USAID FROM THE AMERICAN PEOPLE

AIDSTAR-One | CASE STUDY SERIES March 2011

Prioritizing HIV in Mental Health Services Delivered in Post-Conflict Settings

Melissa Sharer

PCAF Gulu and MOH staff in an HIV voluntary counseling and testing room, down the hall from the trauma clinic.

By Melissa Sharer and Mary Gutmann

"Can you please test me for HIV?" It was the woman's first time at the Peter C. Alderman Foundation (PCAF) Trauma Clinic. She visited the clinic due to "strong pains in the head," diagnosed by PCAF as severe depression. The woman spoke at length to the social worker about her husband's risky behaviors and her husband was urging her to get tested, using the logic, "If you are positive then I am positive." After the woman asked for the test, the social worker walked with her to another room in the hospital, less than 20 feet from the PCAF clinic rooms, delivered pre-test counseling, facilitated testing, and delivered both the results and post-test counseling all in the same visit. The woman tested positive and was immediately referred to care, support, and treatment programs in Gulu, Uganda. The social worker and other PCAF staff also encouraged the woman's partner to come in for services and for testing. Although HIV services such as this are not the core business of PCAF, the social worker had the necessary skills and the benefit of PCAF's flexible clinic model to facilitate the process of HIV testing and counseling. As the clinic is linked with the Ministry of Health (MOH) system, HIV services are provided by referral in the same location as PCAF (see Box 1 for a hypothetical case for a typical client).

After opening the clinic in northern Uganda, PCAF mental health (MH) staff requested specialized HIV training because they felt it was critical to address their clients' MH and HIV care and support needs in a holistic and knowledgeable manner. In northern Uganda, MH service providers must know their individual client, and having HIV knowledge and experience is key to being effective in their work. In comparison to the rest of the

AIDSTAR-One
John Snow, Inc.
1616 North Ft. Myer Drive, 11th Floor
Arlington, VA 22209 USA
Tel.: +1 703-528-7474
Fax: +1 703-528-7480
www.aidstar-one.com

This publication was produced by the AIDS Support and Technical Assistance Resources (AIDSTAR-One) Project, Sector 1, Task Order 1.
USAID Contract # GHH-I-00-07-00059-00, funded January 31, 2008.

Disclaimer: The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

BOX 1. HYPOTHETICAL CASE BASED ON A TYPICAL CLIENT

To understand how HIV is integrated into the flow of MH services provided by PCAF, a hypothetical case based on a "typical" client is offered here.

A young woman from Gulu in northern Uganda was abducted by the Lord's Resistance Army (LRA) when she was 10 years old. She was forced into marriage with a rebel soon after being abducted and lived in the bush with the LRA for 10 years. She returned to her home 2 years ago at age 20 with a 4-year-old child. She recently remarried, but her new husband has rejected her child and is verbally and physically abusive, telling her she behaves like a "bush woman." She no longer lives with him and has no place to live. She was referred to the PCAF Trauma Clinic from the Mental Health Clinic at Gulu University Referral Hospital for further treatment. She arrived with a "burning pain in her head" and exhibits symptoms of severe depression.

On intake at the PCAF Trauma Clinic, the psychiatric clinical officer (PCO) completed an initial questionnaire using the standard PCAF form (see Box 2), which includes a question on her HIV status, which she did not know. After prescribing her drugs for depression (amitriptyline), she was referred to Gulu Youth Center for HIV testing. She requested the PCAF social worker accompany her to the center as she "did not know what to do." The social worker acted as a client advocate, service interpreter, as well as a source of support. The client learned she was living with HIV. The social worker then took her to The AIDS Support Organisation (TASO) to enroll in HIV services, including treatment. To deal with her lack of permanent housing, the social worker performed a home visit with some of her family members and was able to negotiate a place for her and her son to live on her uncle's compound. Her uncle built her a small tukol (dwelling), and she now lives there with her son. She returns quarterly to the PCAF clinic to attend individual trauma counseling sessions with the psychiatric nurse, social worker, and psychologist but no longer takes drugs for depression. She is also a member of TASO and takes part in their support groups. The services she most values from PCAF are the quarterly home visits. This woman now reports a decrease in the "burning pain in her head" and is actively managing her HIV, while remaining a PCAF client receiving MH services and trauma counseling.

country, estimated HIV prevalence in northern Uganda is significantly higher (8 to 12 percent compared to 6.7 percent).[1] When MH services are being delivered in generalized HIV epidemics, such as in northern Uganda, MH providers must understand the association between HIV and MH and provide strong linkages and referrals to services that meet the needs of people living with HIV (PLHIV).

[1] The Uganda UNGASS Report (Government of Uganda 2010) rates from the north of the country vary as conflict has made it difficult to determine a definitive prevalence rate.

