

# Mental health experiences of youths with psychosis during the COVID-19 pandemic in Zimbabwe

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## Research Article

**Keywords:** youth, psychosis, COVID-19, lockdown, social support, case management

**Posted Date:** July 27th, 2026

**DOI:** <https://doi.org/10.21203/rs.3.rs-10305621/v1>

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**Additional Declarations:** No competing interests reported.

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# Abstract

## Background

Historically, people living with disabilities face an elevated risk in disaster situations. Youths with psychosocial disabilities were a particularly vulnerable group during the COVID-19 pandemic in Zimbabwe due to various economic, environmental and demographic factors. This study sought to explore the experiences of youths with psychosis in Zimbabwe with a view to gather lessons that can inform future crisis situations.

## Methodology

Data was generated through telephonic semi-structured qualitative interviews and included 30 youths aged 18–24 with psychosis in remission. The participants were identified through a community mental health programme. Data was transcribed and analysed using thematic analysis.

## Results

Study participants expressed a pervasive sense of anxiety and fear of contracting COVID-19 which they referred to in the local language as *kukwata covid*. This was driven by lack of knowledge about COVID-19, fear of contracting the virus, having sick family members or losing loved ones compounded by conflicting messages especially on social media which was the main source of information. The study also reflected a strong link between socio-economic factors (poverty, individual and collective restriction and income inequalities) and well-being during crisis.

## Conclusions

Our study highlights that people with psychosis were disproportionately affected due to their heightened vulnerability as witnessed during COVID-19. Their disability compounded by inadequate disaster preparedness, resources, response and recovery support means they face a higher risk of depression, relapses and hunger. It is therefore essential to initiate and sustain initiatives that empower and cushion people with psychosocial disabilities during crisis situations through inclusive and targeted mechanisms.

## Introduction

The Coronavirus Disease (COVID-19), originated in the last quarter of 2019 in the Wuhei province of China and rapidly became a public health emergency of international concern (1) (2). On 11 March 2020, the World Health Organization (WHO) declared COVID-19 an emergency and global pandemic (3). In response to the rapid spread of the pandemic, all countries introduced a raft of measures such as travel

restrictions known as lockdowns, suspension of various businesses, education and social gatherings. This was supported by social distancing, quarantine and community containment measures (4). In Zimbabwe, the first lockdown was announced on 30 March 2020, initially for twenty-one days under Statutory Instrument 83 of 2020 (5). This restricted movement for everyone except “essential service providers” (health, electricity, water/sanitation, food, and banking). These restrictions led to the abrupt closure of national borders, intercity travel and public gatherings such as churches and even funerals. Even though the initial lockdown for Zimbabwe was meant for three weeks, on 16 May, it was extended indefinitely subject to fortnightly reviews (6). These public health measures resulted in varied effects on communities (7), and particularly on people with disabilities, including psychosocial disabilities such as psychosis. Whilst the obvious risk faced and feared by most people was physical health (8), the pandemic disrupted their ability to access their regular health care such as access to medical care and rehabilitation, education, food security and support network from the immediate environment such as family and community. Statistics show that adolescents and young adults were less affected by the COVID-19 pandemic itself (contract the virus or death) yet the drastic control measures taken to contain the virus had a huge knock-on effect on them (9) (10). Social disruption and traumatic events including job losses, housing instability, family separation and loss of lives led to mental health challenges (11), while socioeconomic disparities exacerbated their challenges (12) .

Zimbabwe’s economy is largely informal, with 90% of the population engaged in self-employment activities(13). As a result, the lockdown deprived many urban dwellers of their source of livelihoods (14), particularly young people. The negative impact on a culture of togetherness marked by strong social bonds heightened anxiety and mental health challenges (15) .

It is well established that disasters and their impacts disproportionately affect persons living with disabilities compared to the general population due to various functional limitations, living in isolation and living in poverty (16). As a result, people with disabilities experience between two to four times as many fatalities (17). Literature shows that 1 in every 8 people are living with psychosocial disabilities (18) (19) and disability is highest amongst people with psychotic disorders. This has in part been attributed to their exclusion from Community Based Rehabilitation (CBR) programs that are designed to attain and maintain full physical, mental and social ability (20).

