



“THERE IS NO HEALTH WITHOUT MENTAL HEALTH”

MENTAL HEALTH AND HIV SERVICE INTEGRATION IN ZIMBABWE

SITUATIONAL ANALYSIS

AIDSTAR-One
AIDS SUPPORT AND TECHNICAL ASSISTANCE RESOURCES

AUGUST 2012

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ACRONYMS

| | |
|--------|---|
| ART | antiretroviral therapy |
| HTC | HIV testing and counseling |
| MOHCW | Ministry of Health and Child Welfare |
| NECTAR | Novel Education Clinical Trainees and Researchers |
| NGO | nongovernmental organization |
| PEPFAR | U.S. President's Emergency Plan for AIDS Relief |
| PLHIV | people living with HIV |
| PMTCT | prevention of mother-to-child transmission |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| UNGASS | United Nations General Assembly Special Session |
| USAID | U.S. Agency for International Development |
| UZ-CHS | The University of Zimbabwe's College of Health Sciences |
| WHO | World Health Organization |
| ZACH | The Zimbabwe Association of Church-related Hospitals |

EXECUTIVE SUMMARY

HIV and mental illness are significant global public health concerns, including in the southern African country, Zimbabwe. A coordinated and comprehensive response, particularly between HIV treatment, care, and support services and mental health care can improve health outcomes among people living with HIV (PLHIV). The first step is screening PLHIV for mental health issues in a non-stigmatizing environment, followed by early interventions and referrals, which can result in a more holistic care and treatment model. Zimbabwe's national/government-led HIV response is strengthening following years of economic decline. Zimbabwe has developed a national mental health policy with an implementation plan, although it is not fully enacted. Thus, the public health response for mental health is underdeveloped, demonstrating that a vital need exists to build capacity in mental health services among Zimbabwean health care workers. In developing countries, including Zimbabwe, evidence suggests that PLHIV are more likely to experience depression when compared to those who are not infected (Brandt 2009; Collins et al. 2006; Sebit et al. 2003). A public health response to mental health coordinated with the national HIV response is important as approximately half of the 300,000 persons suffering from mental health disorders are HIV-positive (IRIN Global 2004). It is clear that Zimbabwe is a country where mental health and HIV co-morbidity is common. In Zimbabwe, levels of depression and anxiety were found in over 25 percent of those attending standard health care services, and thinking too much (*kufungisisa*), deep sadness (*kusuwisisa*), and painful heart (*moyo unorwadzwa*) are commonly used terms in the Shona language to indicate mental health problems (Chibanda et al. 2011; Patel et al. 1995; Patel et al. 1997). As common co-morbidities, the integration of HIV and mental health is essential to provide appropriate and long-term care and support to PLHIV. Although health care services for HIV and limitedly available mental health services currently run parallel, there is a growing concern that these services require integration to comprehensively provide holistic care for all Zimbabweans, particularly PLHIV.

In collaboration with the U.S. President's Emergency Plan for AIDS Relief Care and Support and Treatment Technical Working Groups, AIDSTAR-One is implementing a pilot activity that will integrate mental health and harmful substance use screening, counseling, and referral into HIV treatment and care sites in Zimbabwe. This country situational analysis was conducted as a first step in the pilot activity.

ZIMBABWE'S HIV RESPONSE

Zimbabwe has endured one of the worst generalized HIV epidemics (United Nations General Assembly Special Session 2010), with an HIV prevalence rate of 13.6 percent (U.S. Agency for International Development 2010). However, the national HIV response has demonstrated progress in HIV prevention efforts through behavior change programs while also emphasizing care and treatment of PLHIV. According to the World Health Organization (WHO 2011a), approximately 65 percent of eligible adults are receiving antiretroviral therapy (ART), compared to only 32 percent of eligible children. However, the Ministry of Health and Child Welfare (MOHCW) reports that a more accurate coverage is 78 percent (436,181) of adults and 41 percent (39,825) of children receiving ART at the end of 2011. Although 46 percent of pregnant, HIV-positive women received

prevention of mother-to-child transmission (PMTCT) services in 2010, ART coverage remained limited among children living with HIV, compared to the coverage of adults (WHO 2011a). Key informant interview findings indicated that HIV treatment is accessible and available, yet barriers remain, which are often associated with drug shortages, availability of the newest drugs, and a lack of training for health care providers. PMTCT programs and voluntary counseling and testing sites were described as very accessible.

Currently, the MOHCW's ART services are centralized and primarily physician led; however, a shift toward decentralization and providing ART services at MOHCW rural primary health centers is underway. HIV treatment is currently initiated at district hospitals, and within each district there are some clinics where clients are referred to management by a nurse. Various local and international organizations are involved in the HIV response, such as the Zimbabwe Association of Church-related Hospitals, and a majority of these organizations coordinate closely with the MOHCW.

ZIMBABWE'S MENTAL HEALTH RESPONSE

Mental illness, particularly depression, is a serious medical condition with a significant public health impact in Zimbabwe. Stigma surrounding the concept of mental illness is prevalent and, culturally, depression is typically expressed through somatic symptoms or by the phrase "thinking too much." Emotional symptoms may only be revealed after a health care provider directly inquires. Many may not consider that mental illness needs a medical response because it may be associated with traditional and cultural beliefs (e.g., caused by "evil spirits"). Thus, patients often seek traditional medication or healing prior to or instead of using the formal health care system (Patel et al. 2001). With the national mental health policy, Zimbabwe is promoting a better understanding of mental health while also promoting access to services. This combined approach aims to reduce associated stigma; however, marginalization still exists.

Through mental health policies and finalization of an implementation plan, it is expected that improved access to mental health services will occur. Mental health services are typically initiated with an informal basic screening and counseling at select health centers. However, these limited services are not standardized. Zimbabwe's essential medicine list includes psychiatric medicines, although stockouts are common. Screening and services for co-occurring alcohol and illicit substance use are limited; however, anecdotal data suggest their use is increasing in Zimbabwe (MOHCW 2012a). Although there is limited formal data collected about drug and alcohol use in Zimbabwe, their impact in society is substantial.

Referral mechanisms to access mental health services, which may include traditional healers, are not formalized between community care and facility-based systems, with follow-up being uncommon. Various mental health and substance use screening tools have been used in Zimbabwe; the most common instruments are the Shona Symptom Questionnaire and WHO's Alcohol, Smoking, and Substance Involvement Screening Test (Patel et al. 2001; MOHCW 2012a); however, the use of these instruments as part of routine care is limited.

Mental health professions have a 50 percent vacancy rate. Key informants identified psychiatric nurses, psychologists, clinical social workers, and psychiatrists as cadres that implement mental health services. Additionally, environmental health technicians, nurses, peer counselors, and police were mentioned. All interviewees stressed the need to increase the number of health care workers who are trained in mental health. With the role of tradition and culture of great importance in Zimbabwe, clients often seek traditional medical practitioners to meet their mental health needs. A specific Department of Traditional Medicine is embedded in the MOHCW to register traditional

medical practitioners, through the Traditional Medicine Practitioners Council (World Health Organization 2001). Efforts should continue to align traditional medical practitioners with mental health practices within the mental health department at the MOHCW. The Traditional Medicine Practitioners Council has 3,500 registered traditional medical practitioners, while estimates suggest there are significantly more practitioners that remain unregistered (Traditional Medicine Practitioners Council staff 2012).

INTEGRATING MENTAL HEALTH AND HIV

There is recognition among key stakeholders of the importance of integrating mental health and HIV services in Zimbabwe; however, actual practice remains nascent at best due to training, financial, and human resource constraints. Discussions and planning surrounding mental health and HIV integration are ongoing in Zimbabwe, resulting in a conducive environment for action. Moving forward with integration requires collaboration within the MOHCW and other partners. The limited human resources available reinforce the need for a two-prong focus: 1) building the capacity of key health and community workers to screen and provide basic care, and 2) standardizing task-shifting (i.e., training and delegating responsibilities to lower level staff to build capacity and share workloads) and follow-up referrals to appropriate health and community care providers within the context of national guidelines. Because the majority of people initially seek traditional medicine, the role of the traditional healers must be included in the collaboration. Additionally, learning from the limited existing HIV and mental health programs is important in integrating services programs for HIV and mental health. These examples provide a small evidence base which highlights that mental health and HIV integration is achievable for Zimbabwe. Steps to integrate mental health screening, basic care, and referrals into standard HIV care protocols can be made and, ultimately, aim to improve quality of life of PLHIV. Standardizing mental health screening into both HIV treatment facilities and community-based care programs in Zimbabwe will add to the evidence base and will inform programming and policy development.

