

# BMJ Open

BMJ Open is committed to open peer review. As part of this commitment we make the peer review history of every article we publish publicly available.

When an article is published we post the peer reviewers' comments and the authors' responses online. We also post the versions of the paper that were used during peer review. These are the versions that the peer review comments apply to.

The versions of the paper that follow are the versions that were submitted during the peer review process. They are not the versions of record or the final published versions. They should not be cited or distributed as the published version of this manuscript.

BMJ Open is an open access journal and the full, final, typeset and author-corrected version of record of the manuscript is available on our site with no access controls, subscription charges or pay-per-view fees (<http://bmjopen.bmj.com>).

If you have any questions on BMJ Open's open peer review process please email [info.bmjopen@bmj.com](mailto:info.bmjopen@bmj.com)

# BMJ Open

## Symptoms of mental disorders and adherence to ART among adults living with HIV in rural Zimbabwe: a cross-sectional survey

Journal:	<i>BMJ Open</i>
Manuscript ID	bmjopen-2021-049824
Article Type:	Original research
Date Submitted by the Author:	03-Feb-2021
Complete List of Authors:	Haas, Andreas D ; Universitat Bern Institut fur Sozial- und Praventivmedizin, Kunzekwenyika, Cordelia ; SolidarMed Hossmann, Stefanie; CTU Bern and Institute of Social and Preventive Medicine (ISPM), University of Bern Manzero, Josphat; SolidarMed van Dijk, Janneke; SolidarMed Manhibi, Ronald; SolidarMed Verhey, Ruth ; Friendship Bench Zimbabwe, Limacher, Andreas; University of Bern, CTU Bern von Groote, Per M; University of Bern, Institute of Social and Preventive Medicine Manda, Ethel; Friendship Bench Zimbabwe Hobbins, Michael; SolidarMed Chibanda, D; University of Zimbabwe, Department of Psychiatry Egger, Matthias; University of Bern, Institute of Social & Preventive Medicine
Keywords:	MENTAL HEALTH, HIV & AIDS < INFECTIOUS DISEASES, EPIDEMIOLOGY

SCHOLARONE™  
Manuscripts



I, the Submitting Author has the right to grant and does grant on behalf of all authors of the Work (as defined in the below author licence), an exclusive licence and/or a non-exclusive licence for contributions from authors who are: i) UK Crown employees; ii) where BMJ has agreed a CC-BY licence shall apply, and/or iii) in accordance with the terms applicable for US Federal Government officers or employees acting as part of their official duties; on a worldwide, perpetual, irrevocable, royalty-free basis to BMJ Publishing Group Ltd ("BMJ") its licensees and where the relevant Journal is co-owned by BMJ to the co-owners of the Journal, to publish the Work in this journal and any other BMJ products and to exploit all rights, as set out in our [licence](#).

The Submitting Author accepts and understands that any supply made under these terms is made by BMJ to the Submitting Author unless you are acting as an employee on behalf of your employer or a postgraduate student of an affiliated institution which is paying any applicable article publishing charge ("APC") for Open Access articles. Where the Submitting Author wishes to make the Work available on an Open Access basis (and intends to pay the relevant APC), the terms of reuse of such Open Access shall be governed by a Creative Commons licence – details of these licences and which [Creative Commons](#) licence will apply to this Work are set out in our licence referred to above.

Other than as permitted in any relevant BMJ Author's Self Archiving Policies, I confirm this Work has not been accepted for publication elsewhere, is not being considered for publication elsewhere and does not duplicate material already published. I confirm all authors consent to publication of this Work and authorise the granting of this licence.

## Symptoms of mental disorders and adherence to ART among adults living with HIV in rural Zimbabwe: a cross-sectional survey

Andreas D Haas<sup>1</sup>, Cordelia Kunzekwenyika<sup>2</sup>, Stefanie Hossmann<sup>1</sup>, Josphat Manzero<sup>2</sup>, Janneke H van Dijk<sup>2</sup>, Ronald Manhibi<sup>2</sup>, Ruth Verhey<sup>3</sup>, Andreas Limacher<sup>4</sup>, Per von Groote<sup>1</sup>, Ethel Manda<sup>3</sup>, Michael Hobbins<sup>5</sup>, Dixon Chibanda<sup>3,6,7</sup>, Matthias Egger<sup>1,8,9</sup>, for leDEA Southern Africa

1) Institute of Social & Preventive Medicine (ISPM), University of Bern, Bern, Switzerland

2) SolidarMed, Masvingo, Zimbabwe

3) Friendship Bench, Harare, Zimbabwe

4) CTU Bern, University of Bern, Bern, Switzerland

5) SolidarMed, Luzern, Switzerland

6) Department of Psychiatry, University of Zimbabwe College of Health Sciences, Zimbabwe.

7) Centre for Global Mental Health, London School of Hygiene and Tropical Medicine, London, UK.

8) Centre for Infectious Disease Epidemiology and Research, University of Cape Town, Cape Town, South Africa

9) Population Health Sciences, Bristol Medical School, University of Bristol, Bristol, United Kingdom

Running head: Mental disorders and ART adherence among adults living with HIV in Zimbabwe

Word count: abstract 239 words, main text 1557 words, 1 table, 25 references.

Correspondence to:

Andreas D Haas  
Institute of Social & Preventive Medicine  
University of Bern  
Mittelstrasse 43  
CH-3012 Bern, Switzerland  
andreas.haas@ispm.unibe.ch

## Abstract

**Objectives:** To examine the proportion of people living with HIV (PLHIV) screening positive for common mental disorders (CMD) and associations between positive CMD screening tests and self-reported adherence to antiretroviral therapy (ART).

**Setting:** Sixteen government-funded health facilities in the rural Bikita district of Zimbabwe.

**Design:** Cross-sectional survey.

**Participants:** HIV-positive non-pregnant adults, aged 18 years or older, who lived in Bikita district and had received ART for at least six months.

**Outcome measures:** The primary outcome was the proportion of participants screening positive for CMD defined as a Shona Symptoms Questionnaire (SSQ-14) score of 9 or greater. Secondary outcomes were the proportion of participants reporting suicidal ideation, perceptual symptoms, and suboptimal ART adherence.

**Results:** Out of 3,480 adults, 18.8% (95% CI 14.8-23.7) screened positive for CMD, 2.7% (95% CI 1.5-4.7) reported suicidal ideations, and 1.5% (95% 0.9-2.6) reported perceptual symptoms. Positive CMD screens were more common in women (adjusted prevalence ratio [aPR] 1.67, 95% confidence interval [CI] 1.19-2.35) than in men and were more common in adults aged 40-49 years (aPR 1.47 95% CI 1.16-1.85) or aged 50-59 years (20.3%; aPR 1.51 95% CI 1.05-2.17) than in those 60 years or older. Positive CMD screen was associated with a higher prevalence of suboptimal adherence (aPR 1.52; 95% CI 1.36-1.70).

**Conclusions:** A substantial proportion of PLHIV in rural Zimbabwe are affected by CMD. There is a need to integrate mental health services HIV programs in rural Zimbabwe.

1  
2  
3 **Keywords:** Mental health, HIV & AIDS, epidemiology  
4

5 **Strengths and limitations of this study**  
6

- 7
- 8 • Inclusion of a large sample of people living with HIV recruited at 16 government-funded primary  
9 and secondary care facilities in a rural district of Zimbabwe.
  - 10 • Use of a locally developed screening tool that showed good psychometric properties for  
11 detecting common mental disorders in Zimbabwe in HIV-positive urban populations.
  - 12 • The screening tool was not validated for the rural setting and the cutoff score was selected  
13 based on data from the urban setting.
  - 14 • Adherence to antiretroviral therapy was self-reported.  
15
- 16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

## Background

In 2019, approximately 1.4 million people were living with HIV in Zimbabwe, of whom more than 1.1 million were receiving antiretroviral therapy (ART) [1]. The long-term effectiveness of ART depends on lifelong retention in HIV care and strict medication adherence [2,3].

Common mental disorders (CMD), which include depression and anxiety disorders are highly prevalent among people living with HIV (PLHIV) [4] and are associated with poor HIV treatment outcomes including low adherence, lack of viral load suppression, loss to follow-up and mortality [5–9], but often remain untreated [10,11]. In 2013, Chibanda and colleagues showed that in Zimbabwe's capital Harare, over 50% of PLHIV attending a primary care facility met diagnostic criteria for either depression or anxiety and 65% screened positive for CMD [12,13], but data are scarce on the prevalence of CMD in Zimbabwe's rural settings.

We assessed the prevalence of positive CMD screening tests and associations between screening positive for CMD and self-reported adherence among PLHIV receiving ART at 16 health facilities in the rural Bikita district of Zimbabwe.

## Methods

We conducted a cross-sectional survey to assess the eligibility of individuals for a cluster-randomized trial (FB-ART) on the effect of a community-based psychological intervention (the friendship bench intervention[14] on ART outcomes and symptoms of CMD in PLHIV. We registered the trial with ClinicalTrials.gov (NCT03704805). Two district hospitals, two rural hospitals, and 12 health centres served as study facilities. All 16 facilities are located in Bikita district. Bikita is a rural district of the Masvingo Province about 300 km south of Harare.

Between October 5, 2018, and December 19, 2019, we offered CMD screening at 16 government-funded health facilities in rural Zimbabwe. Trained research assistants offered screening for CMD using the Shona Symptoms Questionnaire (SSQ-14)[12] to HIV-positive non-pregnant adults, aged 18 years or older, who lived in Bikita district and had received ART for at least six months and assessed adherence using a question from the AIDS indicator survey [15]. The SSQ-14 is a locally developed CMD screening tool [12]. The tool assesses if individuals had experienced common mental health symptoms, including sleep disturbance, suicidal ideations, tearfulness, perceptual symptoms, and impairment of functioning in the past seven days. Each of the 14 symptoms is scored dichotomously (symptom present or absent) [16]. The tool showed good psychometric properties for detecting CMD in HIV-positive and HIV-negative urban populations in Zimbabwe [12]. Adherence was assessed based on self-report using the following question: "In the last 30 days, how many days have you missed taking any of your ARV [antiretroviral] pills?"