Making HIV and Mental Health a Priority in Post-Conflict Areas

For 20 years, northern Uganda suffered a brutal civil conflict. At the conflict's peak (2002 to 2005), more than 1.8 million people, 80 percent of the region's population, were forced to flee their homes and live in overcrowded internally displaced persons (IDP) camps with limited access to resources. During the

war, individuals were subjected to conflict, social upheaval, displacement, poverty, limited resources, and restricted access to support and services needed for daily living. An MH survey in Pader during the height of the conflict revealed that almost all respondents had been exposed to severe traumatic events: 63 percent reported the disappearance or abduction of a family member, 58 percent experienced a death in the family due to insurgency, 79 percent witnessed torture, and 40 percent witnessed at least one killing (IRIN 2004). Since the 2008 peace accord was signed between the government and the Lord's Resistance Army (LRA), the security situation has steadily improved: all the IDP camps are closed and people are resettling into their villages or towns. Particularly at risk during the resettlement period are returned child soldiers and other children exposed to traumatic events who are now entering adulthood and struggling to deal with either witnessing or taking part in horrendous events.

The high HIV rate in the region is a reality for this population. As resettlement continues, there are concerns about a rise in new infections and the inability of an already weak public health system to respond to growing needs. Additionally, the psychological and social impacts of the 20-year conflict have greatly impacted the population in northern Uganda. One priority in post-conflict settings is to protect and improve people's MH and psychosocial well-being (Inter-Agency Standing Committee 2007). Many times, MH and behavioral disorders are overlooked in HIV care, support, and treatment programs in post-conflict settings. Undetected and untreated MH problems may include depression, anxiety, cognitive disorders, personality disorders, and co-occurring conditions such as substance-related disorders, which have been shown to have a profound effect on antiretroviral therapy (ART) adherence, clinic attendance, immunological status, symptom severity and morbidity, mortality, and quality of life; these problems also influence HIV progression and should be part of an integrated approach to the care and support of PLHIV (Gutmann and Fullem 2009). This is particularly important in post-conflict settings when displaced populations return to their homes, trade links are restored, and levels of societal mobility and networking may resume, all of which may contribute to increases in HIV. The high rates of HIV combined with the large numbers of people traumatized by the conflict and the lack of MH and HIV services make individuals and families with both these conditions some of the most vulnerable (Spiegel et al. 2007).

Implementation: Getting Started

PCAF was established by Dr. Stephen and Elizabeth Alderman in memory of their son, Peter C. Alderman, who died on September 11, 2001, in the World Trade Center bombing. PCAF's mission is to "heal the emotional wounds of victims of terrorism and mass violence by training health care professionals and establishing clinics in post-conflict countries around the globe." PCAF opened its first trauma clinic in Cambodia in 2005. Since 2007, PCAF has delivered trauma counseling in Uganda using culturally appropriate, evidence-based therapies. PCAF works in public-private partnership with local governments, medical schools, and religious institutions in Uganda and Cambodia, and works in partnership with Partners in Health in Rwanda and Haiti to provide MH and trauma counseling services. In 2011, PCAF plans to open operations in Liberia.

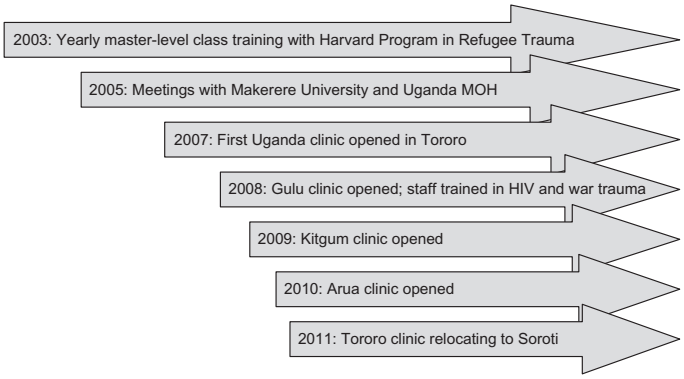
PCAF uses a model of integration, establishing trauma clinics within MOH structures, to provide specialized MH care to trauma survivors. Soon after clinics were opened, it became apparent that the additional burden of HIV needed to be addressed as well. In addition to the Tororo Clinic, opened in

2007, PCAF operates three other clinics in northern Uganda (Kitgum, Arua, and Gulu; see Figure 1 for a progression of services). To better meet the needs of those affected by conflict, in January 2011, the Tororo Clinic relocated to Soroti.

Prioritizing mental health services: PCAF's focus on northern Uganda emerged from their first efforts, in 2003, to provide expert professional training of national MH caregivers from a range of post-conflict countries. PCAF began a partnership with the Harvard Program in Refugee Trauma (HPRT) to provide master-level classes to approximately 20 MH providers from around the world. These classes allowed MH professionals to join together, learn from each other, and translate the HPRT toolkit to make it culturally appropriate to meet the needs of the traumatized in their own countries. Attending this first class were two influential members from the Uganda MOH and Makerere University, who spoke with PCAF about the conflict in northern Uganda and the need to address the effects of trauma and other psychosocial impacts of people in the region.