RECOMMENDATIONS

Policy Recommendations:

- Coordinate HIV and mental health responses at the MOHCW to optimize services for PLHIV.
- Further align traditional medicine practitioners into the formal health system.
- Strengthen strategies for bidirectional referral systems—between community- and facility-level care for mental health and HIV—incorporating traditional medicine practitioners.
- Develop clear policies and devote resources to improve treatment and drug supplies for mental health.

Capacity Assistance and Training Recommendations:

- Strengthen and increase human resources that deliver integrated services, including task-shifting key activities to nurses, social workers, lay health workers, and community health workers.
- Incorporate guidelines for mental health and HIV integration via task shifting into national policies and in guidance documents.

- Train different cadres of health care professionals in mental health screening and basic therapeutic services to increase basic mental health services and referrals.

Practice Recommendations:

- Develop services that provide continuous and holistic care.
- Strengthen linkages and referrals between mental health and HIV services.
- Collaborate with key stakeholders in HIV and mental health. For example, MOHCW departments should strive to align programs and build partnerships with nongovernmental organizations and traditional medicine practitioners to improve linkages between HIV and mental health.
- Recognize existing opportunities, such as HIV testing and counseling sites, as potential opportunities to provide basic mental health care and referral.
- Implement education and sensitization campaigns about the intersection of HIV, mental health, and harmful substance use, particularly in rural areas, to improve awareness and understanding of mental health issues and that these are often prevalent among PLHIV.
- Incorporate screening and referral for substance use into mental health and HIV services, and strengthen programs designed specifically for the treatment and management of harmful substance use.

INTRODUCTION

In collaboration with the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) Care and Support and Treatment Technical Working Groups, AIDSTAR-One is implementing a pilot activity that will integrate mental health screening services into HIV treatment and care sites in Zimbabwe. Screening and referral for mental health early intervention services and follow-up care and treatment can improve the quality of life, treatment adherence, and retention in HIV care and support programs for people living with HIV (PLHIV) in Zimbabwe (Gutmann and Fullem 2009). Mental health screening and follow-up care and treatment are critical components of care necessary for PLHIV; these services are currently limited in Zimbabwe. This country situational analysis was conducted as a first step in the pilot activity. Next, a mental health and HIV services integration "training of trainers" workshop will be conducted with staff from nine select urban and rural clinics and four traditional medicine practitioners, selected based on input from the Ministry of Health and Child Welfare (MOHCW), the Zimbabwe Association for Church-related Hospitals (ZACH), and the Traditional Medicine Practitioners Council. As stakeholders in this activity and in Zimbabwe's health care system, the trained staff will serve as integration leaders and help ensure commitment and roll-out of the integration pilot. Participants who attend the training sessions are expected to agree to accept responsibilities as integration leaders, including training their colleagues, ensuring screening, collecting referral data, and following the mental health/HIV integration standard operation protocol, which clearly delineates roles and responsibilities. A participant manual will provide data collection materials, job aids, an emergency action template, MOHCW guidelines, supportive supervision tools, as well as the mental health screening tools themselves. Following the training and three-month pilot intervention period, AIDSTAR-One will conduct an assessment to determine the degree of integration of the tools and of the stepped-care approach into routine services.

COUNTRY SUMMARY METHODOLOGY

This report was developed based on a desk review and key informant interviews with Zimbabwean stakeholders. For the desk review, the authors reviewed both grey and published literature, using Google, Google Scholar, and PubMed search engines, focusing on documents and studies related to Zimbabwe, HIV, mental illness, substance abuse, and mental health service systems. Key search terms included "HIV prevalence in Zimbabwe," "HIV treatment coverage Zimbabwe," "health systems Zimbabwe," "mental health (disorders) Zimbabwe," "depression and Zimbabwe," "HIV and alcohol use Zimbabwe," "mental health screening tools Zimbabwe," and any references to integrated mental health services and HIV care and treatment. The authors reviewed MOHCW policy/strategy documents, in addition to a strategy focused on the private sector's involvement in Zimbabwe's HIV response. Websites of various nongovernmental organizations (NGOs), community-based organizations, faith-based organizations, and private sector groups that may be involved in HIV and/or mental health services (a majority of these were identified via key informant interviews) were also reviewed. Furthermore, seven key informant interviews with HIV and mental health stakeholders in Zimbabwe were conducted. Using a snowball approach, each interviewer was asked for other names and interviewing stopped when referrals became redundant. Three semi-structured interview protocols for targeted informants were created: 1) HIV and mental health key

informants, 2) HIV key informants only, and 3) mental health key informants only. In speaking with these experts, the authors were able to ascertain the successes and challenges associated with the care and treatment of PLHIV in the context of services for HIV infection, mental health, and integration of services through anecdotal and experiential insights. Furthermore, 10 additional key informant interviews were carried out in Zimbabwe to address gaps and to gather information where it could not be obtained from the literature and prior interviews.

COUNTRY BACKGROUND

Situated in Southern Africa, Zimbabwe has a population estimated at 12 million in 2011 (Bureau of Consular Affairs 2011; Central Intelligence Agency 2012). Although the official languages are English, Shona (which a majority of Zimbabweans speak), and Ndebele, English is the “business language” according to key informants (Bureau of Consular Affairs 2011). Zimbabwe gained its independence from British rule in 1980. From 2000 to 2009, Zimbabwe experienced an economic decline (Chitiyo and Chitiyo 2009; Médecins Sans Frontières 2009; National AIDS Council 2011b) which negatively impacted the health sector (Médecins Sans Frontières 2009; Zimbabwe Health Workforce Observatory 2009). Fortunately, Zimbabwe has experienced increased stability and efforts are underway to strengthen the health system (Zimbabwe Health Workforce Observatory 2009).

THE HIV EPIDEMIC

With an HIV prevalence of 13.6 percent (U.S. Agency for International Development 2010), Zimbabwe has experienced one of the most severe HIV epidemics in sub-Saharan Africa (United Nations General Assembly Special Session [UNGASS] 2010). Although the HIV prevalence rate remains high, the epidemic has improved in recent years. Zimbabwe is the first sub-Saharan nation to significantly sustain a decline in HIV prevalence among adults: from 29 percent in 1997 to 16 percent in 2007 (Joint United Nations Programme on HIV/AIDS [UNAIDS] 2011). The decrease in HIV prevalence has been associated with sexual partner reduction and consistent condom use (Halperin et al. 2011). Despite these strides, real risks remain with recent data showing the number of young women with multiple sexual partners has increased and condom use among young men during high risk sex has decreased (UNAIDS 2011).

ZIMBABWE'S HIV RESPONSE

POLICIES AND PROGRAMS

The Zimbabwean government and other organizations have developed various HIV strategies and policies to combat the HIV epidemic. Within Zimbabwe's MOHCW, the National AIDS and Tuberculosis Programme leads the health sector's HIV response (World Health Organization [WHO] 2005). From the start of the HIV epidemic in 1987, the national response has been guided by strategic plans that advocate a coordinated response among multiple stakeholders. Currently, the Zimbabwe National HIV and AIDS Strategic Plan II 2011 to 2015 (National AIDS Council 2011a) provides the overall strategic guidance for all HIV efforts in Zimbabwe (National AIDS Council 2011b).

Early momentum around HIV policy and planning was stymied in 2000 due to economic conditions and limited resources available to the National AIDS Council (AVERT 2011). To help procure HIV resources in 2001, Zimbabwe introduced a three percent levy for all individual taxpayers (not a corporate tax) to support the National AIDS Trust Fund run by the National AIDS Council (Ray and Kureya 2003). Specifically, all Zimbabwean corporations and citizens who earn a salary pay this tax. One key informant described the National AIDS Council as "instrumental in HIV care and programming throughout the country working closely with the MOHCW."

Private sector organizations also play a role in HIV service scaleup, but the efforts have been largely uncoordinated. Therefore, to work collectively toward national goals, the private sector developed the National Strategic Framework for the Private Sector Response to HIV and AIDS, 2007–2010. The framework helped create partnerships among organizations in their HIV responses and served as an implementation, monitoring, and evaluation guide in the workplace (Zimbabwe Ministry of Public Service, Labour and Social Welfare 2007). Although the private sector provides HIV services, findings from key informant interviews suggest that only a limited number of people access HIV services from private providers due to cost, whereas at MOHCW HIV clinics, HIV services, including antiretroviral drugs, are free of charge. Although health insurance may reduce the costs of private services, the majority of Zimbabweans are without insurance.