We defined SSQ-14 scores of 9 or greater as positive CMD screen [12]. Participants who reported that they "felt like committing suicide" in the past seven days (SSQ-14 item 11) screened positive for suicidal ideation. Participants who reported that they "saw or heard things which others could not see or hear" in the past seven days (SSQ-14 item 5) screened positive for perceptual symptoms. Participants who



1  
2  
3 indicated that they had missed taking one or more ARV pills in the last 30 days were classified as having  
4 suboptimal adherence and those reporting not having missed any ARV pills as having optimal  
5 adherence. We categorized age into the following groups: 18-29 years, 30-39 years, 40-49 years, 50-59  
6 years and 60 years or older.  
7  
8  
9

10  
11  
12 Participants who did not respond to all 14 SSQ items were excluded from the analysis. We calculated the  
13 prevalence of non-adherence and positive screening outcomes with logit-transformed 95% confidence  
14 intervals that adjusted for intragroup correlation at health facilities. We estimated adjusted prevalence  
15 ratios (aPRs) using mixed-effects Poisson regression models with robust standard errors [17]. Models  
16 were adjusted for sex, age, and clustering of data at facility-level using a random intercept for study  
17 facilities. Statistical analysis was done using Stata (Version 16, Stata Corporation, College Station, TX,  
18 USA).  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28

29 The study protocol was approved by the ethics committees of the Medical Research Council of  
30 Zimbabwe (MRCZ), the Research Council of Zimbabwe (RCZ), and the Canton of Bern, Switzerland.  
31  
32 Individuals provided verbal consent for eligibility screening and collection and analysis of screening data.  
33  
34 Eligible participants provided written informed consent to participate in the trial. Research assistants  
35 referred individuals screening positive for suicidal ideation or perceptual symptoms to the nurse in  
36 charge for further assessment and care. Individuals screening positive for CMD were offered CMD  
37 treatment as part of the FB-ART trial.  
38  
39  
40  
41  
42  
43  
44  
45

## 46 Patient and Public Involvement

47  
48 Patients with psychiatric morbidity were involved in ethnographic and qualitative research which  
49 informed the development of the SSQ-14 [16]. The results of this study were shared with the provincial  
50 medical director and the district medical officer.  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

For peer review only

## Results

Research assistants assessed the eligibility for CMD screening of 3,707 individuals; 3,543 (95.6%) of eligible individuals participated in CMD screens. Pregnancy, residency outside of Bikita district, and age below 18 years were the most common reasons for ineligibility for screening. Out of 3,543 individuals screened for CMD, 63 (1.7%) did not respond to all SSQ-14 items and were excluded. The remaining 3,480 individuals were included in the study. The median age of the study population was 45 years (IQR 38–53). Three-quarters of the participants (74.9%, n=2,608) were women.

Table 1 shows the prevalence and aPRs for positive screening for common mental disorders, suicidal ideation, and perceptual symptoms. Out of 3,480 adults, 18.8% (95% CI 14.8-23.7, n=655) screened positive for CMD, 2.7% (95% CI 1.5-4.7, n=93) reported suicidal ideation, and 1.5% (95% CI 0.9-2.6, n=52) reported perceptual symptoms. Positive CMD screens were more common in women (21.0%; aPR 1.67, 95% CI 1.19-2.35) than in men (12.4%) and were more common in adults aged 40-49 years (20.6%; aPR 1.47 95% CI 1.16-1.85) or aged 50-59 years (20.3%; aPR 1.51 95% CI 1.05-2.17) than in those 60 years or older (12.6%). Suicidal ideations were more common in adults 18-29 years (4.7%, 95% CI 0.2-9.2) and in adults aged 30-39 years (4.0%, 95% CI 1.1-7.0) than in older adults, but the statistical uncertainty around these estimates was large.

Out of 3,469 individuals who responded to the adherence question (11, 0.32% did not respond), 83.6% (2,900) reported optimal adherence and 16.4% (569) reported suboptimal adherence. Suboptimal adherence was more common in individuals screening positive for CMD (21.3%, 95% CI 16.8-26.6; aPR 1.53 95% CI 1.37-1.70) than in those screening negative (15.3% 95% CI 12.0-19.3).

## Discussion

We screened over 3,500 PLHIV attending 16 health facilities in rural Zimbabwe using a locally developed CMD screening tool [12]. Less than 20% of PLHIV screened positive for CMD, 2.7% reported suicidal ideation, and 1.5% perceptual symptoms compatible with psychosis. Positive CMD screens were more common in women and middle-aged adults than in men or young or older adults. Of note, positive screens were associated with suboptimal self-reported ART adherence.

The prevalence of positive screens for CMD observed in rural Zimbabwe was much lower than in the urban setting. In 2013, Chibanda and colleagues examined CMD symptoms in PLHIV attending a primary care facility in Zimbabwe's capital, Harare. All participants were screened for CMD using the SSQ-14 and examined by psychiatrists using the Structured Clinical Interview of the DSM-IV (SCID). The prevalence of a positive CMD screen (SSQ-14  $\geq 9$ ) was 65%, and over 50% of participants met diagnostic criteria for either depression or anxiety according to the SCID [12,13]. A higher depression prevalence in urban than in rural settings was also reported in a study from South Africa [18]. The adjusted odds for depression were almost twice as high among HIV-positive and HIV-affected people in urban compared to rural settings [18].

An important factor that likely contributed to the lower prevalence of CMD in our study compared to earlier studies is the change of national ART guidelines to treat PLHIV at less advanced stages of HIV disease. In the last decade, the CD4 threshold for ART eligibility was successively raised from  $<250$  cells/ $\mu\text{L}$  to immediate ART initiation of all PLHIV under WHO's "treat all" guidelines, which was reflected in an increase in the median CD4 at ART initiation in low- and middle-income [19,20]. Low CD4 cell count is associated with a higher risk of CMD [21], and the comparably low prevalence of CMD observed in our study might reflect the higher median CD4 cell count at ART initiation. Also, differences in the

1  
2  
3 prevalence of positive CMD screens between the urban and rural setting could partly be explained by  
4  
5 cultural differences in symptoms presentation [22].  
6  
7

8 In contrast to most other studies, we found middle age to be associated with a higher risk of positive  
9  
10 screening for CMD. The sample size of our study is much larger than in most previous studies, and  
11  
12 earlier studies might have lacked the power to detect associations between age and positive CMD  
13  
14 screening.  
15  
16

17  
18 In line with previous studies, we found that CMDs were more common in women than in men. In our  
19  
20 study women had roughly twice the risk of screening positive for CMD. Studies from other settings  
21  
22 reported similar or slightly stronger associations.[13,23] Our results also confirm earlier data on  
23  
24 associations between symptoms of depression and anxiety disorders and suboptimal adherence to ART  
25  
26 [5,24].  
27  
28

29  
30 Our study has several limitations. We did not validate the SSQ-14 for the rural setting and selected the  
31  
32 CMD threshold based on data from the urban setting [12]. Furthermore, we used a self-reported  
33  
34 adherence measure which might be prone to underreporting of non-adherence. However, there is  
35  
36 evidence for the validity of self-reported measure of ART adherence [25].  
37  
38

39 In conclusion, while the burden of CMD in adult ART patients in a rural district of Zimbabwe seems to be  
40  
41 lower than in the urban setting, there is a need to integrate mental health services in rural ART  
42  
43 programs.  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

## Funding

The study was supported by the National Cancer Institute (NCI), the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD), the National Institute of Allergy and Infectious Diseases (NIAID), the National Institute of Mental Health (NIMH), the National Institute on Drug Abuse (NIDA), the National Heart, Lung, and Blood Institute (NHLBI), the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), and the Fogarty International Center (FIC) through the International epidemiology Databases to Evaluate AIDS (IeDEA) (ME, grant number 5U01-AI069924-05) and the Swiss National Science Foundation (SNSF) (ME, grant number 174281 and AH, grant number P2BEP3\_178602). The funders had no role in study design, data collection and analysis, decision to publish or preparation of the manuscript.

## Competing interest

None

## Ethical considerations

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008. The study protocol was approved by the ethics committees of the Medical Research Council of Zimbabwe (MRCZ) (approval number MRCZ/A/2287), the Research Council of Zimbabwe (RCZ), and the Canton of Bern, Switzerland (approval number 2018-00396). Individuals provided verbal consent for eligibility screening and collection and analysis of screening data. Eligible participants provided written informed consent to participate in the randomized controlled trial.

## Authors' contributions

ME obtained funding for the study. AH, JvD, ME, CK, DC, SH and AL wrote the study protocol. JM and RM assisted with fieldwork and data collection which was overseen by CK and JvD. SH and AH did central data monitoring. AH conducted statistical analysis. AL advised on statistical analysis. AH and wrote the first draft of the paper which was revised by CK, JvD, RV, AL, MH, DC, PvG and ME. All contributed to interpretation of the results, commented on previous versions of the manuscript and read and approved the final manuscript.

