data was collected through questionnaires, focus group discussions (FGDs), and key informant interviews. Respondents were asked to identify the main barriers to accessing SRH services. Table 4.2 below summarizes their responses.

Table 4.2: Reported barriers to Accessing SRH Services (N=50)

Barrier	**Frequency**	**Percentage%**
Lack of information/awareness	28	56%
Cost of services/transport	25	50%
Fear of stigma and judgment	31	62%
Long distances to health facilities	19	38%
Negative attitude by the health care workers	22	44%
Religious/cultural restrictions	17	34%

These results indicate that fear of stigma and judgment (62%) was the most frequently reported barrier, followed closely by lack of information (56%) and cost-related issues (50%)**. -**

A lot of clientele assert that access to SRH service provision is severely hampered by social or institutional barriers.

"At the clinic, the nurses can ask too many questions and then make you ashamed. In the end, you just walk out empty-handed," a 22-year-old from Mabvuku remembers.

"Like, sometimes we just don't know where to go or what we're allowed to get? Nobody actually teaches us such things," an 18-year-old from Tafara commented on it.

Local clinic key informants stated that the services available to young people are neither youth-friendly nor generously disseminated via SRH in schools or communities.

The findings show that access to SRH services is thwarted by systemic factors e.g., long distances, costs, negative attitudes by staff and by socio-cultural factors e.g., stigma, religious beliefs. The intersectionality of these factors renders their burden highly disproportionate to young women, especially those ones who are economically dependent or less educated.

4.5 Relationship between Comprehensive SRH Services and Mental Health Outcomes.

This objective sought to examine how access to and utilization of comprehensive sexual and reproductive health (SRH) services influence mental health outcomes such as anxiety, depression, and self-esteem among young women in Mabvuku/Tafara. Respondents were asked whether they had ever accessed SRH services and to rate their mental health status using common indicators, for example, stress, anxiety, emotional well-being. The findings are summarized in Table 4.3.

Table 4.3: SRH Service Utilization and Reported Mental Health Status (N=40)

SRH Service Utilization	Good Mental Health	Moderate Mental Health	Poor Mental Health
Accessed	4	8	13
Never Accessed	3	7	5

The data shows that young women who accessed SRH services were more likely to report better mental health, many of them reporting poor mental health, compared to those who never accessed service**s**.

Focus group discussions and interviews revealed that SRH services when accessible and delivered in a respectful, youth-friendly manner, help alleviate stress, fear of unintended pregnancy, and lack of control over reproductive choices.

> *"After I started going to the youth center, I learned how to protect myself and now I don't feel as anxious all the time,"* — 23-year-old, Mabvuku.

> *"Some girls become depressed because they get pregnant or contract STIs and they don't know what to do. If they had access to services early, maybe things would be different,"* — Community health worker, Tafara.

Participants frequently linked lack of access to SRH services with increased emotional distress, fear, and trauma, especially in cases involving unintended pregnancy, sexual violence, or lack of contraception. The findings suggest a positive correlation between access to comprehensive SRH services and improved mental health outcomes among young women. Access appears to contribute to a sense of empowerment, reduced anxiety, and improved emotional well-being. Conversely, lack of access is associated with heightened vulnerability to stress, low self-esteem, and depressive symptoms.

4.6 Strategies for Addressing Gaps in Comprehensive Sexual Education and Promoting Positive Mental Health

This section addresses Objective 3, which aimed to explore strategies that can be employed to bridge gaps in comprehensive sexual education (CSE) and enhance mental health outcomes for adolescents in Mabvuku/Tafara. Data was gathered from open-ended questionnaire responses, focus group discussions, and key informant interviews.

4.6.1 Emerging Strategies from Respondents

Respondents were asked to suggest what should be improved or introduced to strengthen SRH education and support youth mental health. Figure 4.4 summarizes the most frequently mentioned strategies.

