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# ASSESSMENT OF MENTAL HEALTH AND HIV INTEGRATION PILOT IN ZIMBABWE

**AIDSTAR-One**  
AIDS SUPPORT AND TECHNICAL ASSISTANCE RESOURCES

**JUNE 2013**

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The authors' views expressed in this publication do not necessarily reflect the views of the U.S. Agency for International Development or the United States Government.

### **AIDS Support and Technical Assistance Resources Project**

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# ACRONYMS

ART	antiretroviral treatment
ARV	antiretroviral (drug)
CBO	community-based organization
CHW	community health worker
MOHCW	Ministry of Health and Child Welfare
OI	opportunistic infection
PCC	primary care counselor
PEPFAR	U.S. President’s Emergency Plan for AIDS Relief
PITC	provider-initiated testing and counseling
PLHIV	people living with HIV
SSQ	Shona Symptom Questionnaire
TMP	traditional medicine practitioner
TMPC	Traditional Medicine Practitioners Council
TOT	training-of-trainers
USAID	U.S. Agency for International Development
VHW	village health worker
WHO	World Health Organization
ZACH	Zimbabwe Association of Church-Related Hospitals
ZIMSTAT	Zimbabwe National Statistics Agency



# EXECUTIVE SUMMARY

HIV and mental health problems, in addition to harmful substance use, are global public health concerns and often comorbid issues. Research has demonstrated that people living with HIV (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. Alcoholism is a contributing factor in sexual risk behaviors and non-adherence to HIV treatment regimens (World Health Organization [WHO] 2004). Substance use, inclusive of alcohol, may also be used as a coping mechanism to deal with stress surrounding an HIV diagnosis and is increasing in Zimbabwe (Ministry of Health and Child Welfare [MOHCW] 2012a), although limited formal data is available. Early screening and referral for mental health and substance use, 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 PLHIV (Gutmann and Fullem 2009). The integration of HIV and mental health services is essential to provide PLHIV appropriate and long-term care and support.

To bridge these gaps and to move toward sustainable integration, AIDSTAR-One, in collaboration with the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) Care and Support and Treatment Technical Working Groups and the MOHCW, implemented Part 1 of a pilot activity in Zimbabwe to assess the feasibility of integrating mental health services in HIV care and support in both urban and rural health care facilities. Following a situational analysis of the HIV and mental health service systems in Zimbabwe, a two-day "training of trainers" (TOT) workshop was conducted in July 2012 on mental health and HIV integration. In total, 16 "integration leaders" (workshop participants who committed to actively participate, to train colleagues and community partners at their respective facilities, and to ensure the pilot implementation) attended from five urban and four rural health facilities. In addition, four traditional medicine practitioners (TMPs) and four MOHCW representatives participated in the two-day training.

The training included the introduction and use of three validated screening tools: the Shona Symptom Questionnaire (SSQ) for mental health problems, the CAGE-AID Screening Tool for harmful substance use, and the Abbreviated Community Screen for both (Annexes A, B, and C respectively). Instruction also included basic counseling skills and guidelines for referral of clients with a positive screen. The integration leaders received a training manual and tools to use in training other health care providers in their facilities and communities as part of a cascade training approach. Immediately following the TOT, AIDSTAR-One conducted follow-up visits at each of the participating facilities to provide further support and guidance. The participating sites were expected to implement the cascade training within two weeks of the TOT and subsequently carry out mental health integration as part of routine HIV care and treatment services for a minimum of three months from August to November 2012. All sites involved in the pilot activity successfully implemented the cascade training following the TOT of integration leaders in July 2012, training a total of 279 health care providers, including 95 facility staff, 140 community-based health care providers, and 44 TMPs. In December 2012, AIDSTAR-One conducted an on-site assessment at each of the nine facilities and one TMP site with the following objectives:

- Assess feasibility of the integration tools through provider acceptability, satisfaction, and feedback
- Assess “what worked well” and identify any challenges to integrating mental health services into HIV services
- Suggest potential recommendations to inform a standard operating procedure for standardizing the approach to integrating mental health services into the HIV service platform in Zimbabwe.

A mixed-methods approach was used to collect qualitative data from semi-structured interviews with clinical staff and quantitative data from aggregate data sheets on screening results. A total of 12 interviews were conducted with nurses, counselors, TMPs, and community health workers (CHWs) at nine sites.<sup>1</sup> In addition, 29 post-test surveys were completed by a variety of staff and CHWs who participated in the cascade training to assess transfer of knowledge and perceived benefits of training.