## Availability of data

Data cannot be made available online because of legal and ethical restrictions. To request data, readers may contact IeDEA for consideration by filling out the online form available at <https://www.iedea-sa.org/contact-us/>

## References

1. Joint United Nations Programme on HIV/AIDS (UNAIDS). AIDSInfo online database [Internet]. [cited 2020 Dec 13]. Available from: <http://www.aidsinfoonline.org/>
2. Haas AD, Zaniewski E, Anderegg N, Ford N, Fox MP, Vinikoor M, et al. Retention and mortality on antiretroviral therapy in sub-Saharan Africa: collaborative analyses of HIV treatment programmes. *J Int AIDS Soc*. 2018 Feb;21(2):e25084.
3. Ford N, Darder M, Spelman T, Maclean E, Mills E, Boule A. Early Adherence to Antiretroviral Medication as a Predictor of Long-Term HIV Virological Suppression: Five-Year Follow Up of an Observational Cohort. Ndhlovu LC, editor. *PLoS One*. 2010 May 5;5(5):e10460.
4. Bernard C, Dabis F, de Rekeneire N. Prevalence and factors associated with depression in people living with HIV in sub-Saharan Africa: A systematic review and meta-analysis. Seedat S, editor. *PLoS One*. 2017 Aug 4;12(8):e0181960.
5. Wykowski J, Kemp CG, Velloza J, Rao D, Drain PK. Associations Between Anxiety and Adherence to Antiretroviral Medications in Low- and Middle-Income Countries: A Systematic Review and Meta-analysis. *AIDS Behav*. 2019 Aug 18;23(8):2059–71.
6. Haas AD, Technau K-G, Pahad S, Braithwaite K, Madzivhandila M, Sorour G, et al. Mental health, substance use and viral suppression in adolescents receiving ART at a paediatric HIV clinic in South Africa. *J Int AIDS Soc*. 2020 Dec 7;23(12):e25644.
7. Haas AD, Ruffieux Y, Heuvel LL Van Den, Lund C, Boule A, Euvrard J, et al. Excess mortality associated with mental illness in people living with HIV in Cape Town, South Africa: a cohort study using linked electronic health records. *Lancet Glob Heal*. 2020;8(10):e1326–34.
8. Uthman OA, Magidson JF, Safren SA, Nachega JB, Group IH, Service M, et al. Depression and adherence to antiretroviral therapy in low-, middle- and high-income countries: a systematic review and meta-analysis. *Curr HIV/AIDS Rep*. 2014 Sep;11(3):291–307.
9. Meffert SM, Neylan TC, McCulloch CE, Maganga L, Adamu Y, Kiweewa F, et al. East African HIV care: depression and HIV outcomes. *Glob Ment Heal*. 2019 May 31;6:e9.
10. Ruffieux Y, Efthimious O, van den Heuvel LL, Joska JA, Cornell M, Seedata S, et al. The treatment gap for mental disorders in adults enrolled in HIV treatment programs in South Africa: A cohort study using linked electronic health records. *medRxiv*. 2020;DOI:10.1101/2020.08.10.20171058.
11. Sikkema KJ, Dennis AC, Watt MH, Choi KW, Yemeke TT, Joska JA. Improving mental health among people living with HIV: a review of intervention trials in low- and middle-income countries. *Glob Ment Heal (Cambridge, England)*. 2015;2(1 Supplement):1–26.
12. Chibanda D, Verhey R, Gibson LJ, Munetsi E, Machando D, Rusakaniko S, et al. Validation of screening tools for depression and anxiety disorders in a primary care population with high HIV prevalence in Zimbabwe. *J Affect Disord*. 2016;198:50–5.
13. Chibanda D, Cowan F, Gibson L, Weiss HA, Lund C. Prevalence and correlates of probable common mental disorders in a population with high prevalence of HIV in Zimbabwe. *BMC Psychiatry*. 2016;16(1):55.

14. Chibanda D. Reducing the treatment gap for mental, neurological and substance use disorders in Africa: lessons from the Friendship Bench in Zimbabwe. *Epidemiol Psychiatr Sci.* 2017;26(4):342–7.
15. AIS. AIDS Indicator Survey (AIS) [Internet]. 2017 [cited 2021 Jan 21]. Available from: <https://dhsprogram.com/What-We-Do/Survey-Types/AIS.cfm>
16. Patel V, Simunyu E, Gwanzura F, Lewis G, Mann A. The Shona Symptom Questionnaire: the development of an indigenous measure of common mental disorders in Harare. *Acta Psychiatr Scand.* 1997 Jun;95(6):469–75.
17. Cummings P. Methods for Estimating Adjusted Risk Ratios. *Stata J Promot Commun Stat Stata.* 2009 Aug 1;9(2):175–96.
18. Nyirenda M, Chatterji S, Rochat T, Mutevedzi P, Newell M-LM-L. Prevalence and correlates of depression among HIV-infected and -affected older people in rural South Africa. *J Affect Disord.* 2013 Oct;151(1):31–8.
19. World Health Organization. Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection Recommendations for a public health approach - Second edition. Geneva: World Health Organization; 2016.
20. The leDEA and COHERE Cohort Collaborations. Global Trends in CD4 Cell Count at the Start of Antiretroviral Therapy: Collaborative Study of Treatment Programs. *Clin Infect Dis.* 2018 Mar 5;66(6):893–903.
21. Ngum PA, Fon PN, Ngu RC, Verla VS, Luma HN. Depression Among HIV/AIDS Patients on Highly Active Antiretroviral Therapy in the Southwest Regional Hospitals of Cameroon: A Cross-Sectional Study. *Neurol Ther.* 2017 Jun 18;6(1):103–14.
22. Office of the Surgeon General (US) Center for Mental Health Services (US); National Institute of Mental Health (US). Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General. Rockville, MD; 2001.
23. Kanmogne GD, Qiu F, Ntone FE, Fonsah JY, Njamnshi DM, Kuate CT, et al. Depressive symptoms in HIV-infected and seronegative control subjects in Cameroon: Effect of age, education and gender. Cysique LA, editor. *PLoS One.* 2017 Feb 23;12(2):e0171956.
24. Uthman OA, Magidson JF, Safren SA, Nachega JB. Depression and adherence to antiretroviral therapy in low-, middle- and high-income countries: a systematic review and meta-analysis. *Curr HIV/AIDS Rep.* 2014 Sep;11(3):291–307.
25. Simoni JM, Kurth AE, Pearson CR, Pantalone DW, Merrill JO, Frick PA. Self-Report Measures of Antiretroviral Therapy Adherence: A Review with Recommendations for HIV Research and Clinical Management. *AIDS Behav.* 2006 May 3;10(3):227–45.



**Table 1: Prevalence of symptoms of common mental disorders, suicidal ideation, and perceptual disorders among people living with HIV in rural Zimbabwe.**

	Positive screens									
	Common mental disorders <sup>a</sup>				Suicidal ideation <sup>b</sup>			Perceptual symptoms <sup>c</sup>		
	Total screened N	N	Prevalence <sup>d</sup> (95% CI)	Adjusted prevalence ratio <sup>e</sup> (95% CI)	N	Prevalence <sup>d</sup> (95% CI)	Adjusted prevalence ratio <sup>e</sup> (95% CI)	N	Prevalence <sup>d</sup> (95% CI)	Adjusted prevalence ratio <sup>e</sup> (95% CI)
	3,480	655	18.8% (14.8-23.7)		93	2.7% (1.5-4.7)		52	1.5% (0.9-2.6)	
Sex										
Female	2,654	547	21.0% (16.5-26.2)	1.67 (1.19-2.35)	78	3.0% (1.2-4.7)	1.47 (0.71-3.03)	43	1.6% (0.7-2.6)	1.47 (0.73-2.96)
Male	886	108	12.4 (6.9-17.9)	1.00	15	1.7% (0.2-3.3)	1.00	9	1.0% (0.1-2.0)	1.00
Age in years										
18-29	280	49	17.8% (10.3-25.3)	1.19 (0.74-1.92)	13	4.7% (0.2-9.2)	2.21 (0.86-5.66)	4	1.5% (0.0-2.9)	2.47 (0.69-8.78)
30-39	761	138	18.5% (13.6-23.4)	1.28 (0.88-1.87)	30	4.0% (1.1-7.0)	1.65 (0.73-3.71)	12	1.6% (0.0-3.3)	2.54 (0.44-14.57)
40-49	1,292	262	20.6% (14.9-26.3)	1.47 (1.16-1.85)	28	2.2% (0.6-3.8)	0.87 (0.51-1.49)	23	1.8% (0.5-3.2)	2.73 (0.87-8.54)
50-59	746	149	20.3% (15.2-25.5)	1.51 (1.05-2.17)	12	1.6% (0.6-2.7)	0.73 (0.43-1.24)	10	1.4% (0.4-2.4)	2.13 (0.63-7.20)
60+	461	57	12.6% (6.9-18.3)	1.00	10	2.2% (0.7-3.7)	1.00	3	0.7% (0.0-1.4)	1.00

Data are numbers of individuals, the prevalence of positive screens, and adjusted prevalence ratios. 95% confidence intervals are shown in parenthesis.

<sup>a</sup> Shona Symptoms Questionnaire (SSQ-14) scores of 9 or greater

<sup>b</sup> Yes to item 11 on the SSQ-14: "At times I felt like committing suicide."

<sup>c</sup> Yes to item 5 on the SSQ-14: "I sometimes saw or heard things which others could not see or hear."

<sup>d</sup> Prevalence of positive screening tests and logit-transformed confidence intervals adjusted for intragroup correlation at health facilities.

<sup>e</sup> Models adjusted for sex, age, and clustering of participants in facilities.

Abbreviations: aPR=adjusted prevalence ratio; CI=confidence interval; SSQ-14= Shona Symptoms Questionnaire.

# Reporting checklist for cross sectional study.

Based on the STROBE cross sectional guidelines.

## Instructions to authors

Complete this checklist by entering the page numbers from your manuscript where readers will find each of the items listed below.

Your article may not currently address all the items on the checklist. Please modify your text to include the missing information. If you are certain that an item does not apply, please write "n/a" and provide a short explanation.

Upload your completed checklist as an extra file when you submit to a journal.

In your methods section, say that you used the STROBE cross sectional reporting guidelines, and cite them as:

von Elm E, Altman DG, Egger M, Pocock SJ, Gotsche PC, Vandenbroucke JP. The Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) Statement: guidelines for reporting observational studies.