The MOHCW provides the majority of HIV services in Zimbabwe, from clinical care to voluntary counseling and testing, prevention of mother-to-child transmission (PMTCT), antiretroviral therapy (ART), palliative care, medical male circumcision, and prevention campaigns. The most recent national HIV strategy incorporates "comprehensive care and services" that should be provided, including counseling; however, it does not specifically incorporate mental health services. In low-income countries such as Zimbabwe, the evidence shows that targeting multiple disciplines is integral to improving mental health services for PLHIV (Mental Health Gap Action Programme 2008; Taylor 2010).

ACCESS TO HIV SERVICES

Despite a decrease in the number of HIV testing and counseling (HTC) facilities in Zimbabwe, there has been a sizable increase in the number of people over 15 years of age receiving HTC from 2009

compared to 2010 (1,142,052 to 1,612,388, respectively). Additionally, more than 90 percent of pregnant women in Zimbabwe received HTC in 2010, compared to 29 percent of pregnant women who received HTC in 2005 (WHO 2011a).

In 2002, there was a severe national antiretroviral drug shortage, in which the Zimbabwean government declared a state of emergency. Leveraging expertise from the government, NGOs, and the University of Zimbabwe, the National Emergency Taskforce on AIDS was developed to coordinate activities (Ray and Kureya 2003). Zimbabwe experienced an increase in the number of people who initiate treatment services; between 2009 and 2010 there was an approximately 50 percent increase in number of people who initiated treatment services (218,589 to 326,241, respectively). According to the WHO (2011a), approximately 65 percent of eligible adults receive ART, compared to only 32 percent of eligible children. However, the MOHCW reports that 78 percent (436,181) of adults and 41 percent (39,825) of children were receiving ART by the end of 2011. Forty-six percent of pregnant, HIV-positive women receive PMTCT services, which include ART, as needed. Key informants mentioned limited drug supply and human resource deficits as barriers to coverage. As the number of PLHIV enrolling in treatment increases, maintaining adequate stocks of antiretroviral regimens is essential to ensure adherence and to retain clients in treatment.

MINISTRY OF HEALTH AND CHILD WELFARE HIV SERVICES

Interview findings suggest that HIV treatment is available and accessible throughout Zimbabwe, with the number of PLHIV receiving HIV treatment increasing. Service improvement targets adults and, therefore, pediatric and adolescent services are lacking. PMTCT programs and voluntary counseling and testing sites are described as very accessible; HIV testing policy is “opt out” in health care facilities. The MOHCW’s NewStart facilities are HTC sites and are part of the ambitious national plan to test 100 percent of the population. NewStart facilities perform CD4 counts when an HIV test is positive, and refer individuals to psychosocial services within the community if the client does not yet require HIV medication. Clients are referred to a health care facility if their CD4 count indicates that they require immediate HIV clinical care and treatment. The MOHCW is also considering furthering their 100 percent testing strategy via mobile HTC units (MOHCW staff 2012).

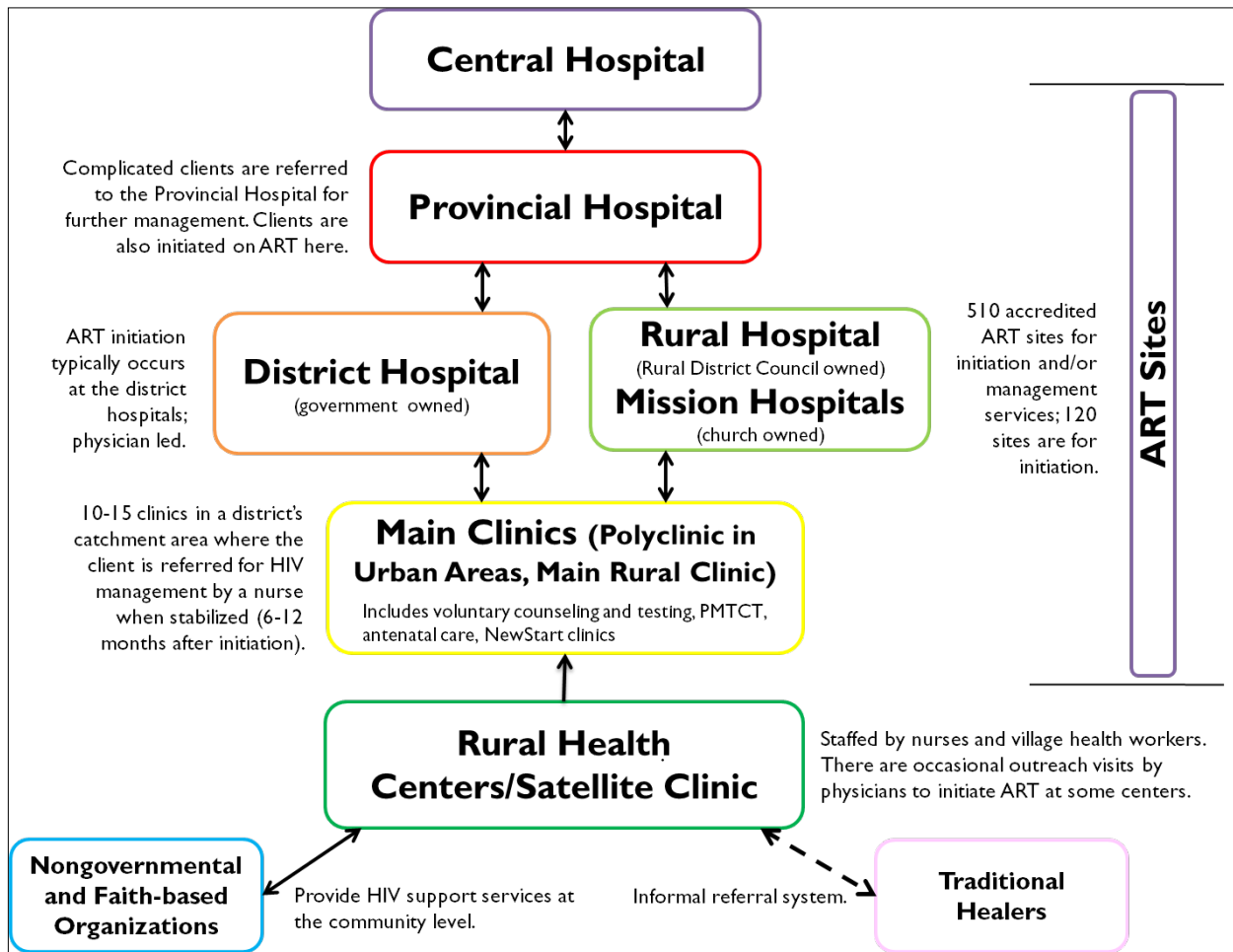
The MOHCW’s ART services are relatively centralized and physician led; however, a current effort at decentralization is occurring. The new strategy consists of physicians routinely visiting health centers within their district to initiate HIV treatment for clients in need. Currently, under the centralized structure, HIV treatment initiation typically occurs at hospitals. Within the district hospital catchment area there are 10 to 15 clinics where a client is referred for HIV management by a nurse. This referral typically occurs within 6 to 12 months after ART initiation (MOHCW staff 2012). Currently, there are 510 accredited ART sites for initiation and follow-up services (some for adults only) in Zimbabwe according to key informants. Approximately 120 of these are accredited

“Before our economic collapse, treatment was widely supported by the Ministry of Health. One of the tragedies of the economic situation is that we haven’t been able to supply our own antiretroviral drugs in the way that we used to. But, working with development partners, such as USAID and the Global Fund [to Fight AIDS, Tuberculosis and Malaria], has contributed a lot and that has helped scale up treatment services.”

–Zimbabwean Infectious Disease
Doctor 2012

initiation sites; the number of facilities that actually have the capacity to carry out quality ART services is uncertain. Additionally, many clinics may be equipped to provide HIV treatment and related services, but are not ART initiation sites. The lowest level MOHCW facilities that provide HIV treatment are rural health centers providing primary health care. The MOHCW also supports village health care workers, who are chosen by community members. Gaps in coverage still exist, particularly in more rural areas and in reaching men and adolescents for HIV services. Additionally, integration between tuberculosis and HIV services is strong in Zimbabwe and may provide a useful model when planning for mental health services and HIV care and treatment integration, and the integration of both services into the primary care model. Figure 1 displays the MOHCW's HIV service system.