Identifying mental health stakeholders: The two psychiatrists who attended the master class training paved the way for PCAF to meet with other key stakeholders and MH leaders in Uganda. Initially, PCAF's vision was to build MH services from within, working in partnership with the government to ensure services would be country-owned and not parallel to existing services. PCAF met with other key stakeholders in the MOH's Department of Psychiatry, who in many instances were also professors in the Department of Psychiatry and Mental Health at Makerere University. The Department at Makerere consists of psychiatrists, a medical sociologist, social workers, clinical psychologists, PCOs, nursing officers, medical health assistants, and other support staff. The department works in close collaboration with practitioners at Butabika Mental Hospital, the only national referral MH facility in the country. Butabika provides comprehensive MH diagnoses, treatment, follow-up care, and training. These links were key in developing the PCAF flow of services, which are detailed in Figure 2. Also, as part of these initial consultations, PCAF and the MOH identified potential locations for the PCAF-supported clinics as well as an appropriate MH service and staffing model.

Figure 1. Evolution and Expansion of the Mental Health Program in PCAF Uganda



Integrating HIV and mental health interventions: Working within Uganda's MH service system, PCAF remained focused on providing services to those who survived the conflict and were most directly affected by trauma.[2] Initially PCAF operated using a strict biomedical approach, focusing on providing needed medication, and after three years of support, the PCAF team broadened its approach to work holistically with clients to better meet their complex needs. Staff increasingly examined the links between the client's social, psychological, physical, spiritual, and cultural environment. This has resulted in staff using a variety of interventions, including medications for relevant MH diagnoses, as well as assessments (clinical assessment and diagnosis), psychological support (cognitive behavioral therapy,

[2] Trauma is an occurrence and post-traumatic disorder (PTSD) is a psychiatric diagnosis (Dona 2010).

group/peer support, individual counseling, and trauma counseling), and social support (home visits, family mediation and counseling, client advocacy, community mobilization/sensitization, and case management).

As PCAF staff worked with traumatized clients, it became increasingly evident that HIV was a significant factor in the ability of individuals to cope. In order to provide the holistic services slowly becoming a part of their approach, it was necessary for PCAF to integrate HIV into its service model. As services at PCAF clinics have shifted to meet the comprehensive and complex MH needs of their clients, the care and support of PLHIV became a greater priority. In 2008, when planning to open up clinics in Gulu and Kitgum, PCAF became aware of the need for staff to better understand the issues related to HIV among MH patients and recognize the special needs of PLHIV. At the time, PCAF considered a study that reported on the comorbidities of depression and HIV in Uganda, with depression being associated with lower CD4 counts (Kaharuza et al. 2006). Responding to this need, PCAF funded four staff to attend the Caritas and World Health Organization's "Management of the Medical and Psychological Effects of War Trauma" course. One of the training's modules, "HIV/AIDS and War Trauma," addressed the following:

- The association between war and the HIV epidemic
- The MH problems associated with HIV and war
- The categories of persons in war situations who are at risk of acquiring HIV
- MH problems and potential interventions at the individual, family, and community levels, to jointly address war trauma and HIV vulnerability.

This training provided a framework for staff to better understand and respond to trauma and HIV. Following the training, PCAF integrated HIV status into their client intake form (see Box 2). At intake, PCAF now routinely asks if HIV status is known or unknown, and then staff refer as necessary. Common referrals are for HIV pre-test and post-test counseling; in some cases, provision of the actual test itself is available on-site. Additionally in some cases PCAF staff have the ability to provide pre and post-test counseling, however PCAF does not provide HIV services, referrals are necessary, and it is recommended that PCAF deepen their referral networks to link their clients to key HIV services. The interventions selected and the existing flow of services (see Figure 2) are a result of PCAF's efforts to learn from practice and shift the model appropriately to best meet the needs of those affected by trauma and conflict in northern Uganda, as well as address HIV at the individual level.

Staffing structure: The staffing structure to implement MH services was initially crafted by key Ugandan psychiatrists[3] and was shaped by their medical perspective. As mentioned previously, the approach has evolved into a more comprehensive model that looks at client well-being using a more holistic perspective, focusing on the client's physical, psychological, and social needs. Currently, each PCAF-supported clinic is staffed with four or five professionals, as follows:

- Consulting psychiatrist: This staff member provides oversight for the case load. The psychiatrist visits the clinic on a regular basis and is available remotely as needed. PCAF strives to hold monthly supervision meetings with the psychiatrist and line staff. The psychiatrist works full-time for the MOH, with PCAF supporting small salaries for project-related consulting duties.

[3] According the Ministry of Health, Uganda has a total 28 psychiatrists (Kinyanda 2010).

BOX 2. PETER C. ALDERMAN FOUNDATION SCREENING ASSESSMENT TOOL

ID_____ **Date of Enrollment** _____
Gender 1. Male 0. Female **Age** _____
Years of Education _____

Has the patient been formerly abducted?		YES	NO
Has the patient been a former combatant?		YES	NO
Has the patient been living in an IDP camp?		YES	NO
Has patient ever suffered physical trauma?		YES	NO
Has the patient ever suffered sexual violence or rape?		YES	NO
Does the patient have a family history of trauma?		YES	NO
Is the patient a victim of domestic violence?		YES	NO
Has the patient lost a family member to violence?		YES	NO
Is the patient employed or working?		YES	NO
Is the patient attending school/ job training?		YES	NO
Is the patient an orphan?		YES	NO
Is the patient the head of the household?		YES	NO
Is the patient married?		YES	NO
Is the patient widowed?		YES	NO
Is the patient divorced/separated?		YES	NO
Is the patient HIV positive?	DK	YES	NO

What diagnosis has patient received? (Circle all that apply.)