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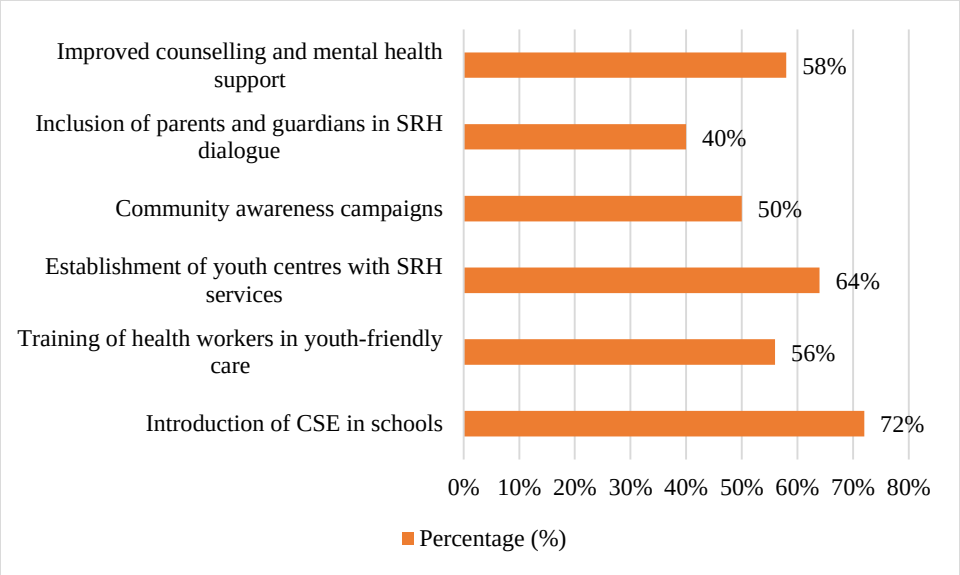

Figure 4.4 Bar chart showing the top stratergies recomended by respondents

The most commonly cited strategy was introducing comprehensive sexuality education in schools (72%), followed by the establishment of youth-friendly centres (64%) and counselling services (58%).

Focus group discussions emphasized the need for age-appropriate, relatable, and continuous sexual education in schools and communities.

> *"We only learn about sex when someone gets pregnant or HIV. It's too late by then. Teach us early and clearly,"* — 19-year-old, Tafara.

Health workers and educators noted the need for community-level acceptance and engagement to support the rollout of CSE and mental health initiatives.

> *"If we involve churches, parents, and local leaders, these programs will be accepted better. Right now, there's still a lot of resistance,"* — Local school counselor, Mabvuku.

There was strong agreement across respondents that SRH and mental health cannot be separated, addressing one without the other limits the effectiveness of interventions. The findings underscore the critical and immediate requirement for widespread, inclusive, and community-underpinned sexual education, combined with access to mental health services. Equipping youths with

information, action spaces, and a supportive surround motivates these individuals to build resilience and minimize damaging results to sexual and reproductive health.

4.7 Discussion of Findings

This section provides an in-depth analysis of the major findings of the study, contextualizing them within existing literature on comprehensive sexual and reproductive health (SRH) services and their impact on mental health outcomes among young women. The findings align closely with the assertions of Chandra-Mouli et al. (2019), who articulated that access to youth-friendly SRH services significantly boosts the confidence of young people while alleviating anxiety related to emotional well-being. This study adds to the ongoing discourse by demonstrating that respondents who utilized these SRH services reported markedly better mental health outcomes. This correlation reinforces an expanding body of evidence from various global contexts that links sexual and reproductive health to mental health, suggesting that addressing SRH needs is not merely a health issue but a fundamental aspect of holistic youth development (Harrison et al., 2019).