	Reporting Item	Page Number
<b>Title and abstract</b>		
Title	<a href="#">#1a</a> Indicate the study's design with a commonly used term in the title or the abstract	1
Abstract	<a href="#">#1b</a> Provide in the abstract an informative and balanced summary of what was done and what was found	2
<b>Introduction</b>		
Background / rationale	<a href="#">#2</a> Explain the scientific background and rationale for the investigation being reported	3
Objectives	<a href="#">#3</a> State specific objectives, including any prespecified hypotheses	3
<b>Methods</b>		
Study design	<a href="#">#4</a> Present key elements of study design early in the paper	4
Setting	<a href="#">#5</a> Describe the setting, locations, and relevant dates, including periods of recruitment, exposure, follow-up, and data collection	4

1	Eligibility criteria	<a href="#">#6a</a>	Give the eligibility criteria, and the sources and methods of selection of participants.	4
2				
3				
4				
5		<a href="#">#7</a>	Clearly define all outcomes, exposures, predictors, potential confounders, and effect modifiers. Give diagnostic criteria, if applicable	4-5
6				
7				
8				
9				
10	Data sources /	<a href="#">#8</a>	For each variable of interest give sources of data and details of methods of assessment (measurement). Describe comparability of assessment methods if there is more than one group. Give information separately for for exposed and unexposed groups if applicable.	4-5
11	measurement			
12				
13				
14				
15				
16				
17				
18	Bias	<a href="#">#9</a>	Describe any efforts to address potential sources of bias	5
19				
20				
21	Study size	<a href="#">#10</a>	Explain how the study size was arrived at	4
22				
23	Quantitative	<a href="#">#11</a>	Explain how quantitative variables were handled in the analyses. If applicable, describe which groupings were chosen, and why	4-5
24	variables			
25				
26				
27				
28	Statistical	<a href="#">#12a</a>	Describe all statistical methods, including those used to control for confounding	5
29	methods			
30				
31				
32	Statistical	<a href="#">#12b</a>	Describe any methods used to examine subgroups and interactions	NA
33	methods			
34				
35				
36	Statistical	<a href="#">#12c</a>	Explain how missing data were addressed	NA
37	methods			
38				
39				
40	Statistical	<a href="#">#12d</a>	If applicable, describe analytical methods taking account of sampling strategy	NA
41	methods			
42				
43				
44	Statistical	<a href="#">#12e</a>	Describe any sensitivity analyses	NA
45	methods			
46				
47	<b>Results</b>			
48				
49				
50	Participants	<a href="#">#13a</a>	Report numbers of individuals at each stage of study—eg numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow-up, and analysed. Give information separately for for exposed and unexposed groups if applicable.	6
51				
52				
53				
54				
55				
56				
57				
58	Participants	<a href="#">#13b</a>	Give reasons for non-participation at each stage	6
59				
60				

1	Participants	<a href="#">#13c</a>	Consider use of a flow diagram	NA
2				
3	Descriptive data	<a href="#">#14a</a>	Give characteristics of study participants (eg demographic, clinical, social) and information on exposures and potential confounders. Give information separately for exposed and unexposed groups if applicable.	6
4				
5				
6				
7				
8				
9				
10	Descriptive data	<a href="#">#14b</a>	Indicate number of participants with missing data for each variable of interest	NA
11				
12				
13				
14	Outcome data	<a href="#">#15</a>	Report numbers of outcome events or summary measures. Give information separately for exposed and unexposed groups if applicable.	6
15				
16				
17				
18				
19	Main results	<a href="#">#16a</a>	Give unadjusted estimates and, if applicable, confounder-adjusted estimates and their precision (eg, 95% confidence interval). Make clear which confounders were adjusted for and why they were included	No unadjusted estimates reported in this short report
20				
21				
22				
23				
24				
25				
26	Main results	<a href="#">#16b</a>	Report category boundaries when continuous variables were categorized	12
27				
28				
29				
30	Main results	<a href="#">#16c</a>	If relevant, consider translating estimates of relative risk into absolute risk for a meaningful time period	NA
31				
32				
33				
34	Other analyses	<a href="#">#17</a>	Report other analyses done—e.g., analyses of subgroups and interactions, and sensitivity analyses	NA
35				
36				
37				
38	<b>Discussion</b>			
39				
40	Key results	<a href="#">#18</a>	Summarise key results with reference to study objectives	7
41				
42	Limitations	<a href="#">#19</a>	Discuss limitations of the study, taking into account sources of potential bias or imprecision. Discuss both direction and magnitude of any potential bias.	8
43				
44				
45				
46				
47	Interpretation	<a href="#">#20</a>	Give a cautious overall interpretation considering objectives, limitations, multiplicity of analyses, results from similar studies, and other relevant evidence.	7-8
48				
49				
50				
51				
52				
53	Generalisability	<a href="#">#21</a>	Discuss the generalisability (external validity) of the study results	8
54				
55				
56				
57	<b>Other</b>			
58	<b>Information</b>			
59				
60				

1 Funding

[#22](#)

2 Give the source of funding and the role of the funders for the  
3 present study and, if applicable, for the original study on which  
4 the present article is based  
5

9

6 Notes:  
7

- 8
- 9 • 16a: No unadjusted estimates reported in this short report The STROBE checklist is distributed under the  
10 terms of the Creative Commons Attribution License CC-BY. This checklist was completed on 29. January  
11 2021 using <https://www.goodreports.org/>, a tool made by the [EQUATOR Network](#) in collaboration with  
12 [Penelope.ai](#)  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

# BMJ Open

## Symptoms of common mental disorders and adherence to antiretroviral therapy among adults living with HIV in rural Zimbabwe: a cross-sectional study

Journal:	<i>BMJ Open</i>
Manuscript ID	bmjopen-2021-049824.R1
Article Type:	Original research
Date Submitted by the Author:	25-May-2021
Complete List of Authors:	Haas, Andreas D ; University of Bern, Institute of Social & Preventive Medicine (ISPM) Kunzekwenyika, Cordelia ; SolidarMed Hossmann, Stefanie; University of Bern, Institute of Social & Preventive Medicine (ISPM); University of Bern, Institute of Social & Preventive Medicine (ISPM) Manzero, Josphat; SolidarMed van Dijk, Janneke; SolidarMed Manhibi, Ronald; SolidarMed Verhey, Ruth ; Friendship Bench Zimbabwe, Limacher, Andreas; University of Bern, CTU Bern von Groote, Per M; University of Bern, Institute of Social and Preventive Medicine Manda, Ethel; Friendship Bench Zimbabwe Hobbins, Michael; SolidarMed Chibanda, D; University of Zimbabwe, Department of Psychiatry; London School of Hygiene and Tropical Medicine, Centre for Global Mental Health Egger, Matthias; University of Bern, Institute of Social & Preventive Medicine; University of Cape Town, Centre for Infectious Disease Epidemiology and Research
<b>Primary Subject Heading</b>:	Mental health
Secondary Subject Heading:	HIV/AIDS
Keywords:	MENTAL HEALTH, HIV & AIDS < INFECTIOUS DISEASES, EPIDEMIOLOGY

SCHOLARONE™  
Manuscripts



I, the Submitting Author has the right to grant and does grant on behalf of all authors of the Work (as defined in the below author licence), an exclusive licence and/or a non-exclusive licence for contributions from authors who are: i) UK Crown employees; ii) where BMJ has agreed a CC-BY licence shall apply, and/or iii) in accordance with the terms applicable for US Federal Government officers or employees acting as part of their official duties; on a worldwide, perpetual, irrevocable, royalty-free basis to BMJ Publishing Group Ltd ("BMJ") its licensees and where the relevant Journal is co-owned by BMJ to the co-owners of the Journal, to publish the Work in this journal and any other BMJ products and to exploit all rights, as set out in our [licence](#).

The Submitting Author accepts and understands that any supply made under these terms is made by BMJ to the Submitting Author unless you are acting as an employee on behalf of your employer or a postgraduate student of an affiliated institution which is paying any applicable article publishing charge ("APC") for Open Access articles. Where the Submitting Author wishes to make the Work available on an Open Access basis (and intends to pay the relevant APC), the terms of reuse of such Open Access shall be governed by a Creative Commons licence – details of these licences and which [Creative Commons](#) licence will apply to this Work are set out in our licence referred to above.

Other than as permitted in any relevant BMJ Author's Self Archiving Policies, I confirm this Work has not been accepted for publication elsewhere, is not being considered for publication elsewhere and does not duplicate material already published. I confirm all authors consent to publication of this Work and authorise the granting of this licence.

## Symptoms of common mental disorders and adherence to antiretroviral therapy among adults living with HIV in rural Zimbabwe: a cross-sectional study

Andreas D Haas<sup>1</sup>, Cordelia Kunzekwenyika<sup>2</sup>, Stefanie Hossmann<sup>1</sup>, Josphat Manzero<sup>2</sup>, Janneke H van Dijk<sup>2</sup>, Ronald Manhibi<sup>2</sup>, Ruth Verhey<sup>3</sup>, Andreas Limacher<sup>4</sup>, Per von Groote<sup>1</sup>, Ethel Manda<sup>3</sup>, Michael Hobbins<sup>5</sup>, Dixon Chibanda<sup>3,6,7</sup>, Matthias Egger<sup>1,8,9</sup>, for leDEA Southern Africa

- 1) Institute of Social & Preventive Medicine (ISPM), University of Bern, Bern, Switzerland
- 2) SolidarMed, Masvingo, Zimbabwe
- 3) Friendship Bench, Harare, Zimbabwe
- 4) CTU Bern, University of Bern, Bern, Switzerland
- 5) SolidarMed, Luzern, Switzerland
- 6) Department of Psychiatry, University of Zimbabwe College of Health Sciences, Zimbabwe.
- 7) Centre for Global Mental Health, London School of Hygiene and Tropical Medicine, London, UK.
- 8) Centre for Infectious Disease Epidemiology and Research, University of Cape Town, Cape Town, South Africa
- 9) Population Health Sciences, Bristol Medical School, University of Bristol, Bristol, United Kingdom

Running head: Mental illness and ART adherence among adults living with HIV in Zimbabwe

Word count: abstract 255 words, main text 2335 words, 2 tables, 36 references

Correspondence to:

Andreas D Haas  
Institute of Social & Preventive Medicine  
University of Bern  
Mittelstrasse 43  
CH-3012 Bern, Switzerland  
andreas.haas@ispm.unibe.ch



## Abstract

**Objectives:** To examine the proportion of people living with HIV who screen positive for common mental disorders (CMD) and the associations between CMD and self-reported adherence to antiretroviral therapy (ART).

