Feature

Integrating Mental Health and HIV Services in Zimbabwean Communities: A Nurse and Community-led Approach to Reach the Most Vulnerable

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Alcohol use and depression negatively impact adherence, retention in care, and HIV progression, and people living with HIV (PLWH) have disproportionately higher depression rates. In developing countries, more than 76% of people with mental health issues receive no treatment. We hypothesized that stepped-care mental health/HIV integration provided by multiple service professionals in Zimbabwe would be acceptable and feasible. A three-phase mixed-method design was used with a longitudinal cohort of 325 nurses, community health workers, and traditional medicine practitioners in nine communities. During Phase 3, 312 PLWH were screened by nurses for mental health symptoms; 28% were positive. Of 59 PLWH screened for harmful alcohol and substance use, 36% were positive. Community health workers and traditional medicine practitioners screened 123 PLWH; 54% were positive for mental health symptoms and 29% were positive for alcohol and substance abuse. Findings indicated that stepped-care was acceptable and feasible for all provider types.

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Globally, mental health disorders, including harmful alcohol and substance use, are the leading causes of years lost to disability, accounting for up to 189 million disability-adjusted life years annually. Depression accounts for up to 50% of disability-adjusted life years caused by mental health disorders, while alcohol and substance use accounts for up to 10% (Whiteford et al., 2013). It is estimated that people living with HIV (PLWH) are more than twice as likely to experience a mental health disorder.

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Mental health disorder estimates among PLWH range from 20% to 48% in developed countries and up to 72% in developing countries (Adewuya et al., 2007; Sittu et al., 2013).

In Zimbabwe, with an adult HIV prevalence rate of 14.7% (United Nations Children's Fund, 2013), mental health and HIV comorbidity rates are high. A recent study found that of 395 patients screening positive for a mental health problem, nearly 50% were also accessing services for an HIV-related issue (Chibanda et al., 2011). Alcohol and substance use is on the increase, which may indicate it being used as a coping mechanism to deal with stress surrounding an HIV diagnosis (Ministry of Health and Child Care Zimbabwe [MOHCC], 2012). High rates of alcohol use, depression, and anxiety in PLWH are known to influence self-care and risk-taking behaviors, exacerbating the risk of contracting other sexually transmitted infections (Brion et al., 2011; Joska, Kaliski, & Benatar, 2008; Sikkema et al., 2010). The evidence shows that PLWH who experience depression have numerous risks that impact their health. They are more likely to initiate antiretroviral therapy at lower CD4+ T cell counts and higher viral loads, have decreased adherence and retention, and delayed viral suppression leading to accelerated progression toward AIDS and AIDS-related mortality, compared to those PLWH who are not depressed (Atkinson et al., 2008; Lall, Lim, Khairuddin, & Kamarulzaman, 2015; World Health Organization [WHO], 2008). Specifically, one study found that PLWH who were depressed and had suboptimal adherence experienced a six-times greater mortality risk (Simoni et al., 2011).

Limited programmatic findings available in the literature have revealed promising results for mental health and HIV care integration in low-resource settings (Chibanda et al., 2011; Chibanda et al., 2015; Mpungu et al., 2015; Pence et al., 2014). However, a significant shortage of mental health professionals in many low-income settings contributes to a treatment gap of as much as 76% of people with mental health disorders who do not receive treatment (Adewuya et al., 2007). Research findings have indicated that among 58 low- and middle-income countries, 67% experience a shortage of psychiatrists, 95% experience a shortage of mental health nurses, and 79% experience a shortage of psychosocial workers (Bruckner et al., 2010). Findings in Zimbabwe are similar, as 50% of mental health professional positions are vacant and 90% of all psychiatric nurses work in one hospital in the capital city of Harare. As the majority of Zimbabweans visit traditional medicine practitioners prior to visiting a health facility (Pitorak, Duffy, & Sharer, 2012), they and other community-care cadres are potential resources to improve access to mental health services for PLWH (George, Chitindingu, & Gow, 2013; Van Ginneken et al., 2013).

The World Health Organization (2007) has provided guidance to address mental health service gaps in developing countries through the Optimal Mix of Mental Health Services Pyramid (Figure 1). In this model, the bulk of services that preserve and maintain the mental health of the populace are provided at the community level by strengthening the capacity of individuals, families, psychosocial service providers, and primary health care providers to address basic mental health needs. More costly specialized services are reserved for advanced mental health problems that are not alleviated by community levels of care (WHO, 2007). To decrease the mental health service gap and to effectively address mental health comorbidities in PLWH, innovative programs that effectively use multiple levels of community service providers—including nurses, community health workers, and

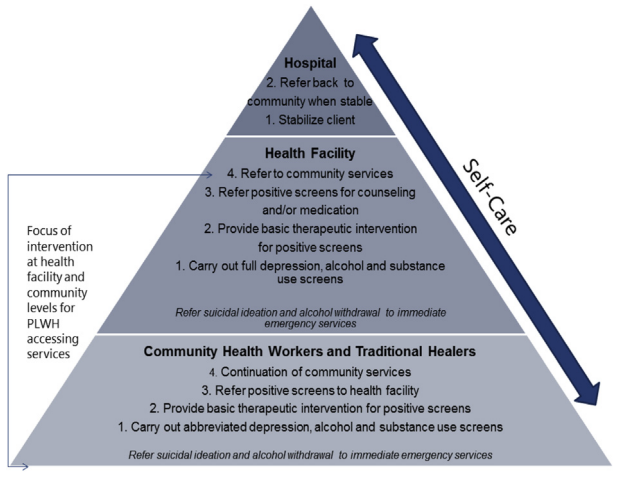

Figure 1. Integrated stepped-care model. (Adapted from World Health Organization, 2007.) PLWH = people living with HIV.