Results of the survey at follow-up indicated that perceived benefits of the training included greater understanding of mental health integration issues, increased comfort in discussing mental health issues with clients, and increased confidence in integrating mental health screening and referrals into routine care. Survey respondents also reported a perceived reduction in mental health stigma at their facilities as a result of the training.

The screening tools used in the pilot were, in general, reported to be understandable and acceptable to both staff and clients.

- A total of 703 SSQs were conducted, of which 159 clients (23 percent) were positive screens with a score of eight or higher. Of those with positive results, 136 clients (86 percent) were referred for further evaluation and treatment, and 86 (61 percent) of the referrals were reported as completed.
- Similarly, 55 positive results (>1) were reported on the CAGE-AID screen for harmful substance use, of which 20 were referred for further care and 9 referrals completed.
- Community partners reported 182 screenings using the Abbreviated Community Screen; 58 clients (32 percent) had positive results and were referred either internally or externally for further follow-up. Of these, 41 clients (76 percent) completed the referral.

Although these data suggest successful use of screening tools at the facility and community level, different facilities used the tools in different ways and with different client populations. The pilot protocol was designed to use mental health screening with all HIV-positive clients, but not all clinics followed the intended protocol. Some clinics used the tools with general clinic clients as well. In addition, some clinics screened all new and existing clients, whereas others were more selective and screened only those alleged as exhibiting signs of mental distress. One of the major perceived benefits of the pilot integration was the identification of mental health problems that might otherwise have been missed and left untreated.

A key theme that emerged from both the quantitative and qualitative data is that the “stepped-care” approach to client care, which uses simple interventions first while reserving more time-intensive interventions for more serious or nonresponsive mental health problems, is not only feasible, but

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<sup>1</sup> Although 10 sites were involved in the pilot and visited, one site implemented only the training portion of the pilot and therefore, no formal interviews were facilitated at this site.

preferred by most providers. Thus, providers typically referred clients with positive screens to a mental health nurse or doctor on-site for further evaluation and management, and provided a referral to more centralized clinics that offer a higher level of mental health services for more serious problems including suicidal ideation. Basic counseling at the site level was reported as one of the most important parts of the pilot program, and staff requested additional training, especially since mental health was a new area of focus for many staff.

Community health workers and TMPs were also seen as important partners in providing a coordinated approach to integrating mental health and HIV care and support. Regular, ongoing, and bidirectional communications between different levels of care is essential for optimal care and support. Although the training included a referral protocol, the actual means of communication between different levels of care was not systematic. The clients themselves are often the source of information on the outcome of referrals when they return to their original providers.

Staff time constraints and work overload present major challenges to the integration of HIV and mental health services. Some sites also mentioned a shortage of screening forms and few incentives for staff to conduct screening, which was seen as “extra work.” Another major challenge was that clients often lacked resources or means of transportation to follow through with referrals. In addition, some providers mentioned the lack of services available for specific problems that were identified during the screenings, such as domestic violence, financial difficulties, or need for basic food and shelter.

Recommendations from the interviewees included:

- Screening should be routine for all clients, not just HIV clients.
- Training in screening and basic counseling should be required of all staff, and “up-skills” training/routine mentoring made available for those already trained.
- Integration procedures should be continued beyond the pilot and scaled-up to other facilities and to the community level to support a culture of mental health and HIV integration.

The following eight recommendations for further work on integrating mental health and HIV services in Zimbabwe are drawn from the key findings and lessons learned in this pilot study:

1. *Scale-up mental health and HIV integration to the community level:* Integration of the screening tools and stepped-care approach was found to be feasible within the nine pilot sites. Scaling up this approach to additional sites within each catchment area will serve to increase awareness surrounding mental health problems and harmful alcohol and substance use, increase identification and treatment for these issues at the community level, and decrease stigma among health care providers, community care providers, and TMPs.
2. *Clarify the role and emphasize the importance of the integration leaders:* Ownership of and commitment to the pilot were important factors to adopting and integrating mental health services. The role and responsibilities of the integration leader need to be well defined and included in any “contractual” agreement with participating sites to ensure that integration leaders are aware of their responsibilities and carry them out in a timely manner. These responsibilities include ensuring that site staff trainings are carried out, that the integration protocol is followed, that strong community linkages are in place, and that quality data is routinely collected for evaluation. Integration leaders should also be available to colleagues as a resource for mental health

integration when questions arise during implementation. Future work with integration leaders should build their capacity for leadership among their peers.