**Setting:** Sixteen government-funded health facilities in the rural Bikita district of Zimbabwe.

**Design:** Cross-sectional study.

**Participants:** HIV-positive non-pregnant adults, aged 18 years or older, who lived in Bikita district and had received ART for at least six months.

**Outcome measures:** The primary outcome was the proportion of participants screening positive for CMD defined as a Shona Symptoms Questionnaire (SSQ-14) score of 9 or greater. Secondary outcomes were the proportion of participants reporting suicidal ideation, perceptual symptoms, and suboptimal ART adherence and adjusted prevalence ratios (aPR) for factors associated with CMD, suicidal ideation, perceptual symptoms, and suboptimal ART adherence.

**Results:** Out of 3,480 adults, 18.8% (95% confidence interval [CI] 14.8-23.7) screened positive for CMD, 2.7% (95% CI 1.5-4.7) reported suicidal ideations, and 1.5% (95% 0.9-2.6) reported perceptual symptoms. Positive CMD screens were more common in women (adjusted prevalence ratio [aPR] 1.67, 95% CI 1.19-2.35) than in men and were more common in adults aged 40-49 years (aPR 1.47 95% CI 1.16-1.85) or aged 50-59 years (20.3%; aPR 1.51 95% CI 1.05-2.17) than in those 60 years or older. Positive CMD screen was associated with suboptimal adherence (aPR 1.53; 95% CI 1.37-1.70).

**Conclusions:** A substantial proportion of people living with HIV in rural Zimbabwe are affected by CMD. There is a need to integrate mental health services and HIV programs in rural Zimbabwe.

**Keywords:** Mental health, HIV & AIDS, epidemiology

## Strengths and limitations of this study

- Inclusion of a large sample of people living with HIV recruited at 16 government-funded primary and secondary care facilities in a rural district of Zimbabwe.
- Use of a locally developed screening tool that showed good psychometric properties for detecting common mental disorders in Zimbabwe in HIV-positive urban populations.
- The screening tool was not validated for the rural setting, and the cutoff score was selected based on data from the urban setting.
- Adherence to antiretroviral therapy was self-reported.

## Background

In 2019, approximately 1.4 million people were living with HIV in Zimbabwe, of whom more than 1.1 million were receiving antiretroviral therapy (ART) [1]. Widespread access to ART has dramatically improved the life expectancy of people living with HIV [2]. However, the long-term effectiveness of ART depends on lifelong retention in HIV care and strict medication adherence [3,4].

Common mental disorders (CMD), which include depression and anxiety disorders are highly prevalent among people living with HIV. In sub-Saharan Africa, the estimated prevalence of major depression in people living with HIV is 15.3%, and of depressive symptoms 27.0% [5]. The median prevalence of anxiety disorders in people living with HIV in developing countries is estimated at 22.8% [6]. The prevalence of depression and anxiety disorders is higher in women than in men [7,8]. In Zimbabwe's capital Harare, over 50% of people living with HIV attending a primary care facility met diagnostic criteria for either depression or anxiety, and 65% screened positive for CMD [9,10]. In Zimbabwe, most people living with HIV receiving ART reside in rural areas [11], and the CMD prevalence in this population is unknown.

The co-occurrence of mental disorders and HIV poses significant challenges in managing and treating HIV. Mental disorders are associated with poor HIV treatment outcomes, including low adherence, lack of viral load suppression, loss to follow-up and mortality [12–16]. Early detection and effective management of mental disorders among people living with HIV may improve the quality of life of affected individuals, ART adherence and viral load suppression [17,18], thus reducing the incidence of HIV-associated complications, preventing drug resistance and HIV transmission. Despite these benefits, there is a large 'treatment gap' in mental health care among people living with HIV in low- and middle-income countries: most people affected by mental illness do not receive appropriate treatment [19,20].

1  
2  
3 The Friendship Bench intervention is a culturally adapted evidence-based psychological intervention  
4 developed to close the treatment gap for CMD in Zimbabwe [21]. The Friendship Bench team trains  
5 community health workers to identify people with CMD symptoms and deliver a brief intervention  
6 consisting of six sessions of problem-solving therapy and optional group support [21]. We are  
7 conducting a cluster-randomised trial to assess the effectiveness of the Friendship Bench intervention in  
8 improving ART outcomes and symptoms of CMD in people living with HIV in rural Zimbabwe. During  
9 recruitment, we screened over 3,500 ART patients for CMD and poor adherence. In this paper, we  
10 report the prevalence of positive CMD screening tests and associations between positive CMD screens  
11 and self-reported adherence among people living with HIV in rural Zimbabwe.  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

## Methods

We conducted a cross-sectional study at 16 health facilities in Bikita district to assess the eligibility of individuals for a cluster-randomised trial (FB-ART) on the effect of the Friendship Bench intervention [22] on ART outcomes and symptoms of CMD in people living with HIV. Bikita is a rural district of the Masvingo Province about 300 km south of Harare. We registered the trial with ClinicalTrials.gov (NCT03704805).

Between October 5, 2018, and December 19, 2019, we offered CMD screening at 16 government-funded health facilities in rural Zimbabwe. HIV-positive non-pregnant adults aged 18 years or older who lived in Bikita district and had received ART for at least six months were eligible. Trained research assistants offered screening for CMD using the Shona Symptoms Questionnaire (SSQ-14) [9] and assessed adherence using a question from the AIDS indicator survey [23]. The SSQ-14 is a locally developed CMD screening tool [9]. The tool assesses if individuals had experienced common mental health symptoms, including sleep disturbance, suicidal ideations, tearfulness, perceptual symptoms, and impairment of functioning in the past seven days. Each of the 14 symptoms is scored dichotomously (symptom present or absent) [24]. The tool showed good psychometric properties for detecting CMD in HIV-positive and HIV-negative urban populations in Zimbabwe [9]. An SSQ-14 score of  $\geq 9$  had a sensitivity of 88% and a specificity of 76% for depression or general anxiety in HIV-positive adults in Harare [9]. The tool had a high internal consistency in the validation study (Cronbach's  $\alpha=0.74$ ) and in our study (Cronbach's  $\alpha=0.82$ ). Adherence was assessed based on self-report using the following question: "In the last 30 days, how many days have you missed taking any of your ARV [antiretroviral] pills?" [23].

We defined SSQ-14 scores of 9 or greater as positive CMD screen [9]. Participants who reported that they "felt like committing suicide" in the past seven days (SSQ-14 item 11) screened positive for suicidal

1  
2  
3 ideation. Participants who reported that they "saw or heard things which others could not see or hear"  
4  
5 in the past seven days (SSQ-14 item 5) screened positive for perceptual symptoms. Participants who  
6  
7 indicated that they had missed taking one or more ARV pills in the last 30 days were classified as having  
8  
9 suboptimal adherence. Those reporting not having missed any ARV pills had optimal adherence. We  
10  
11 categorised age into the following groups: 18-29 years, 30-39 years, 40-49 years, 50-59 years, and 60  
12  
13 years or older.  
14  
15

16  
17 Individuals who participated in SSQ screening were eligible for this analysis. Participants who did not  
18  
19 respond to all 14 SSQ items were excluded. We calculated the prevalence of non-adherence and positive  
20  
21 screening outcomes with logit-transformed 95% confidence intervals (CI) that adjusted for intragroup  
22  
23 correlation at health facilities. We estimated adjusted prevalence ratios (aPRs) for factors associated  
24  
25 with positive screening for CMD, suicidal ideation, and perceptual symptoms using mixed-effects  
26  
27 Poisson regression models with robust standard errors [25]. Models were adjusted for sex, age, and  
28  
29 clustering of data at facility-level using a random intercept for study facilities. We used the same models  
30  
31 to calculate unadjusted and aPRs for factors associated with suboptimal adherence. Statistical analysis  
32  
33 was done using Stata (Version 16, Stata Corporation, College Station, TX, USA).  
34  
35  
36  
37

38 The study protocol was approved by the ethics committees of the Medical Research Council of  
39  
40 Zimbabwe (MRCZ), the Research Council of Zimbabwe (RCZ), and the Canton of Bern, Switzerland.

41  
42 Individuals provided verbal consent for eligibility screening and collection and analysis of screening data.  
43  
44 Research assistants referred individuals screening positive for CMD with suicidal ideation or perceptual  
45  
46 symptoms to the nurse in charge for further assessment and care. Individuals who screened positive for  
47  
48 CMD and provided written informed consent were included in the trial and were offered CMD  
49  
50 treatment as part of the FB-ART trial.  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

## Patient and Public Involvement

Patients with psychiatric morbidity were involved in ethnographic and qualitative research, which informed the development of the SSQ-14 [24]. The results of this study were shared with the provincial medical director and the district medical officer.

For peer review only

## Results

Research assistants assessed the eligibility for CMD screening of 3,707 individuals: 3,543 (95.6%) of eligible individuals participated in CMD screens. Pregnancy, residency outside of Bikita district, and age below 18 years were the most common reasons for ineligibility for screening. Out of 3,543 individuals screened for CMD, 63 (1.7%) did not respond to all SSQ-14 items and were excluded. The remaining 3,480 individuals were included in the analysis. The median age of the study population was 45 years (IQR 38–53). Three-quarters of the participants (74.9%, n=2,608) were women.

Table 1 shows the prevalence and aPRs for positive screening for CMD, suicidal ideation, and perceptual symptoms. Out of 3,480 adults, 18.8% (95% CI 14.8-23.7, n=655) screened positive for CMD, 2.7% (95% CI 1.5-4.7, n=93) reported suicidal ideation, and 1.5% (95% CI 0.9-2.6, n=52) reported perceptual symptoms. Positive CMD screens were more common in women (21.0%; aPR 1.67, 95% CI 1.19-2.35) than in men (12.4%) and were more common in adults aged 40-49 years (20.6%; aPR 1.47 95% CI 1.16-1.85) or aged 50-59 years (20.3%; aPR 1.51 95% CI 1.05-2.17) than in those 60 years or older (12.6%). Suicidal ideations were more common in adults 18-29 years (4.7%, 95% CI 0.2-9.2) and in adults aged 30-39 years (4.0%, 95% CI 1.1-7.0) than in older adults, but the statistical uncertainty around these estimates was large.