Figure 1. Ministry of Health and Child Welfare HIV Services



NONGOVERNMENTAL ORGANIZATION HIV SERVICES

International and local NGOs have played a role in the HIV response in Zimbabwe. Key informant interviews suggest that most organizations work closely or coordinate with the MOHCW, so as to “complement” the MOHCW’s services. Faith-based organizations, such as ZACH, provide HIV treatment in rural areas (WHO 2005). ZACH currently provides services in 126 hospitals and clinics. Fourteen of these hospitals have been designated “district hospitals” by the MOHCW, indicating high levels of coordination between ZACH and the MOHCW. According to ZACH, their facilities provide care for 70 percent of the national population and provide 68 percent of rural health care services and 35 percent nationally. Services include prevention, peer education programs, voluntary counseling and testing, ART, PMTCT, community home-based care, and sexually transmitted infection management. ZACH is also considering various decentralization strategies, for example, advocating for nurse-led initiation of ART.

PEPFAR, through the U.S. Agency for International Development, supports three treatment sites, including a private facility, a mission hospital, and one local authority (i.e., the lowest level of government). The U.S. Centers for Disease Control and Prevention in Zimbabwe provides technical assistance aiming to strengthen the laboratory systems and promote health data collection to inform policy and program improvement (U.S. Centers for Disease Control and Prevention 2012). Additionally, the U.S. Department of Defense HIV/AIDS Prevention Program provides HIV prevention support in Zimbabwe including prevention, care, and treatment (U.S. Department of Defense HIV/AIDS Prevention Program 2005). Population Services International/Zimbabwe was mentioned in key informant interviews as providing HIV services, particularly, voluntary counseling and testing in community settings.

Nongovernmental organizations in Zimbabwe are largely involved in behavior change communication programs, prevention campaigns, community home-based care, and palliative care. Key informants also mentioned the following organizations that deliver HIV services: the Hospice Palliative Care Association of Zimbabwe and the Zimbabwe AIDS Network.

HIV CULTURAL CONTEXT

HIV STIGMA

Although many international organizations and governments have prioritized addressing HIV-related stigma and discrimination, stigma remains a barrier to national HIV responses (Campbell et al. 2005; Ray and Kureya 2003). A recent study in Zimbabwe assessed the relationship between HIV stigma and the uptake of HIV testing, with findings showing stigma, fear of social rejection, and discrimination as the most cited reasons for never having had an HIV test (Sambisa 2008). Key informants reinforced this research with wide acknowledgement that stigma surrounding HIV still exists, despite the significant improvements over recent years as more people seek HTC. Many interviewees associated the increase in testing to higher awareness and knowledge of HIV transmission and treatment options. Furthermore, health care workers have been sensitized, which may improve peoples’ health seeking behaviors. Strides have been made, with HIV now openly discussed in media and news and people being encouraged to seek HIV testing; however, disclosure of HIV-positive status remains a challenge. Key informant interview findings suggest that HIV may be referred to by other names or concepts (in Shona). As described by one key informant: “although aware of HIV, some people in rural areas call HIV different names, for example, ‘you’ve been beaten by the thieves and left weak’ or others refer to HIV as ‘the animal’...”

“We are at a place where people now talk about it [HIV] openly. You have people living with HIV always advocating for services.”

–Zimbabwean HIV Technical Advisor 2012

To help combat stigma, Zimbabwe has established efforts to promote the human rights of PLHIV and to protect vulnerable populations. The Government of Zimbabwe prohibited discrimination of PLHIV under the National HIV and AIDS Policy of 2000 and the Statutory Instrument (SI 202) of 1998. In practice, this policy prohibits employers testing employees or potential employees for HIV without their consent and related research protocols must be approved by an ethics committee (UNGASS 2010).

MENTAL HEALTH BACKGROUND

Mental disorders are among the top five causes of disease burden in Africa and are associated with disability and social isolation (PEPFAR 2011), but they are not routinely recognized as a legitimate public health problem. Mental illnesses, particularly depression, are substantial public health issues in Zimbabwe, with depression being one of the leading causes of morbidity and disability, especially among women and other vulnerable populations (MOHCW 2012a; Patel et al. 2001). Additionally, research has demonstrated that PLHIV experience higher rates of depression and report a poorer quality of life compared with persons who are not infected (Brandt 2009; Collins et al. 2006), which underscores the critical need for mental health support for PLHIV. High rates of depression were particularly identified with diagnosis as one begins to grasp the implications of being HIV-positive, such as a potentially shorter life expectancy, lifelong treatment with side effects, stigmatization, and disclosure (Brandt 2009; Collins et al. 2006; Gutmann and Fullem 2009; Tolle 2009). Mental illnesses are often associated with or exacerbated by environmental or contextual situations. For instance, stress may be increased due to economic concerns, unemployment, and HIV infection (MOHCW 2012a). A recently published, multi-country study looking at mental health programs in Africa identified three key issues that urgently need to be addressed: 1) legitimacy of the problem, 2) feasibility of response, and 3) support for response (Bird et al. 2011; Gutmann and Fullem 2009). In the late 1990s, when Zimbabweans began coping with economic challenges an increase in suicide was noted (Cooper 2008).

The cultural, religious, and traditional beliefs that surround mental illnesses were highlighted in the interviews. In Shona, direct translations of the terms “depression” and “anxiety” do not exist. The term “depression” is most frequently used in Zimbabwe to suggest an “illness,” but is not typically associated with emotional symptoms (Patel et al. 2001). Rather, depression is most frequently presented as a headache, fatigue, or other somatic presentation, and emotional symptoms may be revealed only after a health care provider has inquired. Depression and anxiety are often interrelated. In Zimbabwe, depressed patients often associate their symptoms with “thinking too much” and supernatural or social causes (Patel et al. 2001). Findings suggest that depression is common, yet not well diagnosed, and depression may lead to alcohol or illicit drug use.

“There are cases where children with mental illnesses are locked in a room, months on end, and never seeing daylight because their mother or father doesn’t want people in the community to know.”

–Zimbabwean HIV Technical Advisor 2012

Although less common than depression and anxiety, schizophrenia and psychosis are more frequent reasons for admission into psychiatric departments (MOHCW 2012a). Stranix-Chibanda et al. (2005) examined the prevalence of psychological morbidity among nearly 450 women attending antenatal care in Zimbabwe, and results indicated a high burden of mental illness among pregnant women. The authors recommend the integration of mental health services into antenatal care. Mental illnesses are frequently associated with traditional and cultural beliefs. Some believe they are caused by an “evil spirit” or that the person with the illness is being

“punished.” Stigma surrounding mental illnesses is widespread in Zimbabwe and is sometimes manifested by people pointing, whispering, or laughing at someone who is suffering from a mental disorder. Hiding those who have a mental illness is not uncommon.

Although Zimbabwe is making strides to promote mental health, marginalization still exists. Mental health workers and service providers receive limited financing and experience marginalization from other health care workers according to key informant interview feedback.

Patel et al. (2001) conducted research on depression in Zimbabwe for over 15 years, and compared results with research from other developing countries. Research on depression in Zimbabwe suggests most patients were not receiving effective treatment for depression, and may have been prescribed nonspecific treatments (e.g., vitamins) from general providers (Patel et al. 2001). Although primary care is the initial point of contact with the health system (MOHCW 2012a), many patients seek traditional healing options instead of seeking out mental health professionals (Patel et al. 2001). The investigators suggest that all levels of health care workers should be trained on depression recognition and, in addition, mental health requires funding and policy guidance (Patel et al. 2001). Further, other factors are related to a higher risk of depression and anxiety in developing countries. Patel et al. (1999) analyzed data sets from five developing countries and found that female gender, poverty, and low education are strongly associated with common mental disorders in all countries, which has implications for policy development and health services.

“...You will see other programs like maternal health, HIV, malaria, and children’s health have more money than mental health. I feel we are not yet fully integrated and accepted...not only talking about society, I am also talking about professionals who may face stigma associated with mental conditions. We’re trying to educate people that it is a condition, just like any other condition.”