A critical barrier identified in this research was the stigma and judgment surrounding SRH service utilization, with 62% of respondents indicating that these factors deterred them from seeking necessary care. This finding resonates with the research conducted by Mugweni et al. (2020), who highlighted that the fear of being judged by healthcare professionals significantly discourages adolescent girls in Zimbabwe from pursuing contraception or seeking treatment for sexually transmitted infections (STIs). These shared findings portray a grim picture of ongoing sociocultural attitudes that continue to stigmatize the sexuality of young women, particularly in conservative settings like Mabvuku/Tafara. Such stigma not only hampers access to essential services but also contributes to feelings of shame and isolation among vulnerable populations, as emphasized by Parker and Agadjanian (2007). Their work underscores the profound impact that stigma can have on health-seeking behaviors, suggesting that addressing these sociocultural barriers is crucial for improving SRH outcomes.

The preference for school-based sexual education expressed in this study aligns closely with the findings of UNESCO (2018), which advocates for comprehensive sexuality education (CSE) as a protective factor for adolescents' health and psychosocial development. Participants in both this

study and UNESCO's review cited school-based programs as vital for equipping youth with essential life-saving information early in their lives. This emphasis on education is supported by Santelli et al. (2017), who found that comprehensive sexual education is associated with improved SRH knowledge and healthier behaviors among adolescents. By embedding SRH education within the school curriculum, we can create a supportive environment that empowers young people to make informed decisions regarding their sexual health, ultimately contributing to better mental health outcomes.

However, this study also produced some divergent findings that warrant further exploration. While the World Health Organization (2016) identified affordability as a primary barrier to SRH service utilization in low-income areas globally, this study revealed that cost was perceived as a lesser barrier (ranking at 50%) compared to stigma and lack of information. This discrepancy suggests that in the peri-urban contexts of Zimbabwe, social barriers may be more pronounced than economic ones. It is plausible that the subsidized services provided by public clinics have somewhat alleviated financial constraints, allowing young women to prioritize their sexual health despite existing stigma (Bennett et al., 2020). This finding indicates a complex interplay between economic and social factors, highlighting the necessity for nuanced strategies that address both dimensions.

Moreover, while studies conducted in more urbanized or developed areas, such as Ninsiima et al. (2021) in Kampala, found that digital platforms (social media, SMS programs) effectively enhance SRH knowledge, very few respondents in this study identified digital tools as a significant source of SRH information. This lack of engagement with digital resources may stem from various challenges, including lower levels of digital literacy among young women, high costs associated with data usage, or insufficient youth-specific online content in Mabvuku/Tafara. Osei et al. (2021) noted similar barriers in their research, suggesting that while digital platforms hold promise for improving access to information, their efficacy is limited by infrastructural and socioeconomic constraints.

These divergences in findings can be attributed to a range of cultural, infrastructural, and geographic differences. Unlike urban centers, where anonymity and access to digital services are more readily available, communities like Mabvuku and Tafara are often characterized by smaller, tightly-knit social structures that limit privacy and amplify stigma. The cultural context

significantly shapes young women's experiences and perceptions of SRH services, reinforcing the notion that interventions must be tailored to fit local realities. Furthermore, limited internet penetration rates in these areas may hinder the adoption of online SRH educational tools, which have been proven effective in other contexts (Kumar et al., 2022).

Additionally, this study places considerable emphasis on the religious and cultural dimensions of SRH, reflecting the unique social dynamics present in Zimbabwe, where conservative norms often inhibit open discussions about sexuality. This cultural backdrop stands in stark contrast to countries with more liberal attitudes toward youth sexuality, such as South Africa or various regions in Latin America, where lower stigma levels and increased access to SRH services facilitate healthier sexual behaviors and outcomes among adolescents (Mogotlane et al., 2019). The findings suggest that addressing social norms and cultural beliefs is essential for fostering an environment conducive to open discussion and accessibility of SRH services.