3. *Build the capacity of integration leaders to provide further trainings on mental health care and counseling skills for the initial pilot sites:* Further equipping providers who are providing integrated mental health services with increased skills on mental health screening and counseling will be critical, as mental health care is a new area of service provision for many health care providers in Zimbabwe. The use of on-site cascade training appears to be an effective and cost-efficient way to train facility level and community health care providers on mental health integration processes. Advanced training on the stepped-care approach should be implemented, in line with the National Mental Health Policy and the MOHCW's Mental Health Program.
4. *Build strong bidirectional communication and referral pathways between different levels of health care providers:* Regular, clear, and documented referral and follow-up protocols should be developed and integrated at all sites. Use of a bidirectional client referral form will provide information to the organization receiving the referral, and also provide a means for the originating organization to receive follow-up information including that the client completed the referral.
5. *Explore cultural or contextual issues about substance use and routes to increase screening and management:* Identification of cultural taboos or other contextual issues about discussing alcohol or other substance use issues should be carried out to develop better screening, referral, and management approaches for these clients.
6. *Develop a more robust data monitoring and evaluation system, particularly during supportive supervision:* Data collection methods, as well as the importance of accurate data collection, should be further emphasized during future trainings and pilot preparation, and used for feedback and decision making especially for supportive supervision.
7. *Identify and overcome logistical challenges to ensure sustainability of the integrated program:* Issues surrounding availability of screening tools and data collection forms should be explored with support identified at the country level to ensure a continuous supply is in place. Identification and problem solving for other logistical challenges including privacy, referral completion, and transport for referred clients should also be resolved.
8. *Consider routine mental health and substance use screening at the primary health care level, in addition to HIV-positive clients:* All clients can be screened with the SSQ, CAGE-AID, or Community Abbreviated Screen tool as part of routine care. However, where time is limited, HIV-positive clients could be prioritized.

In conclusion, the assessment of the pilot project indicated that integrating mental health care services was feasible and generally found to be beneficial in identifying and managing mental health needs of PLHIV, as well as the general client population. The overall attitude toward implementing the mental health and substance use screenings was positive and beneficial to holistic care of clients, as without the integration, the mental health issues would have been overlooked. Continued support of and roll-out of the activities will further support mental health and HIV integration to improve health outcomes for PLHIV.

# INTRODUCTION

HIV and mental health problems, in addition to harmful substance use, are global public health concerns and often comorbid issues. A coordinated and comprehensive care and support response is critical to improve health outcomes for people living with HIV (PLHIV). AIDSTAR-One, USAID's global HIV/AIDS project providing technical assistance services to the Office of HIV/AIDS and U.S. Government (USG) country teams, in collaboration with the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) Care and Support and Treatment Technical Working Groups and the Ministry of Health and Child Welfare (MOHCW), implemented a pilot activity that integrated mental health screening, basic counseling, and stepped-care services into HIV treatment and care sites in Zimbabwe. Early screening and referral for mental health and substance use, counseling services, and follow-up care and treatment can improve the quality of life, treatment adherence, and retention in HIV care and support programs for PLHIV (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.

To inform the pilot activity, AIDSTAR-One first developed a situational analysis, *There is no Health without Mental Health: Mental Health and HIV Service Integration in Zimbabwe*, in 2012 (available on AIDSTAR-One's website). Following the situational analysis, AIDSTAR-One conducted a "training of trainers" (TOT) workshop on mental health and HIV integration in July 2012. Following the training, the pilot was conducted at nine health facilities and one TMP. The pilot specifically involved integration of mental health (SSQ) and alcohol and substance use (CAGE-AID) screens into HIV services, provision of basic counseling services for positive screens, as well as a stepped-care approach for referrals within the community for more in-depth services when required. Additionally, an Abbreviated Community Screen was used at the community and TMP level to refer clients to the health facility with potential mental health or alcohol and substance use issues. The pilot activity occurred over three to five months between July and November 2012 (length varied by site). This report discusses the pilot assessment conducted in December 2012.