– Mental health staff, MOHCW’s
Mental Health Department

SUBSTANCE USE INCLUDING ALCOHOL

In addition to mental illnesses, substance use inclusive of alcohol is increasing in Zimbabwe (MOHCW 2012a), although there is limited formal data available. Alcoholism is not only one of the country’s four top diseases (WHO 2004), but it is also a major factor in sexual risk behavior and nonadherence to HIV treatment regimens. Key informant interview findings suggest that substance use is quite common, particularly concerning alcohol (including “home brews” and cough syrups, which may contain alcohol, codeine, or other intoxicants) and cannabis. However, prevalence estimates of alcohol use disorders from 2004 were approximately 3 percent of males and 0.3 percent of females aged 15 and older. In 2003, 39 percent of male adults who consumed alcohol were considered heavy episodic drinkers, in addition to approximately 20 percent of females (WHO 2011b). Interviews revealed that Zimbabwe does not currently have any specific health centers for those affected by substance use; rather, these people are seen within psychiatric units. The lack of government-sponsored substance use support services may deter people from seeking help because of the stigma surrounding people in psychiatric hospitals.

MENTAL HEALTH RESPONSE

Despite the country’s economic situation, Zimbabwe has sought to address mental health through the introduction of the Mental Health Act in 1976 (revised in 1996) and the Zimbabwe National Mental Health Policy introduced in 2004 (MOHCW 2012b; IRIN Global 2004). Key informants reported that an updated national policy (currently in draft form) includes an implementation plan. The Zimbabwe National Mental Health Policy strives to coordinate mental health activities and to improve the quality of mental health care services (MOHCW 2012b). Furthermore, the MOHCW’s Mental Health Department also implements the Mental Health Program, which aims to reduce morbidity and mortality related to mental illnesses through mental health promotion and the prevention of mental illnesses (MOHCW 2012b). The MOHCW’s mental health activities from 2008 to 2013 are and will be focused on preventing mental illness, promoting mental health well-being, improving services for populations afflicted, and ensuring the availability of appropriate drugs and equipment (MOHCW 2012a). Table 1 describes the MOHCW’s mental health program structure.

“In most cases for mental health, people use traditional remedies. They go to traditional healers first, and then they come to the health centers as a last resort.”
 –Psychiatrist, Zimbabwe

Table 1. The Ministry of Health and Child Welfare’s Mental Health Program

| Facility | Quantity | Services |
|----------------------------|---|--|
| Mental health institution* | 9 | Carry out mental health services and regulate the mental health program (MOHCW 2012b) |
| Referral facility† | 4 (of the 9 mental health institutions) | Highest facility-level mental health services; 1,212 total psychiatric beds (MOHCW 2012b; Mental health personnel 2012) |
| Provincial hospital | 4 | Can manage psychiatric clients for short periods if there is insufficient space at a referral hospital; may be managed with sedatives; 108 total psychiatric beds (Mental health personnel 2012) |
| Training school | 1 (Ingutsheni Central Hospital) | Three-year registered mental health nurse program; 18-month mental health certificate for previously registered nurses (Mental health personnel 2012) |
| Rehabilitation centers‡ | 11 | Government and NGO; also referred to as “half-way” homes (MOHCW 2012b) |

*Mukoto and Marondera mental health units (in Mashonaland East Province), Sakubva Psychiatric Ward (in Manicaland Province), Gweru Psychiatric Ward (in the Midlands Province), Chinhoyi Psychiatric Unit (in Mashonaland West Province), Ingutsheni Central Hospital, Harare Psychiatric Unit, Parirenyatwa Hospital Annex, and Ngomahuru Hospital (MOHCW 2012b).

†Ingutsheni Central Hospital, Harare Psychiatric Unit, Parirenyatwa Hospital Annex, and Ngomahuru Hospital (MOHCW 2012b).

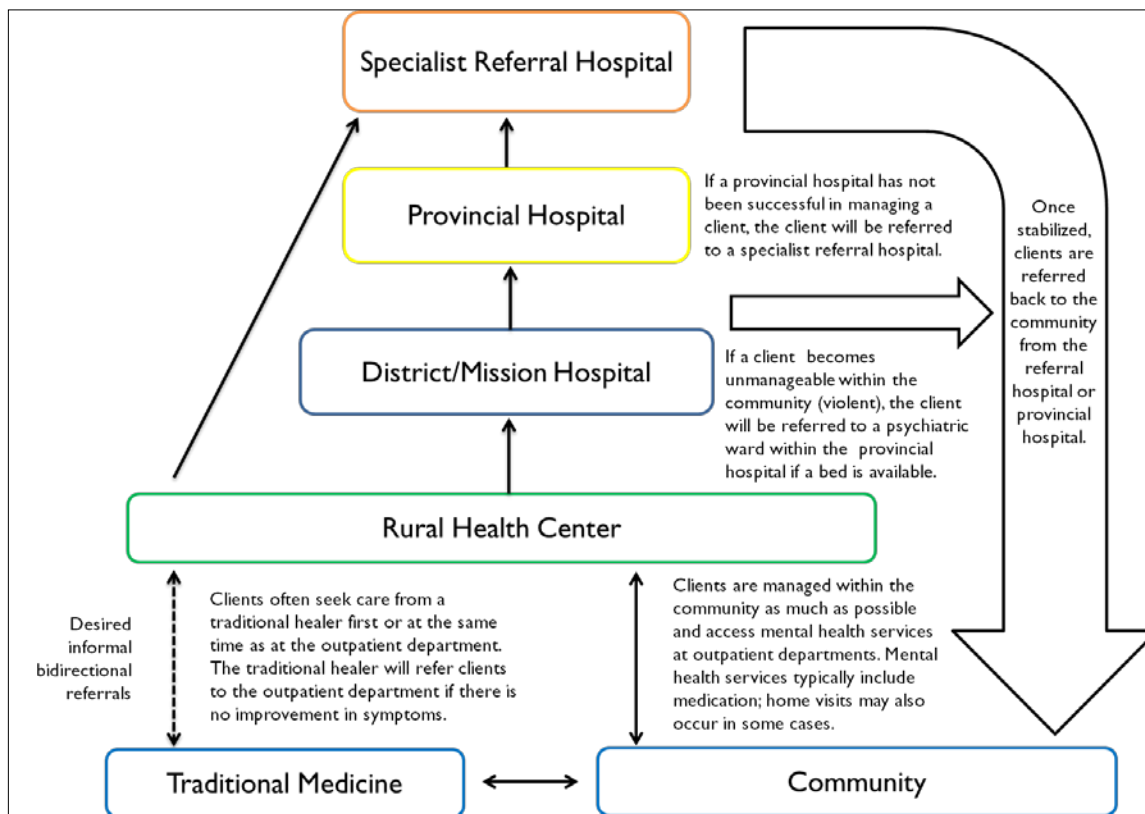
‡Bellevue Halfway Home (in Bulawayo); Emakhandeni Day Care Centre (in Bulawayo); Southerton Day Care Centre, Tirivanhu Halfway Home, and Tariro Halfway Home (in Harare); Beatrice Resettlement Farm (in Beatrice); Ngomahuru Resettlement Farm and Ngomahuru Rural Halfway Home (in Masvingo); Queen of Peace Halfway Home (in Gweru); Chinhoyi Halfway Home (in Chinhoyi); and Rurkaro Halfway Home (in Mutare; MOHCW 2012b).

Forensic care is under the MOHCW’s Mental Health Department (Sithole 2012; MOHCW 2012b). Zimbabwe has two prison institutions for offenders with mental illnesses in Bulawayo and Harare¹ (MOHCW 2012b). The Mental Health Review Tribunal, through Special Mental Boards, provides reports on patient status to determine if patients should remain, be transferred, or be discharged from the prison institutions (Sithole 2012; MOHCW 2012b).

Key informants described the MOHCW’s mental health service delivery model. Patients receive basic screening and counseling at health centers where available, and then may be referred to traditional medical practitioners. This process is not well regulated. Because of cultural and traditional beliefs, many individuals seek mental health services through traditional healers, who were frequently referred to as “witch doctors,” according to key informants. Often, only when patients become violent are they referred to facility-based care. One key informant described a common scenario where, “people can spend years and years going from prophet to prophet,” being told they are bewitched and there is no solution.