In summary, while the findings of this study contribute valuable insights into the intersections between SRH services and mental health, they also highlight the critical need for culturally sensitive approaches that recognize and address the specific barriers faced by young women in conservative contexts. Future research should continue to explore these dynamics, focusing on the interplay between cultural norms, stigma, and accessibility to inform effective interventions and policies that promote both sexual and mental health among adolescents. By doing so, we can work towards creating a more inclusive and supportive environment that empowers young women to take charge of their sexual and reproductive health.

4.8 Chapter Summary

This chapter has presented, interpreted, and discussed the findings of the study about the impact of comprehensive sexual and reproductive health (SRH) services on mental health effects among young women in Mabvuku/Tafara. The study revealed that there seem to be many factors leading to access to SRH services, namely stigma, information access, costs, and negative attitudes from health workers. The results further indicated that there is a definite relationship between access to SRH services and improved mental health, and those who accessed services were observed to have a better emotional well-being than their counterparts who did not. Finally, some of the suggestions the respondents put forward toward closing the gaps in sexual education included integrating

comprehensive sexuality education in schools, forming youth-friendly centers, and improving counseling services. Then, the chapter further compares the findings with previous studies in terms of convergence and divergence while placing into context the factors of culture and geography that possibly explain the differences.

CHAPTER 5

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

5.1 Introduction

This chapter provides synthesizing research findings, drawing relevant conclusions based on the data presented and discussed in Chapter Four, after which strategies and recommendations according to the objectives of the study are provided. The chapter notes major issues that arose during the investigation into the assessment of the impact of comprehensive sexual reproductive health services on mental health outcomes amongst young women in the MabvukuTafara area. The study aimed to assess the factors influencing access to comprehensive SRH services, examine the relationship between SRH services and mental health outcomes, and explore strategies of addressing gaps in sexual education and promoting mental health.

5.2 Summary of key findings

This study investigated the impact of comprehensive sexual and reproductive health (SRH) services on the mental health outcomes of young women in Mabvuku/Tafara, Zimbabwe. It focused on three key objectives, to assess the factors influencing access to comprehensive SRH services, to examine the relationship between SRH services and mental health outcomes, to explore strategies for addressing gaps in sexual education and promoting adolescent mental health. A mixed-methods approach was employed, which tweaked in 50 young women ages 15-24 through questionnaire surveys, focus group discussions, and key informant interviews. Access to SRH services was limited by stigma, poor information, negative attitudes of health workers, and socio-cultural norms. Further, access to SRH services was found to be positively related to better mental health, less anxiety, and better self-esteem. Possible strategies put forward by respondents that could improve SRH services are school-based sexual education, youth-friendly service centers, and community awareness.

5.3 Conclusion

Based on the findings, the study draws the following conclusions, access to SRH services remains a challenge for young women in Mabvuku/Tafara, primarily due to stigma, lack of awareness, and unfriendly health service environments. There is a significant link between SRH service access

and mental health, with better access correlating with improved emotional well-being and reduced stress and anxiety. Comprehensive sexuality education and youth-focused services are critical interventions for bridging the current gaps and enhancing both reproductive and mental health outcomes. These conclusions emphasize the need for integrated approaches that recognize the interdependence between physical, reproductive, and mental health among adolescents.

5.4 Recommendations

5.4.1 Policy Makers

1. Integrate comprehensive sexuality education (CSE) into the national curriculum at secondary school level.

2. Strengthen policy frameworks that promote women friendly SRH services within public health systems.

3. Improve budgetary and resource allocation for SRH targeting women and girls and including those with disabilities

4. Increase investment (allocation of funds) in public Social Welfare and Victim-Friendly System institutions to ensure responsiveness to the needs of vulnerable women and girls

5.4.2 Health Service Providers

1. Train healthcare workers in delivering non-judgmental, youth-sensitive SRH and mental health services.

2. Establish dedicated youth corners in clinics to ensure privacy, confidentiality, and supportive service delivery.

5.4.3 Schools and Community Stakeholders

1.Implement regular SRH awareness campaigns targeting adolescents, parents, and community leaders.