Out of 3,469 individuals who responded to the adherence question (11, 0.32% did not respond), 2,900 (83.6% 95% CI 80.0-87.2) reported optimal adherence and 569 (16.4% 95% CI 12.8-20.0) reported suboptimal adherence. Suboptimal adherence was more common in individuals screening positive for CMD (aPR 1.53 95% CI 1.37-1.70) than in those screening negative (Table 2). Suboptimal adherence was also more common in men (aPR 1.25 95% CI 1.01-1.53) than in women and adults aged 18-29 years (aPR 1.62 95% CI 1.10-2.38) than in those 60 years or older (Table 2).



1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

For peer review only

## Discussion

In a rural district of Zimbabwe, about one in five HIV positive adult screened positive for CMD, almost 3% reported suicidal ideation, and 1.5% perceptual symptoms compatible with psychosis. Positive CMD screens were more common in women and middle-aged adults than in men or older adults. Positive CMD screens were associated with suboptimal self-reported ART adherence.

Our results have to be considered in light of two limitations. First, we used a locally developed CMD screening tool that had been validated in urban Zimbabwe, but we did not validate the tool for the rural setting and selected the CMD threshold based on the urban validation study [9]. Second, we used a self-reported adherence measure which might be prone to underreporting of non-adherence. However, there is evidence for the validity of self-reported measures of ART adherence [26]. The strengths of our study include a large sample size and a multicentre design.

In line with the national [10] and international literature [27,28], we found that CMDs were much more common in women than in men. Biological factors, including sex hormones and sex differences in the neuroendocrine response to stress, psychosocial factors such as gender differences in interpersonal orientation, self-esteem, body shaming, and rumination might contribute to the gender gap in CMD [7,8]. In addition to these individual-level factors, gender inequity and higher exposure of women and girls to traumatising life events, including gender-based violence or sexual abuse, may further contribute to the gender gap in CMD [7,10,29].

The prevalence of positive CMD screens observed in our study of a rural HIV positive population was less than a third of the prevalence observed in a study of a similar urban population conducted in Harare in 2013 [9,10]. An important factor that likely contributed to the lower prevalence of CMD in our study compared to earlier studies is the change of national ART guidelines to treat people living with HIV at

1  
2  
3 less advanced stages of HIV disease. In the last decade, the CD4 threshold for ART eligibility was  
4  
5 successively raised from <250 cells/ $\mu$ L to immediate ART initiation of all people living with HIV under  
6  
7 WHO's "treat all" guidelines. These changes were reflected in an increase in the median CD4 at ART  
8  
9 initiation in low- and middle-income [30,31]. Low CD4 cell count is associated with a higher risk of CMD  
10  
11 [32], and the comparably low prevalence of CMD observed in our study might reflect the higher median  
12  
13 CD4 cell count at ART initiation. The gap in CMD prevalence between the urban and the rural setting  
14  
15 might also be explained by a high prevalence of adverse living condition in the urban areas: 42% of the  
16  
17 HIV positive individuals included in the urban study were unemployed, and 92% reported that they  
18  
19 experienced a negative life event (e.g., death in the family, physical or sexual assault, forced eviction,  
20  
21 HIV diagnosis, or hospitalisation of the participant or an immediate family member) in the six months  
22  
23 before data collection [9,10]. Furthermore, cultural differences in symptoms presentation between  
24  
25 urban and rural populations might explain differences in the prevalence between the two settings [33].  
26  
27  
28  
29  
30 Our results confirm earlier data on associations between symptoms of depression and anxiety disorders  
31  
32 and suboptimal adherence to ART [12,15]. A meta-analysis of eight studies from low-income countries  
33  
34 found that the odds of suboptimal adherence were 92% higher in patients with depressive symptoms  
35  
36 than those without depressive symptoms (odds ratio 1.92 95% CI 1.47-2.5) [15]. Another meta-analysis  
37  
38 of 11 studies from low- and middle-income countries showed that anxiety disorders were associated  
39  
40 with a substantial increase in the odds of suboptimal adherence (odds ratio 1.59, 95% CI 1.29–1.96) [12].  
41  
42  
43  
44 The strength of the association observed in our study was consistent with these meta-analyses.  
45  
46

47  
48 Our findings show a substantial burden of CMD among people living with HIV in rural Zimbabwe and  
49  
50 underline the need to integrate interventions for detecting and addressing CMD in this population. The  
51  
52 Friendship Bench project is an evidence-based psychological intervention for delivering mental health  
53  
54 care in primary care [21]. The intervention has been rigorously evaluated in a large cluster randomised  
55  
56 controlled trial in Harare, which showed that the Friendship Bench intervention substantially improved  
57  
58  
59  
60

1  
2  
3 CMD symptoms [21]. As part of the FB-ART trial, we have implemented the FB intervention at the 8  
4  
5 intervention sites participating in the FB-ART trial, and will further roll out to the 8 control sites to  
6  
7 provide access to evidence-based mental health services for people attending these clinics.  
8  
9

10 Treatment of mental disorders among people living with HIV may also positively affect HIV treatment  
11  
12 outcomes [17,18]. A meta-analysis of 29 observational studies and randomised trials showed that  
13  
14 depression and psychological distress treatment enhances ART adherence [18]. A further meta-analysis  
15  
16 of three randomised controlled trials provides weak evidence for the benefit of cognitive behavioral  
17  
18 therapy for depression and adherence on viral load suppression [17,34–36]. Despite these promising  
19  
20 results, the evidence for the benefit of mental health care for improving HIV treatment outcomes is still  
21  
22 limited.  
23  
24

25  
26 Further work is needed to evaluate the effect of mental health care on the mental health of people  
27  
28 living with HIV and HIV treatment outcomes. We are currently evaluating the effect of the Friendship  
29  
30 Bench intervention on ART adherence, viral load suppression and symptoms of CMD among people  
31  
32 living with HIV in rural Zimbabwe. There is also a need for continued routine program monitoring and  
33  
34 implementation science to ensure the quality and effectiveness of the Friendship Bench intervention in  
35  
36 various settings.  
37  
38  
39

40  
41 In conclusion, our findings show a substantial burden of CMD among people living with HIV in rural  
42  
43 Zimbabwe and underline the need to integrate mental health services in HIV treatment programs.  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

## Funding

The study was supported by the National Cancer Institute (NCI), the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD), the National Institute of Allergy and Infectious Diseases (NIAID), the National Institute of Mental Health (NIMH), the National Institute on Drug Abuse (NIDA), the National Heart, Lung, and Blood Institute (NHLBI), the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), and the Fogarty International Center (FIC) through the International epidemiology Databases to Evaluate AIDS (IeDEA) (ME, grant number 5U01-AI069924-05) and the Swiss National Science Foundation (SNSF) (ME, grant number 189498 and AH, grant number P2BEP3\_178602). The funders had no role in study design, data collection and analysis, decision to publish or preparation of the manuscript.

## Competing interest

None

## Ethical considerations

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008. The study protocol was approved by the ethics committees of the Medical Research Council of Zimbabwe (MRCZ) (approval number MRCZ/A/2287), the Research Council of Zimbabwe (RCZ), and the Canton of Bern, Switzerland (approval number 2018-00396). Individuals provided verbal consent for eligibility screening and collection and analysis of screening data. Eligible participants provided written informed consent to participate in the randomised controlled trial.

## Authors' contributions

ME obtained funding for the study. AH, JvD, ME, CK, DC, SH and AL wrote the study protocol. JM and RM assisted with fieldwork and data collection which was overseen by CK and JvD. SH and AH did central data monitoring. AH conducted statistical analysis. AL advised on statistical analysis. AH drafted the initial manuscript. CK, SH, JM, JvD, RM, RV, AL, PvG, EM, MH, DC, and ME provided substantive edits to the manuscript. All authors contributed to interpretation of the results and have read and approved the final manuscript.

## Availability of data

Data cannot be made available online because of legal and ethical restrictions. To request data, readers may contact IeDEA for consideration by filling out the online form available at <https://www.iedea-sa.org/contact-us/>