A. Anxiety	YES	NO
B. Depression	YES	NO
C. Post-traumatic stress disorder	YES	NO
D. Epilepsy	YES	NO
E. Somatoform	YES	NO
F. Psychosis	YES	NO
G. Organic psychosis	YES	NO
H. Psychosis—postpartum	YES	NO
I. Suicidal	YES	NO
J. Grief reaction	YES	NO
K. Deliberate self-harm	YES	NO
L. Insomnia	YES	NO
M. Schizophrenia	YES	NO
N. Organic brain disorder	YES	NO
O. Seizure	YES	NO
P. Mental retardation	YES	NO
Q. Dementia	YES	NO
R. Bipolar	YES	NO
S. Alcohol/substance abuser	YES	NO
T. Spousal/child abuser	YES	NO
U. Childhood disorders	YES	NO
V. Other (specify below)	YES	NO

continued

How many clinic visits did the patient make in each quarter?

	Quarter 1		Quarter 2		Quarter 3		Quarter 4	
Clinic Visits								
Has the patient been discharged?	YES	NO	YES	NO	YES	NO	YES	NO
Has the patient been admitted?	YES	NO	YES	NO	YES	NO	YES	NO

Which of the following drugs have been prescribed for the patient? (Circle all that apply and include the dose taken per day and the total dose per quarter.)

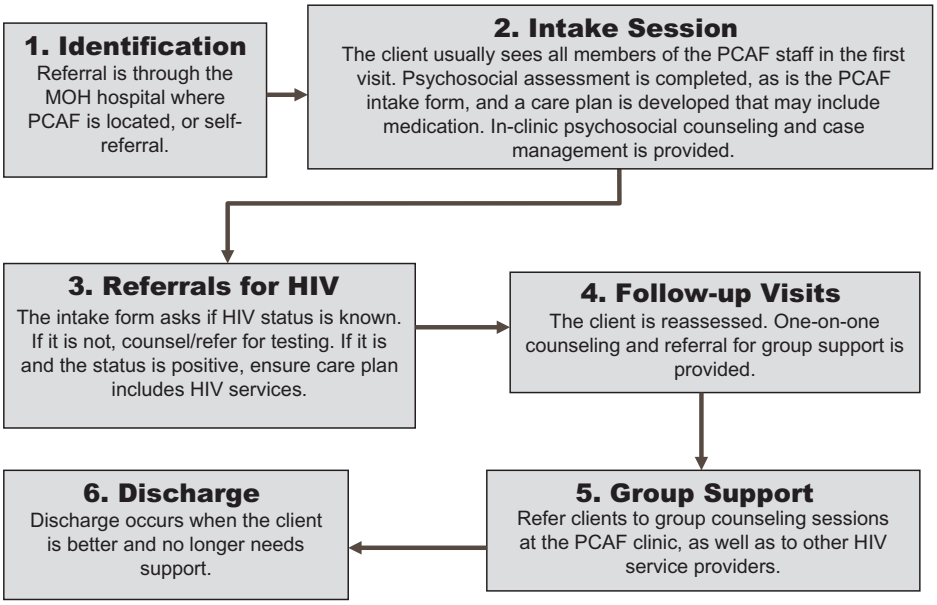
				Dose/Quarter			
			Dose/Day	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
Chlorpromazine	YES	NO					
Haloperidol	YES	NO					
Fluoxetine	YES	NO					
Amitriptyline	YES	NO					
Imipramine	YES	NO					
Benzodiazepines	YES	NO					
Anticonvulsants	YES	NO					
Other treatments							

Which of the following non-drug treatments have been prescribed for the patient? (Circle all that apply and state the number of sessions received per quarter.)

			Number of Sessions	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
Group counseling	YES	NO					
Individual counseling	YES	NO					
Family counseling	YES	NO					
Spiritual healing	YES	NO					
Home visit	YES	NO					
Other treatments or therapy	YES	NO					

- Psychiatric Clinical Officer: The PCO provides general program and staff supervision, writes reports, and collects and analyzes data. The PCO also completes intake, clinical assessments, makes referrals, and prescribes medications. This position refers individuals who need psychosocial care to the psychologist or social worker. The PCO is the key liaison with the consulting psychiatrist. This position is fully supported by PCAF.
- Psychiatric nurse: This staff member completes intake and clinical assessments, develops treatment plans, makes referrals, and prescribes medications. This position also refers individuals who need psychosocial care to the psychologist or social worker. As many activities are similar to that of the PCO role, the psychiatric nurse role may be duplicative. This position is fully supported by PCAF.
- Psychologist: The psychologist completes intake, makes diagnoses, and provides psychological counseling, including trauma counseling, cognitive behavioral therapy, and facilitates support groups. This position is fully supported by PCAF.
- Social worker: This position is the most recent addition to the PCAF model. The social worker