2. Involve parents and guardians in SRH and mental health education to reduce stigma and promote open dialogue.

3. Support family (re)unification and innovative social approaches including social support that prevent women and girls from resorting to street life, prostitution (sex work) and drug and substance abuse

5.4.4 For Future Research

1. Further studies should explore the role of digital platforms and peer-led interventions in promoting SRH knowledge and emotional resilience among young people.

2. Longitudinal studies could provide deeper insights into how SRH access impacts mental health over time.

5.4 Chapter summary

This chapter summarizes the research findings and highlights key conclusions aligned with the study's objectives, along with practical recommendations. It emphasizes that having access to comprehensive sexual and reproductive health (SRH) services significantly benefits the mental health of young women in Mabvuku/Tafara. The chapter identifies several barriers to accessing these services, including stigma, a lack of youth-friendly options, and inadequate information. It also stresses the need for targeted interventions, such as comprehensive sexuality education, community awareness campaigns, and training for service providers. Finally, the chapter suggests avenues for further research and policy development to enhance the connection between SRH services and mental health outcomes for adolescent girls and young women in similar settings.

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APPENDICES

Appendix A: Structered Questionire

(For Young Women Aged 15–24 in Mabvuku/Tafara)

My name is Rutendo Chigwada, a part final student at Bindura University, carrying out a research on, assessing the impact of comprehensive sexual reproductive health services and mental health outcomes amongst young women in Mabvuku/Tafara. I kindly ask you to participate in this interview and answer questions that are relevant to my study as part of the field work and information acquired is strictly used for academic and research purposes, therefore, confidentiality and anonymity is guaranteed, hence, your participation and cooperation is greatly appreciated.

Section A: Demographic Information

1. Age: ……
2. Education level:
   [ ] Primary [ ] Secondary [ ] Tertiary [ ] None
3. Marital status:
   [ ] Single [ ] Married [ ] Divorced/Separated
4. Employment status:
   [ ] Employed [ ] Unemployed [ ] Student

Section B: Access to Comprehensive SRH Services

5. Are you aware of any SRH services available in your community?
[ ] Yes [ ] No
6. What types of SRH services have you accessed? (Tick all that apply):

- Contraceptive services
- HIV testing and counseling
- STI screening and treatment
- Menstrual hygiene support

- Sexuality education
- Other
  (specify): ……
  ……
  ……

7. What are the main challenges you face when trying to access SRH services? (Tick all that apply):
    - Cost
    - Distance to facilities
    - Lack of information
    - Stigma/discrimination
    - Provider attitude
    - Parental or societal disapproval
8. Do you feel the services meet your needs?
   [ ] Yes [ ] No (Please
   explain): ……
   ……
   ……
   ……
   ……..

Section C: Mental Health Outcomes

9. Have you ever experienced any of the following mental health challenges? (Tick all that apply):

- Depression
- Anxiety
- Low self-esteem
- Suicidal thoughts
- None

10. Do you think accessing SRH services has affected your mental health?
[ ] Positively [ ] Negatively [ ] No effect

11. In what ways has access to SRH services affected your mental health?

- Reduced stress and anxiety
- Increased confidence and self-awareness
- Caused stigma or judgment from others
- Other
  (specify): ……
  ……
  ……
  ……..

Section D: Sexual Education and Mental Well-being

12. Have you received any formal or informal sexual education?
[ ] Yes, at school [ ] Yes, through health services [ ] No

13. Do you feel the information was sufficient and age-appropriate?
[ ] Yes [ ] No

14. What improvements would you suggest for sexual education in your community?
……
……
…….

15. What support do you think would help promote better mental health for young women in your area?.....
.....
.....END OF QUESTIONNAIRE.

THANK YOU!!