In Zimbabwe, little is known about the experiences of people with psychosocial disabilities during COVID-19 making it difficult to understand their needs and challenges in crisis situations. As part of its ongoing work and response to COVID-19, the Support Comprehensive Care and Empowerment for People with Psychosocial Disabilities study (SUCCEED Africa- Zimbabwe) undertook this study to understand the psycho-social experiences, socio-economic and community involvement of people with psychosis during the COVID-19 period with a view to inform future crisis practice and policies. The study particularly focused on youths with psychosis to build on the ongoing work being done by the Friendship Bench (21) for youth. Due to control measures instituted to contain the spread and impact of COVID-19, the feasible option to identify participants was through established databases as there was need to minimise contact. For the purposes of this study, we adopted the ICD definition of psychosis as any

psychotic illness meeting DSM-5 and ICD11 diagnostic criteria. The set of syndromes described in global diagnostic criteria (DSM 5 and ICD11) which are characterised by common symptoms and signs including hallucinations, delusions, and changes in thought processing and behaviours and social interactions.

## **Methods**

### **Study setting**

The study was conducted in Harare, the capital city of Zimbabwe. Participants were identified from high density suburbs and government primary care clinic attenders aged between 18 and 24. There are 42 primary care clinics in Harare spread across 12 districts. The clinics are divided into polyclinics (providing broad acute services, maternity care and up to 12 Lay Health Workers) and small satellite clinics (providing acute care services and home-based services supported by 4–6 Lay Health Workers).

### **Study population**

Participants were recruited through the Friendship Bench, a community mental health programme (22). The Friendship Bench is a task shifting community based mental health program offered by Lay Health Workers in Zimbabwe and involves one-on-one counselling at primary care clinics or in the community. Individuals identified as having a psychotic illness through the Friendship Bench are referred for psychiatric care which often involves administration of anti-psychotic medication. Once they are deemed stable by a clinician, they are referred to the community for continued care through the local primary health care facilities. These clients also have the option to join peer-led community-based support groups.

### **Inclusion criteria**

We recruited male and female youths aged between 18 and 24 years with a diagnosis of psychosis who were in remission according to clinic records and were receiving mental health services/support from Friendship Bench. Only those with a functional phone were asked for consent as the interviews were conducted via telephone.

### **Recruitment procedure**

We identified potential participants from Friendship Bench client data base. We searched the Friendship Bench database with the help of the program data manager, identified people with psychosis, and phoned them using the numbers provided in the database. Those who met the inclusion criteria described above were recruited in the study.

## Data collection

Data was collected through in-depth one-to-one interviews using an in-depth interview guide (see supplementary file). The interview guide was in Shona and English, however all participants preferred local Shona language. The interviews covered knowledge of COVID-19; impact of COVID-19 on daily life and COVID-19 in the wider context of People Living with Disabilities. All the interviews were audio recorded and each lasted between 30–45 minutes.

## Data analysis

The recordings of the interviews were transcribed verbatim and then translated into English by four research assistants independently. This was followed by level agreement comparison followed by discussions to resolve discrepancies. Emerging key themes were identified through thematic analysis following a deductive-inductive thematic approach to draw out data driven themes.

## Ethical considerations

The study was approved by the Medical Research Council of Zimbabwe, approval number MRCZ/2130. Verbal consent was sought over the phone using approved MRCZ procedures for carrying out research with minimal physical contact. Confidentiality was assured based on the MRCZ protocol before permission to record each interview was sought from participants.

## Results

Thirty youths aged between 18 and 24 (mean age 19) met study inclusion criteria and gave consent from a sampling frame of 54 youths. 20 potential participants were not reachable to give consent, while 4 participants were disoriented and unable to comprehend the study. Of those who consented twenty of them were females. All participants had high school education with fourteen (nine female and five male) attending tertiary level education. Eight participants were self-employed whilst the other twenty-two were unemployed. Five females were cohabiting with partners while the remaining twenty-five were residing with parents or guardians.

We grouped our findings into four key themes based on our final analysis of the transcripts as: 1) Awareness and knowledge about COVID-19; 2) Wellbeing and health during the pandemic, 3) Livelihood 4) community participation (social, family, education, work). A cross-cutting theme which was reflected through key themes was fear of catching COVID-19 which was locally described as *kukwata covid*. We developed a framework reflecting the themes underpinning the concept of *kukwata covid* (Fig. 1).

### Awareness and knowledge about COVID-19

Most participants (n = 26) said their first encounter with information about COVID-19 was via the radio, television, and social media, while a few (n = 4) said they first heard about it from their family members.