Figure 2. Client Flow of Services, Showing HIV Integration in PCAF Uganda



completes intake, provides psychological, trauma, and supportive counseling. This role also facilitates support groups, HIV testing-inclusive of pre and post-test counseling, and acts as a client advocate. Social workers work with the client and conduct home visits and provide individual and family counseling to optimize the strengths of the client's environment. Social workers also advocate for the client and facilitate HIV testing and referrals, working with the family and community to ensure the needs of the client are met. This position is fully supported by PCAF.

With the integration of this model into the MOH system, PCAF provides funding for staff salaries, some staff training expenses, limited home visits, and some linkages to community support systems. This is a cost-effective, cost-sharing model that can be simple to replicate in other countries. PCAF will support each clinic for five years, then support the process of transitioning the clinic fully over to the MOH over the next five year time period. As a result, all staff costs will be covered by the MOH 10 years after the PCAF clinics have started.

Initial results and next steps: Data collected thus far show PCAF has screened more than 3,000 people in Uganda, with a regular quarterly client flow of approximately 1,000 MH clients spread out among three clinics (174 in Tororo, 260 in Gulu, and 600 in Kitgum). PCAF uses a screening tool that flags particular vulnerabilities, such as formerly abducted, formerly combatant, known HIV status, etc. (see Box 2). Of PCAF's current clients (recorded from the fourth quarter of 2009), 393 responded as knowing their HIV status; of these 393, 26 percent reported being HIV positive. Among the total population sampled, rates of known HIV are higher among women (4.9 percent of men and 8.1 percent of women).

An emerging issue has been the need to examine and address the quality of services and implement quality improvement activities. Beginning in 2009, PCAF began collecting uniform data on all clients in order to track trends, document services received, and specifically look at emerging gaps. One immediate need emerging was for PCAF to track clients living with HIV, and provide follow-up data

collection that documents their referral and follow-up processes to monitor adherence and retention to treatment, and care and support programs. Additional gaps included the need to respond more holistically to clients, with PCAF responding by organizing a spiritual training for PCAF staff in October 2010. Also PCAF is developing deeper links with civil society organizations and community services. It is recommended that PCAF build a more formal relationship with Uganda's leading HIV service organization, The AIDS Support Organisation (TASO), to better meet the needs of clients living with HIV.

Additionally, MH providers are being encouraged to know their client in the HIV context. Specifically, it is recommended that providers actively manage their clients who are living with HIV in a way that acknowledges and addresses the comorbidities that may exist in PLHIV who also are in need of MH services. Box 3 provides more information on integrating MH services to meet the specific MH needs of clients in different points on the HIV continuum.

What Worked Well

Integration into existing services: PCAF is fully integrated with the MOH's systems to provide a supportive, specialized program to augment the overstretched MH services in northern Uganda. Two modest rooms are allocated in the MH wing of the Gulu regional hospital where PCAF provides services in sparsely furnished offices. The benefit of the location outweighs the sparseness of the offices, as proximity to MOH professionals and services allows PCAF to cultivate relationships and trust. These relationships allow PCAF to provide specialized trauma treatment within the Uganda health system and contribute to systems strengthening, a key operational goal of PCAF. The MOH provides critical in-kind donations, such as MH drugs, inpatient beds, and secure sites for services and patient records to ensure confidentiality and cost-effectiveness. Working closely with MOH and national partners also fosters country ownership that leads to greater sustainability of culturally appropriate models of care and support.

Starting small: The first clinic was opened in 2007 in Tororo, where PCAF could test its model in a less challenging environment and use the experience as a road map for establishing additional clinics in Gulu, Kitgum, and Arua where there were fewer resources and the impact of the civil conflict was more devastating. Lessons learned from the first clinic helped to inform the scale-up of services in subsequent clinics and strengthened the relationship with the MOH and Makerere University as key implementing partners. Staff were subsequently more sensitized to the special needs of PLHIV.

Fostering country ownership: From the beginning, it was made clear that PCAF would provide funding and technical assistance for 10 years, during which time MOH partners would build capacity and mobilize resources to continue the program. Early engagement of the MOH and Makerere University in developing the model and identifying sites was critical in fostering country ownership. PCAF's approach to fostering country ownership involved working in partnership with the government to ensure that MH services were integrated into primary health care, and providing funding for staff to attend the Caritas/World Health Organization training to increase their understanding of the MH needs of PLHIV. As the clinics gain more experience and develop human resources, more of the management functions can be shifted to MOH staff. For example, PCAF plans to shift the existing part-time staff member to full-time status in March 2011 so that he can be responsible for more of the day-to-day operations of the clinics and lead future planning efforts in Uganda.