## References

1. Joint United Nations Programme on HIV/AIDS (UNAIDS). AIDSInfo online database [Internet]. [cited 2020 Dec 13]. Available from: <http://www.aidsinfoonline.org/>
2. Johnson LF, Mossong J, Dorrington RE, Schomaker M, Hoffmann CJ, Keiser O, et al. Life expectancies of South African adults starting antiretroviral treatment: collaborative analysis of cohort studies. *PLoS Med*. 2013 Jan;10(4):e1001418.
3. Haas AD, Zaniewski E, Anderegg N, Ford N, Fox MP, Vinikoor M, et al. Retention and mortality on antiretroviral therapy in sub-Saharan Africa: collaborative analyses of HIV treatment programmes. *J Int AIDS Soc*. 2018 Feb;21(2):e25084.
4. Ford N, Darder M, Spelman T, Maclean E, Mills E, Boule A. Early Adherence to Antiretroviral Medication as a Predictor of Long-Term HIV Virological Suppression: Five-Year Follow Up of an Observational Cohort. Ndhlovu LC, editor. *PLoS One*. 2010 May 5;5(5):e10460.
5. Lofgren SM, Bond DJ, Nakasujja N, Boulware DR. Burden of Depression in Outpatient HIV-Infected adults in Sub-Saharan Africa; Systematic Review and Meta-analysis. *AIDS Behav*. 2020 Jun 13;24(6):1752–64.
6. Brandt C, Zvolensky MJ, Woods SP, Gonzalez A, Safren SA, O’Cleirigh CM. Anxiety symptoms and disorders among adults living with HIV and AIDS: A critical review and integrative synthesis of the empirical literature. *Clin Psychol Rev*. 2017 Feb;51:164–84.
7. Kuehner C. Why is depression more common among women than among men? *The Lancet Psychiatry*. 2017 Feb;4(2):146–58.
8. Li SH, Graham BM. Why are women so vulnerable to anxiety, trauma-related and stress-related disorders? The potential role of sex hormones. *The Lancet Psychiatry*. 2017 Jan;4(1):73–82.
9. Chibanda D, Verhey R, Gibson LJ, Munetsi E, Machando D, Rusakaniko S, et al. Validation of screening tools for depression and anxiety disorders in a primary care population with high HIV prevalence in Zimbabwe. *J Affect Disord*. 2016;198:50–5.
10. Chibanda D, Cowan F, Gibson L, Weiss HA, Lund C. Prevalence and correlates of probable common mental disorders in a population with high prevalence of HIV in Zimbabwe. *BMC Psychiatry*. 2016;16(1):55.
11. Haas AD, Radin E, Hakim AJ, Jahn A, Philip NM, Jonnalagadda S, et al. Prevalence of nonsuppressed viral load and associated factors among HIV-positive adults receiving antiretroviral therapy in Eswatini, Lesotho, Malawi, Zambia and Zimbabwe (2015 to 2017): results from population-based nationally representative surveys. *J Int AIDS Soc*. 2020 Nov 22;23(11).
12. Wykowski J, Kemp CG, Velloza J, Rao D, Drain PK. Associations Between Anxiety and Adherence to Antiretroviral Medications in Low- and Middle-Income Countries: A Systematic Review and Meta-analysis. *AIDS Behav*. 2019 Aug 18;23(8):2059–71.
13. Haas AD, Technau K-G, Pahad S, Braithwaite K, Madzivhandila M, Sorour G, et al. Mental health, substance use and viral suppression in adolescents receiving ART at a paediatric HIV clinic in South Africa. *J Int AIDS Soc*. 2020 Dec 7;23(12):e25644.

14. Haas AD, Ruffieux Y, Heuvel LL Van Den, Lund C, Boulle A, Euvrard J, et al. Excess mortality associated with mental illness in people living with HIV in Cape Town, South Africa: a cohort study using linked electronic health records. *Lancet Glob Heal*. 2020;8(10):e1326–34.
15. Uthman OA, Magidson JF, Safren SA, Nachega JB, Group IH, Service M, et al. Depression and adherence to antiretroviral therapy in low-, middle- and high-income countries: a systematic review and meta-analysis. *Curr HIV/AIDS Rep*. 2014 Sep;11(3):291–307.
16. Meffert SM, Neylan TC, McCulloch CE, Maganga L, Adamu Y, Kiweewa F, et al. East African HIV care: depression and HIV outcomes. *Glob Ment Heal*. 2019 May 31;6:e9.
17. Shi Y, Zhao M, Chen S, Wang S, Li H, Ying J, et al. Effects of cognitive behavioral therapy on people living with HIV and depression: A systematic review and meta-analysis. *Psychol Health Med*. 2019 May 28;24(5):578–94.
18. Sin NL, DiMatteo MR. Depression Treatment Enhances Adherence to Antiretroviral Therapy: a Meta-Analysis. *Ann Behav Med*. 2014 Jun 14;47(3):259–69.
19. Ruffieux Y, Efthimious O, van den Heuvel LL, Joska JA, Cornell M, Seedata S, et al. The treatment gap for mental disorders in adults enrolled in HIV treatment programs in South Africa: A cohort study using linked electronic health records. *Epidemiol Psychiatr Sci*. 2021;DOI:10.1017/S2045796021000196.
20. Sikkema KJ, Dennis AC, Watt MH, Choi KW, Yemeke TT, Joska JA. Improving mental health among people living with HIV: a review of intervention trials in low- and middle-income countries. *Glob Ment Heal (Cambridge, England)*. 2015;2(1 Supplement):1–26.
21. Chibanda D, Weiss HA, Verhey R, Simms V, Munjoma R, Rusakaniko S, et al. Effect of a Primary Care–Based Psychological Intervention on Symptoms of Common Mental Disorders in Zimbabwe. *Jama*. 2016 Dec 27;316(24):2618.
22. Chibanda D. Reducing the treatment gap for mental, neurological and substance use disorders in Africa: lessons from the Friendship Bench in Zimbabwe. *Epidemiol Psychiatr Sci*. 2017;26(4):342–7.
23. AIS. AIDS Indicator Survey (AIS) [Internet]. 2017 [cited 2021 Jan 21]. Available from: <https://dhsprogram.com/What-We-Do/Survey-Types/AIS.cfm>
24. Patel V, Simunyu E, Gwanzura F, Lewis G, Mann A. The Shona Symptom Questionnaire: the development of an indigenous measure of common mental disorders in Harare. *Acta Psychiatr Scand*. 1997 Jun;95(6):469–75.
25. Cummings P. Methods for Estimating Adjusted Risk Ratios. *Stata J Promot Commun Stat Stata*. 2009 Aug 1;9(2):175–96.
26. Simoni JM, Kurth AE, Pearson CR, Pantalone DW, Merrill JO, Frick PA. Self-Report Measures of Antiretroviral Therapy Adherence: A Review with Recommendations for HIV Research and Clinical Management. *AIDS Behav*. 2006 May 3;10(3):227–45.
27. Seedat S, Scott KM, Angermeyer MC, Berglund P, Bromet EJ, Brugha TS, et al. Cross-National Associations Between Gender and Mental Disorders in the World Health Organization World Mental Health Surveys. *Arch Gen Psychiatry*. 2009 Jul 1;66(7):785.

- 1
- 2
- 3
- 4 28. Kuehner C. Gender differences in unipolar depression: an update of epidemiological findings and
- 5 possible explanations. *Acta Psychiatr Scand*. 2003 Sep;108(3):163–74.
- 6
- 7 29. Oram S, Khalifeh H, Howard LM. Violence against women and mental health. *The Lancet*
- 8 *Psychiatry*. 2017 Feb;4(2):159–70.
- 9
- 10 30. World Health Organization. Consolidated guidelines on the use of antiretroviral drugs for treating
- 11 and preventing HIV infection Recommendations for a public health approach - Second edition.
- 12 Geneva: World Health Organization; 2016.
- 13
- 14 31. The IeDEA and COHERE Cohort Collaborations. Global Trends in CD4 Cell Count at the Start of
- 15 Antiretroviral Therapy: Collaborative Study of Treatment Programs. *Clin Infect Dis*. 2018 Mar
- 16 5;66(6):893–903.
- 17
- 18 32. Ngum PA, Fon PN, Ngu RC, Verla VS, Luma HN. Depression Among HIV/AIDS Patients on Highly
- 19 Active Antiretroviral Therapy in the Southwest Regional Hospitals of Cameroon: A Cross-Sectional
- 20 Study. *Neurol Ther*. 2017 Jun 18;6(1):103–14.
- 21
- 22 33. Office of the Surgeon General (US) Center for Mental Health Services (US); National Institute of
- 23 Mental Health (US). *Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health:*
- 24 *A Report of the Surgeon General*. Rockville, MD; 2001.
- 25
- 26 34. Safren SA, Bedoya CA, O’Cleirigh C, Biello KB, Pinkston MM, Stein MD, et al. Cognitive
- 27 behavioural therapy for adherence and depression in patients with HIV: a three-arm randomised
- 28 controlled trial. *Lancet HIV*. 2016;3(11):e529–38.
- 29
- 30 35. Safren SA, O’Cleirigh CM, Bullis JR, Otto MW, Stein MD, Pollack MH. Cognitive behavioral therapy
- 31 for adherence and depression (CBT-AD) in HIV-infected injection drug users: A randomized
- 32 controlled trial. *J Consult Clin Psychol*. 2012;80(3):404–15.
- 33
- 34 36. Brown LK, Kennard BD, Emslie GJ, Mayes TL, Whiteley LB, Bethel J, et al. Effective Treatment of
- 35 Depressive Disorders in Medical Clinics for Adolescents and Young Adults Living With HIV. *JAIDS J*
- 36 *Acquir Immune Defic Syndr*. 2016 Jan 1;71(1):38–46.
- 37
- 38
- 39
- 40
- 41
- 42
- 43
- 44
- 45
- 46
- 47
- 48
- 49
- 50
- 51
- 52
- 53
- 54
- 55
- 56
- 57
- 58
- 59
- 60



**Table 1: Prevalence of symptoms of common mental disorders, suicidal ideation, and perceptual disorders among people living with HIV in rural Zimbabwe.**

Positive screens										
Common mental disorders <sup>a</sup>										
Suicidal ideation <sup>b</sup>										
Perceptual symptoms <sup>c</sup>										
	Total screened		Prevalence <sup>d</sup> (95% CI)	Adjusted prevalence ratio <sup>e</sup> (95% CI)	N	Prevalence <sup>d</sup> (95% CI)	Adjusted prevalence ratio <sup>e</sup> (95% CI)	N	Prevalence <sup>d</sup> (95% CI)	Adjusted prevalence ratio <sup>e</sup> (95% CI)
	N	N								
	3,480	655	18.8% (14.8-23.7)		93	2.7% (1.5-4.7)		52	1.5% (0.9-2.6)	
Sex										
Female	2,654	547	21.0% (16.5-26.2)	1.67 (1.19-2.35)	78	3.0% (1.2-4.7)	1.47 (0.71-3.03)	43	1.6% (0.7-2.6)	1.47 (0.73-2.96)
Male	886	108	12.4 (6.9-17.9)	1.00	15	1.7% (0.2-3.3)	1.00	9	1.0% (0.1-2.0)	1.00
Age in years										
18-29	280	49	17.8% (10.3-25.3)	1.19 (0.74-1.92)	13	4.7% (0.2-9.2)	2.21 (0.86-5.66)	4	1.5% (0.0-2.9)	2.47 (0.69-8.78)
30-39	761	138	18.5% (13.6-23.4)	1.28 (0.88-1.87)	30	4.0% (1.1-7.0)	1.65 (0.73-3.71)	12	1.6% (0.0-3.3)	2.54 (0.44-14.57)
40-49	1,292	262	20.6% (14.9-26.3)	1.47 (1.16-1.85)	28	2.2% (0.6-3.8)	0.87 (0.51-1.49)	23	1.8% (0.5-3.2)	2.73 (0.87-8.54)
50-59	746	149	20.3% (15.2-25.5)	1.51 (1.05-2.17)	12	1.6% (0.6-2.7)	0.73 (0.43-1.24)	10	1.4% (0.4-2.4)	2.13 (0.63-7.20)
60+	461	57	12.6% (6.9-18.3)	1.00	10	2.2% (0.7-3.7)	1.00	3	0.7% (0.0-1.4)	1.00

Data are numbers of individuals, the prevalence of positive screens, and adjusted prevalence ratios. 95% confidence intervals are shown in parenthesis.