As patients move up through the MOHCW’s mental health system, physicians intervene with more complex medications and may refer patients to district, provincial, or central hospitals’ psychiatric units. (See Figure 2 for the formal mental health referral system.) However, most facilities do not provide comprehensive or holistic health services. Furthermore, when a mental health professional assesses a patient, firm diagnostic criteria, such as the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, are generally not utilized to make a diagnosis of a mental disorder (Mental health personnel 2012).

Figure 2. Referral System for Mental Health



¹ Mlondolozhi Special Institution in Khami Maximum Prison, Bulawayo and Chikurubi Special Institution in Chikurubi Maximum Prison, Harare.

Zimbabwe's essential medicine list includes psychiatric medicines (see Box 1), but these medicines are often older drugs. The newest drugs are often underutilized and unaffordable. MOHCW facilities order medications through central medical stores where stockouts are common. Private physicians can prescribe outside of the essential medicine list. A variety of mental health professionals (e.g., psychologists, nurse counselors, social workers, occupational therapists, and village health workers) implement mental health services and provide psychosocial support, but human resources remain limited and additional training is needed. Zimbabwe has fewer than 10 psychiatrists nationwide, indicating a significant challenge for the provision of physician-based mental health services (Mangezi 2012; Sithole 2012).

Nongovernmental and community-based organizations are also involved in mental health services in Zimbabwe. Key informants identified the Zimbabwe National Association for Mental Health as a major stakeholder that works closely with the MOHCW's Mental Health Department and the University of Zimbabwe. There are various "half-way homes" organized by NGOs or hospitals, which provide long-term care and community mental health services, such as the Friendship Bench Model (see Box 2). The Red Cross, World Vision, and CARE carry out community mental health services and psychosocial support programs. Although informal referral systems among NGOs and health clinics or hospitals were discussed, they remain weak and loss to follow up is common.

The MOHCW has led campaigns that aim to promote mental health awareness by sensitizing the general public to the realities of mental health issues, including their ability to be treated. These campaigns take place on World Mental Health Day (October 10) and World Day of Drug Abuse and Illicit Drug Trafficking (June 26) in each province and utilize radio, newspapers, and TV shows to target schools, communities, and families. As a component of the campaigns, each province hosts a cultural show in which mental health is addressed through speeches that address the prevention of illness and the promotion of mental health (Sithole 2012).

SCREENING TOOLS

Aiming to improve the mental health of Zimbabweans, the national health system has implemented a variety of mental illness and substance use screening tools. For instance, the WHO self-report

Box 1. Essential Psychiatric Medicines

Psychoses and Anxiety disorders: diazepam, chlorpromazine, haloperidol, thioridazine, sulpiride, trifluoperazine

Depression: amitriptyline, imipramine, fluoxetine, sertraline, fluvoxamine

Alcohol Dependence/Withdrawal: diazepam

Box 2. The Friendship Bench Model

Utilizing the Shona Symptom Questionnaire to screen patients and provide problem-solving therapy, the Friendship Bench Intervention was piloted outside of three clinics in Harare, in areas with high HIV prevalence. This model used task shifting by training lay workers to screen and provide problem-solving therapy to patients with common mental disorders. Many of the patients were HIV-positive, which suggests that there is a further need to evaluate whether mental health services for depression and other disorders could improve adherence to treatment and retention in care. Findings suggested that lay health workers in primary care settings can implement problem-solving therapy and may improve mental health (Chibanda et al. 2011).

depression questionnaire was used during the 1980s. This screening tool was translated and adapted into Shona (Shona Symptom Questionnaire) to diagnose depression (Patel et al. 2001). Key informants reported that the Shona Symptom Questionnaire is commonly used. Additionally, the Edinburgh Postnatal Depression Scale has been validated and utilized in Zimbabwe (Mangezi 2012). Zimbabwe has also participated in the WHO's Assessment Instrument of Mental Health Systems, which gathers data on the mental health information system. The WHO's Alcohol, Smoking, and Substance Involvement Screening Test has also been implemented in Zimbabwe (MOHCW 2012a); however, it is cumbersome and time consuming. In addition, the CAGE screening tool for substance use is widely used, and although not formally validated in Zimbabwe, it has wide international use (Mangezi 2012). Lastly, the Alcohol Use Disorders Identification Test, developed by WHO, is a screening method for excessive alcohol use (Babor et al. 2001) and is also used in Zimbabwe (Sithole 2012).

CADRES IMPLEMENTING MENTAL HEALTH SERVICES

Key informant interviews indicate that mental health services exist but are challenged with limited human resources and financing for affordable drugs. Although interviewers explained that there are cadres of nurse and peer counselors who provide basic mental health services at the ground level, it is not systemized and there is a dearth of mental health professionals at the higher level. The National Health Strategy reports that there is a 50 percent vacancy rate of psychiatric nurses, psychologists, clinical social workers, and psychiatrists in Zimbabwe, and that 90 percent of psychiatric nurses in Zimbabwe are employed at Ingutsheni Central Hospital (MOHCW 2012a). Additionally, a greater number of general practitioners and internists are needed to carry out mental health services. Due to the limited number of mental health professionals, even if an individual screens positive for depression, the major challenge for the health care system is to provide continuing services through a referral as well as follow-up care visits with a mental health professional. The National Health Strategy calls for the integration of mental health services within primary care in order to respond to the dearth of psychiatrically trained health professionals. Table 2 displays cadres that provide mental health services.

Table 2. Mental Health Services Cadres (Mental health personnel 2012)

| Mental Health Cadre | Role |
|---|--|
| Psychiatric nurses (diploma and masters level) | Carry out services within the clinics and hospitals |
| Psychiatrists | Seven practicing in Zimbabwe who work within the MOHCW at the provincial and referral hospitals; one psychiatrist has a private practice |
| Occupational therapists | Provide rehabilitation for mentally ill patients (home-based services) |
| Psychologists | Receive referrals from psychiatrists and psychiatric nurses to lead psychotherapy and counseling sessions |
| Social workers | Provide social assistance, conduct home visits, and connect mentally ill patients to family members |
| Environmental health technicians (primary care level) | Provide follow-up visits to mentally ill clients in the community |

The University of Zimbabwe offers a master's degree in mental health/psychiatric nursing, as well as a degree in psychiatric medicine (Mental health personnel 2012). The University of Zimbabwe's College of Health Sciences (UZ-CHS), along with partnering universities (Harvard University, the University of Cape Town, the Institute of Psychiatry [London], the University of Bristol, and the University of London), developed a consortium titled, Improving Mental Health Education and Research Capacity in Zimbabwe, as part of the Novel Education Clinical Trainees and Researchers (NECTAR) Program initiated in 2010.² The nascent consortium aims to improve mental health education, expertise, health care, and research among UZ-CHS staff, although staff and research are limited. One of NECTAR's long-term goals is to increase the number of medical graduates (PEPFAR 2011).

“We have a structure from the central hospital that goes down to the clinic in the community, where we then have village health workers and community health nurses who actually work for the family health care clinic. So a structure is in place, but there are shortages and problems in infrastructure, such as vehicles, transport, and resources. It's not working the way it should be working.”