BOX 3. INTEGRATION OF MENTAL HEALTH SERVICES AND KEY ISSUES TO MANAGE FOR PEOPLE LIVING WITH HIV

Mental Health Client 1: Unknown HIV Status

Key Management Issues	Mental Health Issues	Services to Link/Provide/Refer
Counseling and testing	• Lack of voluntary counseling and testing access • Emotional reaction to test results • Stigma and discrimination, disclosure • Risky behaviors and substance abuse (SA)	• Targeted HIV screening among MH population • Post-test clubs and peer support • Screen and brief MH and SA interventions
Initiation of care	• Anxiety • Depression • Isolation/marginalization • Disclosure • SA	• Screen for depression, anxiety • Screen for SA and brief interventions/therapies for SA and dependence • Psychosocial, peer, and community support groups
Retention and maintenance in care	• Adherence and drop-out • Risky behaviors and SA, co-occurring	• Screen and provide pharmacologic and psychotherapeutic interventions • Adherence counseling • Psycho-educational approaches to reduce risk of transmission • Psychosocial, peer, and community support groups • Management of mild, moderate depression and anxiety (World Health Organization MH series)

Mental Health Client 2: Known to be Living with HIV and on Antiretroviral Therapy

Key Management Issues	Mental Health Issues	Services to Link/Provide/Refer
Initiation of ART	• Access to ART • Stigma and discrimination • Risky behaviors and SA	• Adherence counseling • Psychosocial, peer, and community support and recovery groups • Screening and brief intervention for hazardous SA; treatment for SA and dependence
Maintenance on ART	• Treatment adherence and drop-out • Risky behaviors and SA, co-occurring • Side effects and neurocognitive changes	• Adherence counseling • Psycho-educational approaches to reduce risk of transmission • Manage mild, moderate depression and anxiety (World Health Organization MH series) • Assess and treat MH and SA problems (pharmacologic and psychotherapeutic interventions) • Assess and manage side effects of neurocognitive changes • Psychosocial, peer, and community support and recovery groups

continued

Mental Health Client 3: Known to be Living with Advanced HIV Disease

Key Management Issues	Mental Health Issues	Services to Link/Provide/Refer
End of life care and support, palliative care	• Physical decline and increased symptoms • Depression and suicidal thoughts • Stigma and discrimination	• Management of major depression and suicidal risk • Palliative care • Psychosocial and family support • Home- and community-based care
Care for caregivers	• Burden of care on family members (typically women) • Grief and loss	• Grief and bereavement counseling and support • Manage mild, moderate depression and anxiety (World Health Organization MH series) • Respite care • Spiritual support • Social and legal support

Challenges

Continuum of mental health care for people living with HIV—psychosocial support to psychiatric response: PLHIV experience a range of emotional, social, physical, and spiritual needs that vary over time. Throughout Uganda, the stigma associated with the term *mental health* is present. When this stigma is coupled with HIV-related stigma, feelings of marginalization become apparent. During a focus group discussion with TASO staff and TASO clients (including PLHIV), most people assumed that MH problems associated with HIV involved severe psychological manifestations (e.g., schizophrenia, delusions, etc.). With deeper questioning, PLHIV and TASO staff began to tell more complex stories that included common complaints such as "burning pains in the head," problems with forgetfulness, partner violence in the home, etc. Talking to PLHIV during this field visit was informative to both PCAF providers and providers at specific HIV service organizations like TASO. This pushed the providers to think of MH as a continuum, with issues such as anxiety and depression most prevalent, and existing at the beginning of the continuum. Severe trauma and other diagnoses that need more advanced and longer term therapeutic interventions and medical treatment exist at the other end of the continuum. The need to reinforce the continuum of MH care needs within the PCAF model specifically and among the MH activities of the MOH and Makerere University more broadly poses a challenge for both the design and delivery of services, especially for PLHIV.

Staff training and mentoring: Professional training and capacity building are cornerstones of PCAF's mission and are building blocks for establishing MH clinics in northern Uganda. Close linkages with the MOH and the Department of Psychiatry at Makerere University ensured the availability of professional expertise in MH for staff training and supervision, and monitoring of quality care. The use of a multidisciplinary staff (social workers, psychiatric nurses, and psychologists) also added depth and scope to the MH services provided and the ability to address multiple psychosocial needs of clients, including those living with HIV. The challenge remains in keeping staff current on key issues and providing them with regular and scheduled training opportunities with other clinic providers. PCAF is working to improve this by providing yearly opportunities for training and trying to provide regular in-service training. However, this is difficult as the ability to provide training opportunities is dependent on funding, which is limited. Additionally, standard operating procedures are not established for

all PCAF clinics. To address this, PCAF is standardizing manuals and protocols to ensure consistency in services; it is recommended that this standardization also include templates for HIV service linkages and referrals at all PCAF clinics. The strength related to cost-effectiveness of this model can also present challenges, and in this case more funds are required to provide more staff training, and in particular training on HIV. This need was mentioned by all PCAF staff.