Social media was by far the most frequent source of information and all participants noted that social media largely negatively affected them. Twenty-eight participants were troubled the first time they heard about COVID-19 on social media, because it was something new, and they had seen pictures and videos of people falling sick and dying after being infected. The most common thread running through the interviews influenced by social media was that the pandemic was due to *“a virus which kills people”*. Participants believed that social media provided critical information but sometimes led to infodemic. Despite the challenges in verifying the authenticity of information shared through social media, participants noted its impact. For instance, one participant remarked *“Yes. I heard that it is a sickness that is found spreading across all countries and it is affecting all countries. It is not discriminating anyone but the elderly, disabled and poorest are the ones that are suffering the most.”* (FBZ 0611).

Study participants also demonstrated deep distress directly related to social media as it was highly difficult to regulate the circulation of information on WhatsApp and news sites including sensitive pictures and videos showing some people collapsing or dying, and overcrowded health facilities. It was difficult to verify whether the information was real. One participant noted that *“We live every day to see how people are dying every second, when we go on social media, we want to learn how to protect ourselves but the first thing you see there are people dying everywhere”* (FBZ 0597).

Participants also demonstrated an awareness of how COVID-19 spread and tried to follow steps to protect themselves and their loved ones. *“I cook my food well, make sure my utensils are clean, make sure my hands are clean, when I sneeze I make sure I am covering my mouth. I avoid visiting people and stay indoors. If I happen to go out, I make sure I am wearing a mask. Also, when it comes to social distancing, we stand spaced out.”* (FBZ 0122) Most participants noted that local news outlets such as radio and televisions helped them on this note even though they lacked consistency for some due to other factors such as power outages as Zimbabwe also battled power supply during the same period.

Even though participants appreciated protection measures shared and recommended by government and health bodies such as World Health Organisation (WHO), most participants bemoaned how most of them were not practical or applicable in low resource settings such as high-density suburbs in Harare. One participant noted that *“I heard that if someone falls sick, they must be separated from everyone else including using their own plates, sleep alone and have their own bathroom. Can you imagine our situation, eleven of us use one bathroom because this is what we have. So how do you do that...”* (FBZ 0412)

## **Psychosocial support**

Another major concern expressed by the study participants was the disruption of psychosocial support normally received from close support systems such as friends, relatives and community systems such as churches. In African communities such as Zimbabwe, individuals and families usually provide support in times of distress. In the face of COVID-19, such support systems were severely strained due to restrictions placed as containment measures. For instance, one needed a permit to be seen going anywhere whilst church and other social gatherings were halted. This was completely novel for everyone, and the inability to openly interact with other community members in a time of despair worsened their

plight. One participant strongly felt let down by the suspension of church gatherings as religion was her immediate pillar of strength. The participant remarked *"For some of us we do not rely on anything else except God but now we are not even allowed to gather to worship and pray. Can you tell me how do we face such a challenge, remember everyone else is also burdened so I cannot rely on another person"* (FBZ 0661).

Other participants also highlighted the abrupt disruption brought by COVID-19 on support groups they had joined and participated in for a long time as a mental health and coping mechanism. The Friendship Bench program introduces clients to support groups for ongoing support and healing and some of the study participants had been part of the support groups. Some participants highlighted that even though they were encouraged to form groups on WhatsApp it was never the same because being physically together made them feel a stronger sense of connectedness as they engaged in group activities such as sharing their stories/challenges and income generating activities. *"Yah at this moment it feels like everything is collapsing. Imagine even our support groups have stopped. We were told to use WhatsApp groups, but it does not help anymore. How do you share your feelings or emotions there, not to mention the money we used to get from projects but this is what we are dealing with right now..."* (FBZ 0519).

The study also revealed that COVID-19 resulted in direct health challenges for some participants who had other underlying chronic conditions. This was due to the travel restrictions that required one to have a pass to go anywhere including visiting health facilities. One participant expressed how COVID-19 had negatively affected her life and feared for her children as she thought she was going to die. *"It affected me because things were moving smoothly before COVID-19. I used to go where I want to when I wanted, I would also call at any time and get help from my mother, the clinic, but now I think so much as if I am going to die."* (FBZ0671) The onset of COVID-19 brought concerns about potential exclusion from healthcare and development for people with severe mental health conditions and the World Health Organisation and the research community advocated for urgent action to support them in their recovery efforts (23).