Appendix B: Focus Group Discussion (FGD) Guide

My name is Rutendo Chigwada, a part final student at Bindura University, carrying out a research on, assessing the impact of comprehensive sexual reproductive health services and mental health outcomes amongst young women in Mabvuku/Tafara. I kindly ask you to participate in this interview and answer questions that are relevant to my study as part of the field work and

information acquired is strictly used for academic and research purposes, therefore, confidentiality and anonymity is guaranteed, hence, your participation and cooperation is greatly appreciated.

Participants: 6–8 young women aged 15–24 from Mabvuku/Tafara

- Can you share your understanding of sexual and reproductive health (SRH)?
- What kinds of SRH services are young women accessing in this community?
- What encourages or prevents young women from using SRH services here?
- How do family, religious beliefs, or peers influence your decisions to seek SRH services?
- Are there trusted service providers in the community?
- Have you or your peers experienced any mental or emotional changes after accessing or being denied SRH services?
- How does lack of access to SRH services affect your emotional well-being?
- In what ways do SRH services help reduce stress or anxiety?
- What kind of sexual education have you received (school, peers, internet)?
- Do you feel this education helped you understand your health and choices?
- What is lacking in current sexual education programs?
- What are your suggestions to improve mental health among girls in your community?
- If you could design a program to improve both SRH and mental health services, what would it look like?

THANK YOU!!!

Appendix C : In-depth Interview Guide (For Key Informants: Health Workers, Educators, and Community Leaders)

My name is Rutendo Chigwada, a part final student at Bindura University, carrying out a research on, assessing the impact of comprehensive sexual reproductive health services and mental health outcomes amongst young women in Mabvuku/Tafara.I kindly ask you to participate in this interview and answer questions that are relevant to my study as part of the field work and information acquired is strictly used for academic and research purposes, therefore confidentiality and anonymity is guaranteed, hence, your participation and cooperation is greatly appreciated.

Interview Themes:

Theme 1: Factors Affecting Access to SRH Services

- What SRH services are available for young women in Mabvuku/Tafara?
- What are the main challenges young women face in accessing these services?
- How do community norms, policies, or institutions affect access?

Theme 2: SRH and Mental Health

- What mental health concerns do you observe among young women in this area?
- How are these linked to their sexual and reproductive experiences?
- Have you seen improvements in mental health when SRH services are accessed?

Theme 3: Addressing Gaps and Promoting Well-being

- Are there initiatives currently addressing both SRH and mental health?
- What are the gaps in sexual education and how do they affect young women?
- What strategies would you recommend for integrated SRH and mental health support?

Conclusion:

- What key message would you give to policymakers or NGOs about SRH and youth mental health in this community?

Thank You!!!

Appendix D: Approval Letter

SCHOOL OF GEOLOGICAL SCIENCES, DISASTER & DEVELOPMENT

SUSTAINABLE DEVELOPMENT DEPARTMENT

BINDURA, ZIMBABWE
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BINDURA UNIVERSITY OF SCIENCE EDUCATION

CHAIRPERSON'S OFFICE

Thursday 03 April 2025

TO WHO IT MAY CONCERN

Dear Sir or Madam

RE: RESEARCH SUPPORT LETTER FOR SUSTAINABLE DEVELOPMENT STUDENT

I am writing on behalf of the Sustainable Development Department requesting your collaboration on the research of our fourth-year student, **RUTENDO HILDA CHIGWADA REGISTRATION NUMBER B210980B.**

The student is studying for a 4-year Bachelor of Science (Honours) Degree in Development Studies (HBSc.DG). During the fourth year of study, students are required to do field research which require them to do their data collection for research purposes.

We will be highly obliged to furnish you with additional information about the research project if our request meets your favorable consideration.

Yours faithfully,

Dr. J. Bowora
(Chairperson)

CHAIRMAN
GEOGRAPHY DEPARTMENT
FACULTY OF SCIENCE

WALPE ACADEMY
19 APR 2025
CELL
Signature

Appendix E

TURNITIN REPORT