Mental health needs of women and men: The combined effects of trauma and HIV affect women and men differently; therefore, their support needs and their ability to routinely access MH and HIV services will differ. Client data for PCAF show that women more frequently seek services than men (57 percent of clients are women while 43 percent are men). Tailored approaches may be needed to reach female and male clients and link them to necessary MH and HIV services. Program planning needs to take into account gender differences and provide services targeting the specific needs of women and men, as well as couples, to address both trauma and HIV. Additionally, some populations are more vulnerable to HIV infection, which is many times heightened in post-conflict settings. Women are biologically, socially, and economically more at risk than men in terms of contracting HIV. Women also face a double burden of caring for children, the sick, and ensuring family survival. In many post-conflict settings, women's vulnerabilities are amplified, and they face increasing amounts of gender-based violence (Samuels, Harvey, and Bergmann 2008).

Mental health needs of children: Returning child soldiers and other children affected by war require a comprehensive approach to help them regain mental and physical health and rebuild their lives. Orphans and vulnerable children, as well as children living with HIV, are special subsets of at-risk groups and present unique challenges to service providers.

Recommendations

Recommendations for the Peter C. Alderman Foundation: Some recommendations for PCAF to better integrate HIV into existing MH services are as follows:

- *Referrals and linkages for comorbidities:* Improve referral and linkages with HIV service providers. Each PCAF-supported clinic should have standardized and clear referral pathways so all individuals who are living with HIV or who do not know their status are offered and referred to appropriate care and support services and/or testing (see Box 3 for more detail).
- *Improve data collection related to HIV clients:* Collect data identifying the number of clients with known HIV-positive status for a true rate of HIV among PCAF clients, and use this to track referrals for relevant HIV services. Also, collecting data on client referrals for voluntary counseling and testing and other HIV services should be included in regular data collection and inform MH services for each client. Collecting initial intake data provides a mechanism for follow-up care so PCAF can track those patients who did not know their status to see if they were tested. Patient records should be standardized to incorporate this referral and linkages tracking process.
- *Revisit staffing structure:* PCAF staff spoke to the need to deepen care and support services at the community and household levels. PCAF responded by adding a social worker to their staffing model. This additional staff position should be supported as the program develops further and more appropriately responds to clients' determined and defined needs. Along with the consulting psychiatrist, it may be useful to have a consulting HIV specialist from TASO, or a similar HIV service organization, allocated to each clinic. PCAF should also revisit the overlapping roles of the PCO and psychiatric nurse.

- *Initiate regular training on HIV:* All staff visited recorded the need for more training related to HIV and the special needs of PLHIV. With prevalence being so high in PCAF's areas of operations, regular training on the special MH needs of PLHIV are recommended. MH providers need to have a good understanding in order to recognize and be able to address the comorbidities that occur among PLHIV.

Recommendations for other countries:
PCAF staff, clients, and HIV service organizations had the following recommendations on how to ensure MH services best address the needs of PLHIV. Please note that although these are divided into steps, a country's actions may evolve differently; the steps may overlap significantly in reality.

Step One (setting the stage):

- Plan for the future but start small.
- Build on what already exists.
- Engage a wide range of country partners from the beginning to foster country ownership and sustainability.

Step Two (design, implementation, and capacity building):

- Establish linkages and referrals for comorbidities. It is critical to establish bidirectional protocols to manage linkages and referrals, including testing for those who do not know their status and HIV services for those who are living with HIV.

  For HIV providers: Ensure MH services are available in generalized epidemic settings, and link clients to appropriate MH services, as emotional well-being is known to impact disease progression. Estimated rates of depression among PLHIV vary widely and range between 20 percent and 48 percent among PLHIV in high-income countries and up to 72 percent in resource-limited countries. Mental illness may also be a risk factor for HIV infection due to impaired judgment and high-risk behaviors.

  For MH providers: Ensure the need for HIV services is identified so clients can improve their quality of life by increasing their access to HIV services. Providing PLHIV with MH services and support has been shown to increase ART adherence and clinic attendance, and to reduce symptom severity, morbidity, and mortality (Gutmann and Fullem 2009). MH providers need to have a firm grasp on the impact of both MH and HIV on a client's well-being, and that grasp is central to a comprehensive approach to care and support services. MH providers need to know the general HIV prevalence of the population and understand the HIV and MH comorbidities that may be present.

- Engage in-country MH and HIV experts where possible. Use existing MH systems to identify health trainers, mentors, and advocates. Supervisory systems led by in-country professionals can help establish and maintain quality while also provide culturally appropriate MH services linked to HIV programs.
- Address the specific needs of at-risk populations in program design.
- Routinely monitor results and use data to inform program improvement and scale-up.

Step Three (sustainability and transitioning to country ownership):

- Formalize a system for staff training, mentoring, and supervision to enhance workforce development for long-term sustainability.
- Develop a plan for sustainability and country ownership by empowering national partners (e.g., ministries, nongovernmental organizations, and academic institutions) to take a greater role in program management and support.