## **Livelihood and community participation**

Another major theme generated was the disruption to livelihood sources resulting in other challenges such as household food insecurity. One male said the pandemic negatively affected his father's efforts to take care of his family: *"It is difficult for him to take care of us the same way he used to because he is a barber so where he used to work as a barber was shut down. So, he does not have anywhere to get more money from. He spends most of his time looking for ways he can make more money and he fails at most times. We spend most days at home just sitting. Life is very difficult. Rent money, food and water bills all need to get paid for"* (FBZ 0619).

Most of the Zimbabwean population is supported by the informal sector engaging in activities such as vending and cross border trade. These sectors were all affected by the COVID-19 pandemic resulting in more challenges for people with psychosocial disabilities some of whom are usually dependent on their families others for their livelihood and structures for social relationships critical for recovery. One such measure that affected informal sector activities were curfews where there were time restrictions for when businesses could open and when people could be moving around. (24). *Sometimes we would go*

*and sell at the market when we were at home together with my mother. We used to sell tomatoes, now we cannot do that because of what is happening, even if you go to the market you cannot stay there until it's dark because at 3 o'clock one has to be where it's safe (home)" (FBZ 0413).*

*"I was about to start a business since I finished school and that business is now behind because of this virus. I wanted to buy clothes from outside Zimbabwe and sell them here, but it is a problem to do so due to the lockdown. Now my Emergency Travel Document (ETD) is about to expire because of it." (FBZ 0624)*

## Discussion

Both COVID-19 and the severe containment measures introduced in Zimbabwe to contain its spread had far reaching consequences among youths with psychosis. The infodemic that followed the onset of COVID-19 created increased uncertainty and anxiety amongst young people with disabilities who already faced other various challenges. As the world struggled to understand causes, spread and control measures, it took time to separate facts from myths about COVID-19. Study participants acknowledged the importance of the information they received to empower them on how they could protect themselves, for example use of masks and staying home to protect themselves. However, due to the multiple sources of information, and the absence of established information and communication protocols/communication systems governing social media there were a few misconceptions. In 2021 Zimbabwe introduced a new Information, Communication and Technology policy that sought to improve the circulation of information with due regard to the public and national interest whilst encouraging the lawful use of technology (Data Protection Act Chap. 11: 22). In view of some observations where some individuals circulated disturbing information on social media, the government must consider increased awareness campaigns on dangers of acts such as deliberate circulation of misleading information, tighten social media control measures and intensify dissemination of credible information. The information dissemination must also be stakeholder specific and include people with psychosocial disabilities such as psychosis because the onset of crisis situations often triggers mental health challenges that often go uncontrolled or unmitigated. Targeted information dissemination will assist in making sure minority groups that are sometimes overlooked receive tailored information such as how and where to continue receiving support services during crisis situations.

Our study revealed that travel restrictions that exempted "essential service" providers created mechanisms that promoted continued access to treatment and care for people with special needs such as medical care from health facilities but some of our study participants seemed uncertain about how they were to continue seeking and receiving support services as they assumed everyone was not allowed to move. This posed a serious risk for relapses and loss of gained recovery benefits, which also adds strain to family members who commit their time and resources to support the person with psychosocial disabilities.

Collaborative approaches are required in pre-disaster activities and post disaster situations to map, design and implement disability inclusive ways that do not sideline those most vulnerable. Our findings

are in line with challenges faced by people with disabilities globally particularly young people (26) (27). There are practices that promote inclusion of marginalised groups such as Community-Based Rehabilitation (CBR), a comprehensive person centred approach towards addressing a wide range of complex economic, social and clinical needs in low resource settings (28). WHO's CBR matrix covers five pillars, health, livelihoods, education, social and empowerment and is built on the 8 core principles of the Convention on the Rights of Persons with Disabilities (29). It seeks to maximise the mental and physical abilities, to access regular services and opportunities whilst becoming active members of the society.