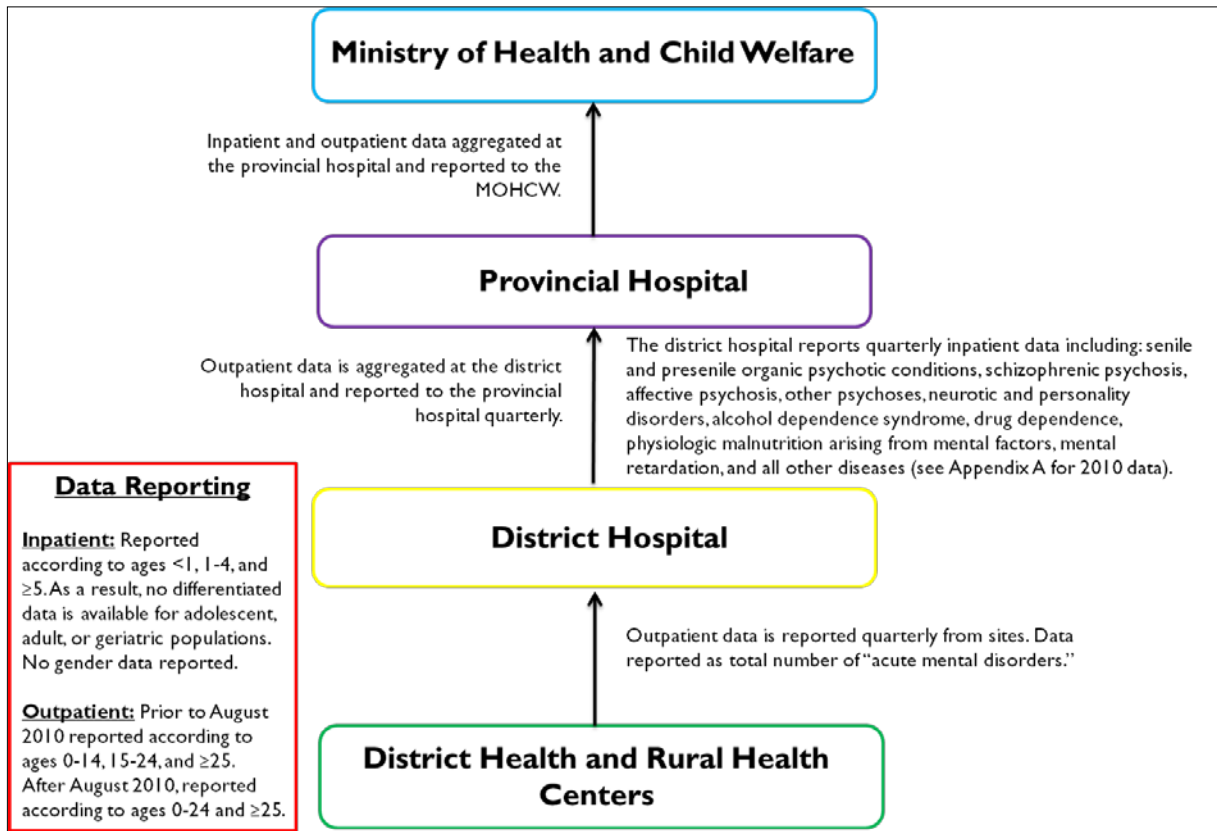
–Psychiatrist, Zimbabwe

MENTAL ILLNESS DATA

Data for mental illness are collected at outpatient and inpatient levels (see Figure 3). A policy change in 2010 for data reported at the outpatient level has led to a decrease in differentiated data by age. Additional issues with data collection include knowledge deficits in data capturing and disease coding at the site level and utilization of an antiquated MS-DOS operating system, which has led to poor data management, reporting, and data shortages in 2011. There are no formal data collected on suicide attempts or substance use (MOHCW staff 2012).

² Awarded and linked to the NECTAR Program through PEPFAR's Medical and Nursing Education Partnership Initiative.

Figure 3. Mental Illness Data Collection System and Flow



THE ROLE OF TRADITIONAL MEDICINE

The Department of Traditional Medicine lies within the MOHCW and aims to register and license traditional healers to become traditional medicine practitioners. This regulation recognizes the legitimacy of this group and helps to ensure safe practices. Additionally it can strengthen the links between traditional and biomedical services and serve as a way to standardize culturally based traditions. Within the department, the Traditional Medicine Practitioners Council is a membership organization that is composed of 3,500 registered traditional medicine practitioners in the country, and it is estimated that there are more practitioners who are not currently registered (Traditional Medicine Practitioners Council staff 2012).

It was indicated throughout several interviews that the majority of persons suffering from mental illness symptoms will first seek out assistance from a traditional medicine practitioner prior to accessing the formal health care system. According to one of the registered Traditional Medicine Practitioners Council organizations, the Zimbabwe National Practitioners Council, mental illness may stem from a variety of physiologic factors including brain damage, poor brain development, chronic illness, and substance use. Psychological factors contributing to mental illness may include stress, which is a result of a social agent (e.g., “angry spirits” and “witches”). “Possession by a spirit” can be a result of severe stress that occurred earlier in life including family and marital problems, miscarriages or the death of a child, unemployment, and crop failures. Possession is manifested by hysterical attacks. If it is determined by a traditional medicine practitioner that the symptoms can be attributed to an evil spirit, the practitioner will chase the evil spirits away or put the client into a trance to overcome the evil spirit. Clients who access services from a traditional medicine practitioner for mental illness will be referred to the medical system if the practitioner believes that the etiology is physiologically based.

The Traditional Medicine Practitioners Council acknowledges the gravity of the HIV epidemic and supports practitioners to recognize symptoms of HIV where they are evident. Traditional medicine practitioners interviewed stated that when a client presents with complaints, including gastrointestinal distress and long-term dermatologic conditions, the traditional healer will suspect HIV and will refer the client to HTC and ART as needed.

The referral system between the traditional medicine practitioners and the health facility is informal and not regulated. Traditional medicine practitioners generally provide verbal direction that the client should seek care at the health facility. In cases where the client is severely ill, the practitioner will personally escort the person to the facility. Traditional Medicine Practitioners Council members report that they frequently visit a client within a health facility to supplement the medical care, but that there is still a need to further legitimize their practice within the health care system (Chisanyu 2012; Traditional Healing Department personnel 2012).

INTERSECTION OF MENTAL HEALTH AND HIV IN ZIMBABWE

For many PLHIV, strong emotional responses to diagnosis, as well as stigma and discrimination suffered after the diagnosis, may manifest in clinically impaired cognitive function, depression, anxiety, and suicidal tendencies (Gutmann and Fullem 2009). Issues related to HIV treatment that are impacted by mental health problems include adherence to complex drug regimens, the management of mental illness and substance use co-morbidity, the assessment of side effects, and the neuropsychiatric co-morbidities of HIV and its treatment. Many programs do not identify or provide support to address mental health needs of PLHIV. Results from key informant interviews suggest that depression and substance use are most common among PLHIV, and it was also mentioned that people may acquire HIV while being under the influence of alcohol. One key informant suggested that mental health issues may be more common in HIV-positive men and persons in denial of their status (Nhiwatiwa 2012), which may be related to poorer health-seeking behaviors among men (Lancet 2001).

“In my clinic...the issue is quite alarming; 24 to 26 of 30 patients have alcohol abuse problems. There is also the problem of cannabis.”

–Psychiatrist, Zimbabwe

“In our culture, talking about mental health or having a mental health illness, alone, is a huge stigma. So having dual diagnoses [HIV and mental illness] is even more challenging.”

–Zimbabwean Infectious Disease Doctor 2012

In 2004, the Government of Zimbabwe linked its mental health policy to the National HIV Mitigation and Information Strategy to provide a policy framework to improve information, treatment, and counseling for HIV among those accessing mental health services. Concerns remain that these policy changes may not have trickled down to practice. Current work in Zimbabwe pertaining to HIV and mental health integration carried out by the MOHCW includes the establishment of a Mental Health Day (WHO Regional Office for Africa 2010), which acknowledges the intersection of morbidity and

mortality associated with HIV and its effects on mental health. Furthermore, momentum from partners includes work by the Global Initiative on Psychiatry, which builds the capacity for secondary caregivers to provide mental health support for PLHIV through the creation of training and educational materials, and supports policy and advocacy work at the national level (Global Initiative on Psychiatry 2010).

MENTAL HEALTH AND HIV SERVICE INTEGRATION NEEDS STRENGTHENED

Key informants noted the importance of mental health and HIV services integration, yet in actual practice, integration remains nascent due to financial and human resource constraints. According to a key informant, financial support is necessary to gather baseline data on mental illnesses and substance use (including information from remote areas) and to create materials for awareness campaigns. Yet, despite limitations, some PLHIV in Zimbabwe have access to mental health services and, if severe, they will be referred to one of the nine government hospitals' psychiatric units. The present HIV and mental health strategies and services were described as, "running as parallel services" (Mangezi 2012; Sithole 2012). Discussions surrounding integrating these strategies and services are occurring, and the aim of AIDSTAR-One's pilot activity is to catalyze action by supporting what exists to promote a sustainable service model.

"At the moment, the mental health department develops our own policies and programs, as does the HIV and tuberculosis department. I think there should be a time when we integrate because there's an association...HIV patients need a lot of psychosocial support and that should come from the mental health department. The two departments run parallel, but we know there is a need to integrate with other conditions because there is no health without mental health."