Future Programming and Scale-Up

As of March 2010, PCAF provided psychosocial screening for 3,081 clients, of which approximately 70 percent (2,160 clients) required MH treatment. PCAF's strong linkages with the MOH and Makerere University ensured the availability of professional expertise in MH for staff training and supervision, as well as monitoring of quality care. PCAF is continuing to use a multidisciplinary staff model of social workers, psychiatric nurses, and psychologists to add depth and scope to the MH and trauma services provided. Using a strength-based approach, PCAF efforts aim to strengthen the resiliency of their clients and at the same time continue to build linkages and referrals with appropriate HIV services to provide their clients living with HIV the care and support they deserve.

The next steps for PCAF Uganda include the following:

- Hire full-time staff to provide oversight and leadership for PCAF Uganda.
- Expand the community outreach and home visit program.
- Develop stronger links and referral mechanisms with community care and support services, including faith-based programs, to provide more effective case management for clients, including HIV services.
- Develop stronger linkages to encourage bidirectional referrals between PCAF and HIV services organizations such as TASO and others.
- Review services to incorporate more gender-sensitive programming and counseling to address the constraints and strengths of men and women.
- Strengthen services and referrals for children who are affected by trauma and HIV.
- Continue to advocate for MH services for PLHIV.
- Further training for PCAF staff on the special needs of those living with and affected by HIV. ■

REFERENCES

Dona, G. 2010. Rethinking Well-Being: From Context to Processes. *International Journal of Migration, Health and Social Care 6*(2):3–14.

Government of Uganda. 2010. *UNGASS Country Progress Report Uganda: January 2008-December 2009.* Available at http://data.unaids.org/pub/Report/2010/uganda_2010_country_progress_report_en.pdf (accessed September 2010)

Gutmann, M., and A. Fullem. 2009. *Mental Health and HIV/AIDS.* Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1. Available at www.aidstar-one.com/sites/default/files/AIDSTAR-One_Mental_Health_and_HIV.pdf (accessed July 2010)

Inter-Agency Standing Committee. 2007. *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings.* Geneva: Inter-Agency Standing Committee.

IRIN. 2004. Uganda: End the Suffering in Northern Region, MSF Urges. Available at www.irinnews.org/Report.aspx?ReportID=51976 (accessed September 2010)

Kaharuza, F., R. Bunnell, S. Moss, D. Purcell, E. Bikaako-Kajura, N. Wamia, et al. 2006. Depression and CD4 Cell Count Among Persons with HIV Infection in Uganda. *AIDS Behavior* 10:S105–S111.

Kinyanda, Eugene. 2010. Email communication on November 24.

Samuels, F., P. Harvey, and T. Bergmann. 2008. *HIV in Emergency Situations.* London: Overseas Development Institute.

Spiegel, P., A. R. Bennedsen, J. Claass, L. Bruns, N. Patterson, D. Yiweza, et al. 2007. Prevalence of HIV Infection in Conflict-Affected and Displaced People in Seven sub-Saharan African Countries: A Systematic Review. *The Lancet* 369(9580):2187–2195.

RESOURCES

HIV, Mental Health and Emotional Wellbeing (NAM). Available at www.aidsmap.com/page/1321435/

Mental Health and HIV/AIDS: Basic Counseling Guidelines for Antiretroviral Therapy Programmes (World Health Organization). Available at http://whqlibdoc.who.int/publications/2005/9241593067_eng.pdf

ACKNOWLEDGMENTS

AIDSTAR-One would like to thank the team at PCAF, including Dr. Steve and Elizabeth Alderman, Alison Pavia, Dr. Eugene Kinyanda, Dr. Seggane Musisi, and Ethel Nakimuli-Mpungu for their full support in the development of this case study. Likewise, the authors wish to thank the leadership of the Ugandan MOH and PCAF staff in each clinic visited for sharing their experiences and insights. Special thanks also to staff and clients at TASO Gulu and TASO Tororo for sharing their experiences and knowledge on this topic and taking the time to meet with the authors. Thanks also to AIDSTAR-One Uganda, who provided critical logistical support. The case study could not have been successful without the vision, support, and guidance of Andrew Fullem at AIDSTAR-One. Finally, thanks to the PEPFAR team in Uganda and the PEPFAR Care and Support Technical Working Group (co-chairs: John Palen, USAID and Jon Kaplan, CDC) for their vision, technical insight, and financial support for this case study.

RECOMMENDED CITATION

Sharer, Melissa, and Mary Gutmann. 2011. *Prioritizing HIV in Mental Health Services Delivered in Post-Conflict Settings.* Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.

Please visit www.AIDSTAR-One.com for additional AIDSTAR-One case studies and other HIV- and AIDS-related resources.

AIDSTAR-One

AIDS SUPPORT AND TECHNICAL ASSISTANCE RESOURCES

AIDSTAR-One's Case Studies provide insight into innovative HIV programs and approaches around the world. These engaging case studies are designed for HIV program planners and implementers, documenting the steps from idea to intervention and from research to practice.

Please sign up at www.AIDSTAR-One.com to receive notification of HIV-related resources, including additional case studies focused on emerging issues in HIV prevention, treatment, testing and counseling, care and support, gender integration and more.