Our study also established that COVID-19 increased the psycho-social strain upon youths with psychosis due to the ban on human movements and gatherings. Whilst the motive was noble, the consequences brought about separation of people from their usual source of social and mental support. For instance, families, support groups and churches are sources of immense support in times of distress in African communities. However, movements and physical contact increased the spread of COVID-19 making it imperative to activate restrictions on movements. Unfortunately, this left people with psychosocial disabilities cut off from their support systems such as support groups where they engaged in different activities essential for their well-being, without any established substitute mechanisms. For participants of this study, this was not only separation from peers but subjection to severe emotional strain. Even though participants bemoaned the negative impacts of social media, they also highlighted the potential impact of utilising IT platforms such as bulk SMS services and noted that they expect the Ministry of Public Service, Labour and Social Welfare to have specific and active platforms such as hotlines and disability centres in local communities to disseminate information and interact with communities. Despite the positive efforts by the ministry, the disruption to their usual care and support systems left people without adequate support and at the risk of encountering systems that do not meet their exact needs and expectations.

Another major observation from our study was the impact of COVID-19 on the livelihoods of youths with psychosis. Before COVID-19, Zimbabwe battled other challenges such as extended droughts for 2 years with negative implications for food security and agriculture related employment. Zimbabwe's Agriculture sector contributes 15–18% of Gross Domestic Product (GDP) to the economy and 23 percent to the total formal employment, and the advent of COVID-19 further weakened the sector due to the restrictions that prevented movement of produce from outside or from rural to urban areas where people rely on buying and selling produce. Even though there were gradual relaxations to enable humanitarian food distributions and opening registered formal businesses, restricted intercity movement and enforced closure of informal markets was damaging to the livelihoods for most Zimbabweans engaged in the informal sector. Difficulties in transporting produce from farms and rural areas led to spoilage and losses for farmers and in response limited supplies in urban areas meant increases in prices for people whose sources of income were severely disrupted. In line with this, our findings show that youths with psychosis were also deeply affected as these developments crippled the capacity of care givers due to food shortages and limited access to medications. Whilst we could not establish the extent in the reduction in income levels, we noted that from the eight participants who were self-employed, five reported having stopped their activities due to police presence in their areas. The other three (all

females) noted that they were working from home. Building on this, it seems as if the major factor that influenced the impact of COVID-19 was reliance on the informal sector which itself was most affected by the restrictions as this led to loss or reduction of income and loss of access to food.

## Recommendations

Based on the findings of our study, we recommend that development and disaster mitigation plans must reflect mental conditions and associated psychosocial disabilities as a priority. Direct and meaningful involvement of people living with psychosocial disabilities, their families and communities strengthen their participation realisation of their full capacity and opportunities. To this end, we recommend the utilisation of CBR initiatives. As noted, the challenges faced range from livelihoods, education, health and social structural disruptions. The WHO Mental Health Action Plan (31) places a strong emphasis on the provision of comprehensive and integrated mental health and social care with a focus on both promotion and prevention in community-based settings. The person-centred approach central to CBR will ensure that people living with psychosocial disabilities receive tailored assistance whilst fully integrating with their communities. The use of case managers who coordinate and refer service users to access a range of diverse opportunities and resources tailored to their need optimises usage of pre-existing resources through collaborations with different stakeholders, referrals. Working with community systems and resources builds their capacity to support individual recovery needs. Even though case management is not yet widely used, evidence from programs such as RISE (32) from Ethiopia suggesting that the person-centred approach using case management to coordinate access to health, social and livelihood linkages help in reducing poverty and social exclusion for people with psychosocial disabilities. On this basis, CBR serves as a model that can be used within communities to address these diverse challenges at the same time by building the capacity of NGOs, families, communities and institutions to enhance the full participation and capabilities of people with psychosocial disabilities.

## Limitations

This qualitative study cannot be generalised to other settings. The study was conducted through telephone interviews, hence those youths without cell phones or poor network were left out. Inclusion was limited to a few areas in Harare, hence it did not cover the whole country, particularly rural areas. There was a small sample size and overrepresentation of females which may have contributed to biases in the study.

## Declarations

### Ethics approval

This study was approved by the Medical Research Council of Zimbabwe in accordance with the guidelines and regulations set forth by Medical Research Council of Zimbabwe. The protocol number for this approval is MRCZ/2130.

**Availability of supporting data:** The anonymized data used during the current study are available from the corresponding author on reasonable request.

### **Consent to participate**

Informed consent to participate in the study was obtained using approved Medical Research Council of Zimbabwe procedures. Informed consent was obtained from the parents/ legally authorized representatives of subjects who are under 16.

### **Consent to publish**

Not applicable

Competing interests: The authors have no competing interests.