<sup>a</sup> Shona Symptoms Questionnaire (SSQ-14) scores of 9 or greater

<sup>b</sup> Yes to item 11 on the SSQ-14: "At times I felt like committing suicide."

<sup>c</sup> Yes to item 5 on the SSQ-14: "I sometimes saw or heard things which others could not see or hear."

<sup>d</sup> Prevalence of positive screening tests and logit-transformed confidence intervals adjusted for intragroup correlation at health facilities.

<sup>e</sup> Models adjusted for sex, age, and clustering of participants in facilities.

Abbreviations: aPR=adjusted prevalence ratio; CI=confidence interval; SSQ-14= Shona Symptoms Questionnaire.

**Table 2: Prevalence ratios for factors associated with suboptimal adherences among people living with HIV in rural Zimbabwe.**

	Unadjusted prevalence ratio (95% CI) <sup>c</sup>	Adjusted prevalence ratio <sup>d</sup> (95% CI)
CMD screening		
Negative <sup>a</sup>	1.00	1.00
Positive <sup>b</sup>	1.46 (1.29-1.66)	1.53 (1.37-1.70)
Sex		
Female	1.00	1.00
Male	1.17 (0.96-1.44)	1.25 (1.01-1.53)
Age in years		
18-29	1.60 (1.10-2.31)	1.62 (1.10-2.38)
30-39	1.29 (0.90-1.85)	1.31 (0.91-1.89)
40-49	1.00 (0.72-1.38)	0.99 (0.71-1.38)
50-59	1.04 (0.72-1.51)	1.03 (0.71-1.49)
60+	1.00	1.00

Data are unadjusted and adjusted prevalence ratios. 95% confidence intervals are shown in parenthesis.

<sup>a</sup> Shona Symptoms Questionnaire (SSQ-14) scores of smaller than 9.

<sup>b</sup> Shona Symptoms Questionnaire (SSQ-14) scores of 9 or greater.

<sup>c</sup> Models adjusted for clustering of participants in facilities.

<sup>d</sup> Models adjusted for CMD screening, sex, age, and clustering of participants in facilities.

Abbreviations: CI=confidence interval; CMD, common mental disorders ; SSQ-14= Shona Symptoms Questionnaire.

# Reporting checklist for cross sectional study.

Based on the STROBE cross sectional guidelines.

## Instructions to authors

Complete this checklist by entering the page numbers from your manuscript where readers will find each of the items listed below.

Your article may not currently address all the items on the checklist. Please modify your text to include the missing information. If you are certain that an item does not apply, please write "n/a" and provide a short explanation.

Upload your completed checklist as an extra file when you submit to a journal.

In your methods section, say that you used the STROBE cross sectional reporting guidelines, and cite them as:

von Elm E, Altman DG, Egger M, Pocock SJ, Gotsche PC, Vandenbroucke JP. The Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) Statement: guidelines for reporting observational studies.

	Reporting Item	Page Number
<b>Title and abstract</b>		
Title	<a href="#">#1a</a> Indicate the study's design with a commonly used term in the title or the abstract	1
Abstract	<a href="#">#1b</a> Provide in the abstract an informative and	2

1 balanced summary of what was done and what  
2  
3 was found  
4  
5

## 6 Introduction

7  
8  
9 Background / [#2](#) Explain the scientific background and rationale for 4-5  
10  
11 rationale the investigation being reported  
12  
13

14 Objectives [#3](#) State specific objectives, including any 5  
15  
16 prespecified hypotheses  
17  
18

## 19 Methods

20  
21  
22  
23 Study design [#4](#) Present key elements of study design early in the 6  
24  
25 paper  
26  
27

28 Setting [#5](#) Describe the setting, locations, and relevant 6  
29  
30 dates, including periods of recruitment, exposure,  
31  
32 follow-up, and data collection  
33  
34

35  
36 Eligibility criteria [#6a](#) Give the eligibility criteria, and the sources and 6  
37  
38 methods of selection of participants.  
39  
40

41 [#7](#) Clearly define all outcomes, exposures, 6-7  
42  
43 predictors, potential confounders, and effect  
44  
45 modifiers. Give diagnostic criteria, if applicable  
46  
47

48  
49 Data sources / [#8](#) For each variable of interest give sources of data 6-7  
50  
51 measurement and details of methods of assessment  
52  
53 (measurement). Describe comparability of  
54  
55 assessment methods if there is more than one  
56  
57 group. Give information separately for for  
58  
59

exposed and unexposed groups if applicable.

1			
2			
3			
4	Bias	<a href="#">#9</a>	Describe any efforts to address potential sources
5			
6			of bias
7			
8			
9	Study size	<a href="#">#10</a>	Explain how the study size was arrived at
10			
11			
12	Quantitative	<a href="#">#11</a>	Explain how quantitative variables were handled
13			
14	variables		in the analyses. If applicable, describe which
15			groupings were chosen, and why
16			
17			
18			
19	Statistical	<a href="#">#12a</a>	Describe all statistical methods, including those
20			
21	methods		used to control for confounding
22			
23			
24			
25	Statistical	<a href="#">#12b</a>	Describe any methods used to examine
26			
27	methods		subgroups and interactions
28			
29			
30	Statistical	<a href="#">#12c</a>	Explain how missing data were addressed
31			
32	methods		
33			
34			
35			
36	Statistical	<a href="#">#12d</a>	If applicable, describe analytical methods taking
37			
38	methods		account of sampling strategy
39			
40			
41	Statistical	<a href="#">#12e</a>	Describe any sensitivity analyses
42			
43	methods		
44			
45			
46	<b>Results</b>		
47			
48			
49	Participants	<a href="#">#13a</a>	Report numbers of individuals at each stage of
50			
51			study—eg numbers potentially eligible, examined
52			
53			for eligibility, confirmed eligible, included in the
54			
55			study, completing follow-up, and analysed. Give
56			
57			
58			
59			
60			

1		information separately for for exposed and	
2			
3		unexposed groups if applicable.	
4			
5			
6	Participants	<a href="#">#13b</a> Give reasons for non-participation at each stage	9
7			
8			
9	Participants	<a href="#">#13c</a> Consider use of a flow diagram	NA
10			
11			
12	Descriptive data	<a href="#">#14a</a> Give characteristics of study participants (eg	9
13		demographic, clinical, social) and information on	
14		exposures and potential confounders. Give	
15		information separately for exposed and	
16		unexposed groups if applicable.	
17			
18			
19			
20			
21			
22			
23			
24	Descriptive data	<a href="#">#14b</a> Indicate number of participants with missing data	NA
25		for each variable of interest	
26			
27			
28			
29	Outcome data	<a href="#">#15</a> Report numbers of outcome events or summary	17
30		measures. Give information separately for	
31		exposed and unexposed groups if applicable.	
32			
33			
34			
35			
36			
37	Main results	<a href="#">#16a</a> Give unadjusted estimates and, if applicable,	No unadjusted
38		confounder-adjusted estimates and their precision	prevalence ratios for
39		(eg, 95% confidence interval). Make clear which	CMD, suicidal ideation
40		confounders were adjusted for and why they were	and perceptual
41		included	symptoms were
42			reported
43			
44			
45			
46			
47			
48			
49			
50			
51	Main results	<a href="#">#16b</a> Report category boundaries when continuous	6-7
52		variables were categorized	
53			
54			
55			
56			
57	Main results	<a href="#">#16c</a> If relevant, consider translating estimates of	NA
58			
59			
60			

1		relative risk into absolute risk for a meaningful	
2			
3		time period	
4			
5			
6	Other analyses	<a href="#">#17</a> Report other analyses done—e.g., analyses of	NA
7			
8		subgroups and interactions, and sensitivity	
9			
10		analyses	
11			
12			
13	<b>Discussion</b>		
14			
15			
16	Key results	<a href="#">#18</a> Summarise key results with reference to study	10
17		objectives	
18			
19			
20			
21			
22	Limitations	<a href="#">#19</a> Discuss limitations of the study, taking into	10
23			
24		account sources of potential bias or imprecision.	
25			
26		Discuss both direction and magnitude of any	
27			
28		potential bias.	
29			
30			
31			
32	Interpretation	<a href="#">#20</a> Give a cautious overall interpretation considering	11-12
33			
34		objectives, limitations, multiplicity of analyses,	
35			
36		results from similar studies, and other relevant	
37			
38		evidence.	
39			
40			
41			
42	Generalisability	<a href="#">#21</a> Discuss the generalisability (external validity) of	10
43			
44		the study results	
45			
46			
47	<b>Other</b>		
48			
49	<b>Information</b>		
50			
51			
52	Funding	<a href="#">#22</a> Give the source of funding and the role of the	13
53			
54		funders for the present study and, if applicable,	
55			
56		for the original study on which the present article	
57			
58			
59			
60			

1 is based

2  
3  
4 Notes:

- 5  
6
- 7 • 16a: No unadjusted prevalence ratios for CMD, suicidal ideation and perceptual symptoms were  
8 reported The STROBE checklist is distributed under the terms of the Creative Commons  
9 Attribution License CC-BY. This checklist was completed on 29. January 2021 using  
10  
11 <https://www.goodreports.org/>, a tool made by the [EQUATOR Network](#) in collaboration with  
12  
13 [Penelope.ai](#)  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60