–Deputy Director, Mental Health Department, MOHCW

RECOMMENDATIONS

Zimbabwe is well placed to integrate mental health screening and referrals into HIV and other health services. Discussions surrounding mental health and HIV integration are currently happening, and programs and policies need to be collaborative. However, findings suggest that existing structures run parallel largely due to funding silos. The standardization of mental health screening in both HIV treatment facilities and community-based care programs could provide the necessary data for evidence-based treatment programming and policy development. Recommendations for integration, additional considerations, and actions that are being taken by AIDSTAR-One as part of the pilot activity are presented in Table 3.

Table 3. Recommendations and AIDSTAR-One Actions for HIV and Mental Health Integration in Zimbabwe

| POLICY RECOMMENDATIONS | | |
|--|--|---|
| Recommendation | Additional Considerations | AIDSTAR-One Actions |
| Coordinate HIV and mental health responses at the MOHCW to optimize services for PLHIV. | The current HIV strategic plan includes ensuring comprehensive care for PLHIV, but it is unclear whether mental health is incorporated. The MOHCW is integral in carrying out Zimbabwe's health systems. | Collaborate with the MOHCW's AIDS and TB Programme and the Mental Health Department to develop and implement the HIV/mental health integration pilot program, ensure buy-in, and help build a foundation for future integration. |
| Further align traditional healers into the formal health system. | Because the majority of the population initially seeks traditional remedies, systems should examine engaging the traditional healer in mental health screenings and referrals. | Collaborate with the Zimbabwe National Practitioners Association to select traditional healers to participate in the HIV/mental health integration pilot. All health care providers, including traditional healers, who participate in the training, will serve as integration leaders in their respective facilities following guidelines. |
| Strengthen strategies for bidirectional referral systems—between community- and facility-level care for mental health and HIV—incorporating traditional healers. | Referral practices of the health system and traditional healer should be standardized and include required documentation, referral guidelines, and a formalized referral system. | Document and/or develop standard operating procedures to further clarify and define roles and responsibilities at the facility level. |
| Develop clear policies and devote resources to improve treatment and drug supplies for mental health. | The capacity to deliver integrated services will depend on mitigating treatment stockouts and developing mental health treatment policies that result in an increased availability of resources. | Action is beyond the scope of the current pilot and mandate. |

CAPACITY ASSISTANCE AND TRAINING RECOMMENDATIONS

| Recommendation | Additional Considerations | AIDSTAR-One Actions |
|---|--|--|
| Strengthen and increase human resources that deliver integrated services, including task-shifting key activities to nurses, social workers, lay health workers, and community health workers. | Focus on task-shifting models of care to increase access to mental health services. Provide more opportunities for educational programs for mental health at the university and degree program level. Provide in-service training for mental health at the district level. | Focus on task shifting to ensure more PLHIV are accessing mental health screens, services, and referrals. |
| Incorporate guidelines for mental health and HIV integration via task shifting into national policies and in guidance documents. | Document the evidence that exists in task-shifting models (Chibanda et al. 2011). Build on these known models to scale up. | The pilot will add to the existing evidence via a program evaluation that will occur three months postpilot (estimated October 2012). |
| Train different cadres of health care professionals in mental health screening and basic therapeutic services to increase basic mental health services and referrals. | In line with national policy and guidelines, build the capacity of the traditional healer to better align their services/referrals within the existing health care system. Traditional healers are already providing basic counseling services and can better link clients into the formal health care system. | The pilot targets three cadres of staff that provide services: health care workers, community care workers, and traditional medicine practitioners; use a cascade training approach to increase impact in nine clinic catchment areas. |

PRACTICE RECOMMENDATIONS

| Recommendation | Additional Considerations | AIDSTAR-One Actions |
|---|--|---|
| Develop services that provide continuous and holistic care. | Incorporate routine feedback from clients living with HIV to develop the holistic package of services (e.g., psychosocial, economic, spiritual, physical). | Action is beyond the scope of the current pilot and mandate. |
| Strengthen linkages and referrals between mental health and HIV services. | Strengthening referrals and follow-up is critical to improving services to reduce HIV and mental health co-morbidities. | Conduct a postpilot program assessment to examine the feasibility of a more coordinated mental health and HIV response. |
| Collaborate with key stakeholders in HIV and mental health. | The National AIDS Council and Zimbabwe's National Association of Mental Health should be engaged along with traditional healers. Partnerships with select nongovernmental and faith-based organizations will be critical to ensure better referrals and linkages among HIV and mental health services. | Continue to engage and collaborate with key stakeholders in the HIV and mental health fields in Zimbabwe. |

PRACTICE RECOMMENDATIONS

| <i>Recommendation</i> | <i>Additional Considerations</i> | <i>AIDSTAR-One Actions</i> |
|--|--|--|
| Recognize existing opportunities, such as HTC sites, as potential opportunities to provide basic mental health care and referral. | Antenatal care scale-up has increased the amount of Zimbabwean women who receive HTC to 90 percent, which can help provide existing venues for mental health screening and referrals. Learning from the Friendship Bench Intervention or modeling off of other highly integrated health areas in Zimbabwe (e.g., HIV and tuberculosis services) will be useful. | Action is beyond the scope of the current pilot and mandate; however, the pilot will identify and promote existing areas where basic mental health care is provided. These mechanisms will be documented in the standard operating procedures to be produced in late 2012. |
| Implement education and sensitization campaigns. | Continued education and sensitization, particularly in rural areas, about HIV, mental health, and substance abuse issues may improve awareness and understanding that mental health issues can be treated like other conditions and are often common among PLHIV, which may reduce marginalization. An emphasis on women and other vulnerable populations is essential because these populations are more affected by depression (Brandt 2009; Surkan et al. 2011). Being knowledgeable on cultural and traditional practices will be important for improving education about mental health and HIV. | Action is beyond the scope of the current pilot and mandate; however, the pilot will identify and promote existing areas where basic mental health care is provided. These mechanisms will be documented in the standard operating procedures to be produced in late 2012. |
| Incorporate screening and referral for substance use into mental health and HIV services, and strengthen programs designed specifically for the treatment and management of substance abuse. | Identifying and/or creating national services and policies specific for substance use issues will be necessary, especially for PLHIV. These services may be integrated into existing routine services (e.g., primary care and voluntary counseling and testing). | Action is beyond the scope of the current pilot and mandate, however, the pilot will identify and promote existing areas where substance use care is provided. These mechanisms will be documented in the standard operating procedures to be produced in late 2012. |

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APPENDIX A: 2010 MENTAL DIAGNOSIS DATA REPORTED BY DISTRICT HOSPITALS IN ZIMBABWE

Inpatient data

| Disease/Condition | Under 1 year | | | | 1 - 4 years | | | | 5 years and over | | | | Pt. days |
|--|--------------|---|---|---|-------------|---|---|---|------------------|----|----|---|----------|
| | C | D | T | A | C | D | T | A | C | D | T | A | |
| 21 Mental Disorders | | | | | | | | | | | | | |
| 210 Senile and presenilen organic psychotic conditions | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 13 | 2 | 3 | 0 | 99 |
| 211 Schizophrenic psychoses | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 231 | 11 | 14 | 4 | 1621 |
| 212 Affective psychoses | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 55 | 2 | 6 | 3 | 409 |
| 213 Other psychoses | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 316 | 17 | 19 | 8 | 1502 |
| 214 Neurotic and personality disorders | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 87 | 5 | 1 | 4 | 414 |
| 215 Alcohol dependence syndrome | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 10 | 1 | 0 | 1 | 19 |
| 216 Drug dependence | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 6 | 0 | 2 | 0 | 22 |
| 217 Physiological malnutrition arising from mental factors | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 15 |
| 218 Mental retardation | 0 | 0 | 0 | 0 | 3 | 0 | 0 | 0 | 32 | 3 | 2 | 1 | 363 |
| 219 All other diseases in 21 | 6 | 1 | 0 | 0 | 5 | 1 | 0 | 0 | 294 | 38 | 4 | 1 | 972 |

Outpatient data

| | 0-14 yrs | | 15-25yrs | | 26yrs & over | |
|------------------------|----------|--------|----------|--------|--------------|--------|
| | Male | Female | Male | Female | Male | Female |
| January to July 2010 | | | | | | |
| Acute Mental Disorders | 156 | 66 | 205 | 143 | 659 | 622 |

| | 0-24 yrs | | 25yrs & over | |
|------------------------|----------|--------|--------------|--------|
| | Male | Female | Male | Female |
| August-December 2010 | | | | |
| Acute Mental Disorders | 135 | 91 | 609 | 585 |

For more information, please visit aidstar-one.com.

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