Funding: Funding for DC, EM, LD came through the Friendship Bench Trust. TS, VS and RK are funded by FCDO from the UK government; however, the views expressed do not necessarily reflect the UK government's official policies.

Authors' contributions: The study was designed by TS, DC, LD and EM, using an interview schedule developed by TS. The research was conducted by EM and LD under the direction of DC. The first draft was written by LD and reviewed by VS, TG, RK, NG and MB. All authors have read and approved the final draft.

Acknowledgements: Not applicable.

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## Figures

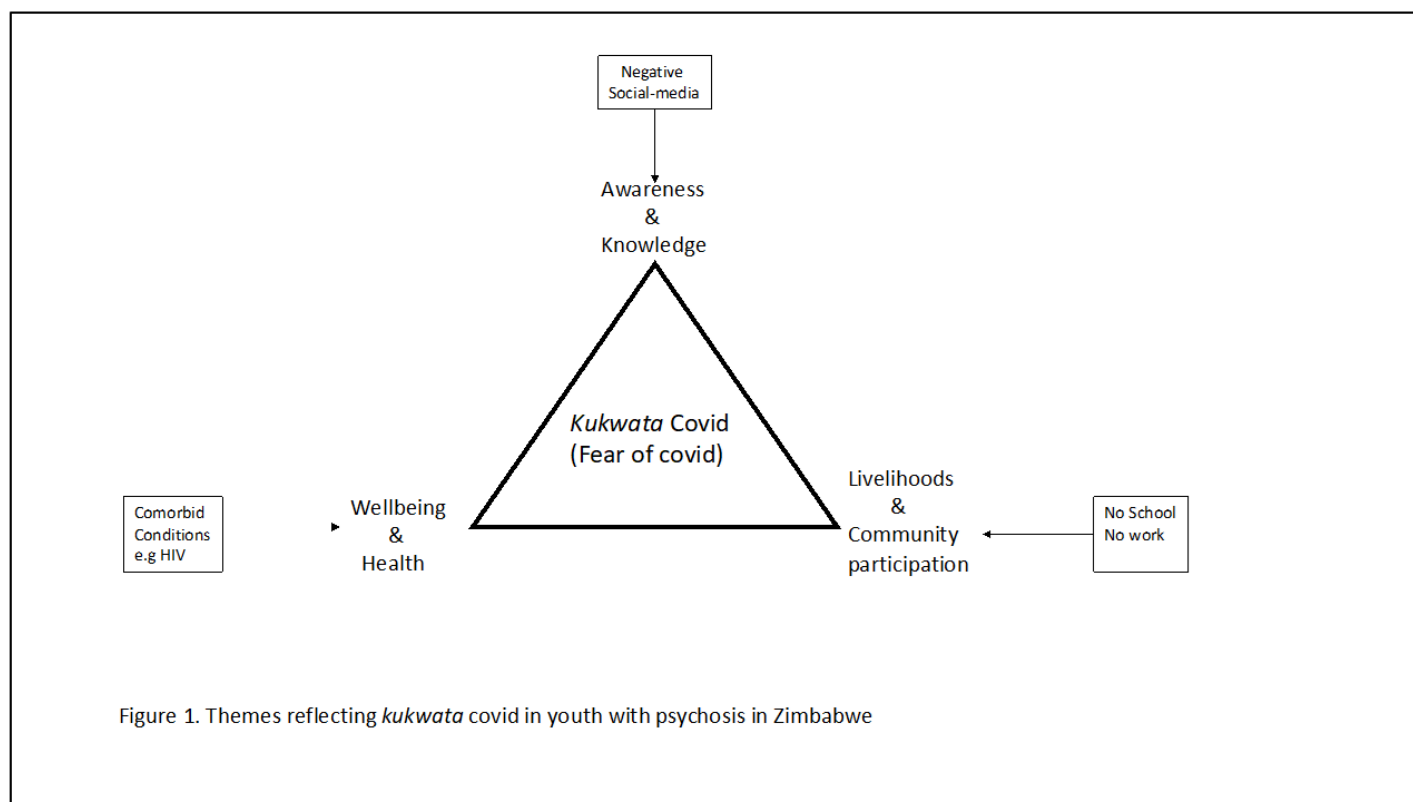


Figure 1

*Themes reflecting fear of COVID in youth with psychosis in Zimbabwe*

## Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- [COVID19InterviewguideYouthswithpsychosis.docx](#)