## HIV IN ZIMBABWE

Although slight improvements have been made in HIV prevalence rates in Zimbabwe in recent years, Zimbabwe has one of the largest HIV epidemics globally, with an overall adult (ages 15–49) HIV prevalence rate of 15 percent (Zimbabwe National Statistics Agency [ZIMSTAT] and ICF International 2012). The prevalence rate among women is 18 percent and is slightly lower for men at 12 percent (ZIMSTAT and ICF International 2012). Zimbabwe's HIV response has demonstrated progress in HIV prevention efforts through behavior change programs and scale up of care and treatment for PLHIV. In 2002, economic conditions limited resources available to the government's National AIDS Council, hindering the country's HIV strategies (AVERT 2011). To better coordinate strategies between the public and private sectors, the MOHCW developed the National Strategic Framework for the Private Sector Response to HIV and AIDS, 2007–2010. At the end of 2011, the MOHCW reported antiretroviral treatment (ART) coverage was 78 percent of adults and 41 percent of children. Findings from AIDSTAR-One's 2012 situational analysis suggest that, overall, HIV treatment is accessible and available, yet barriers remain, including drug shortages,

difficulty obtaining the newest drugs, and a lack of training for health care providers. Zimbabwe's MOHCW ART services are primarily centralized and physician-led; however, the decentralization of services in recent years has resulted in the availability of ART at MOHCW rural primary health centers (the lowest level of MOHCW health facility) and increased access to HIV treatment. HIV treatment is initiated at district hospitals, but within each district some clients are referred to clinics, where their treatment is managed by a nurse (Pitorak, Duffy, and Sharer 2012).

## **MENTAL HEALTH IN ZIMBABWE**

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 consistently recognized as a public health problem. Poor mental health is a significant public health issue 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). Mental health problems are often associated with or intensified by the environment and context. In Shona, a primary language in Zimbabwe, direct translations of the terms “depression” and “anxiety” do not exist. The term “depression” is most often used in Zimbabwe to suggest an “illness” but is not typically associated with emotional symptoms (Patel et al. 2001). Rather, depression is most often presented as a headache, fatigue, or other somatic presentation, and emotional symptoms may be revealed only after a health care provider has inquired. Depression may be depicted as “thinking too much” in Zimbabwean context.

Mental illness is often associated with traditional, cultural, or religious beliefs in Zimbabwe, which was highlighted in the findings of the 2012 situational analysis. Therefore, persons with mental health problems typically seek care and treatment from TMPs before, or instead of, seeking care from the formal health care system (Patel et al. 2001). Traditional medicine remains an active and main component of health care in Zimbabwe, and therefore, including TMPs in the health system structure is essential. In the formal health system the initial point of care for mental health issues is the primary care level, with referral up the system to psychiatric nurses and psychiatrists as needed (MOHCW 2009).

Although limited formal data have been collected about drug and alcohol use in Zimbabwe, their impact in society is substantial. Screening and services for co-occurring alcohol and harmful substance use are also limited; however, anecdotal data suggest their use is increasing in Zimbabwe (MOHCW 2012a). Findings from the situational analysis suggest that substance use is quite common, particularly concerning alcohol and cannabis. Zimbabwe does not currently have any specific health centers for those affected by substance use; instead, these clients are referred to psychiatric units.

Under the national mental health policy, Zimbabwe aims to increase awareness about mental health issues and reduce stigma (MOHCW 2012b). While the structure exists, the mental health care system remains limited, largely uncoordinated with other health services, and suffers from poor infrastructure and limited trained mental health personnel. Specifically, a shortage of psychiatric nurses, psychologists, clinical social workers, and psychiatrists exists, with a 50 percent vacancy rate for psychiatric trained nurses (MOHCW 2009). However, the MOHCW is currently gaining momentum, and steps to revitalize mental health care and increase mental health training are underway. The Zimbabwe National Health Strategy 2009–2013 addresses the status of mental health in Zimbabwe and identifies objectives and strategies to improve the mental health system (MOHCW 2009). In addition, the MOHCW recently developed the Zimbabwe National Strategic Plan for

Mental Health Services, 2012–2016, which provides a framework for mental health and psychiatric services across the country. The MOHCW’s strategy aims to ensure accessible, culturally appropriate, and comprehensive mental health services are available within the Primary Health Care approach (MOHCW internal document 2012c).

## **MENTAL HEALTH AND HIV CONNECTION**

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). Further, alcoholism is not only one of Zimbabwe’s four top diseases (WHO 2004); it is also a major factor in high risk sexual behavior and non-adherence to HIV treatment regimens. The MOHCW has led efforts to highlight the connection between HIV and mental health and move policies forward to address the comorbid conditions. At present, findings from the 2012 situational analysis described the HIV and mental health strategies and services in Zimbabwe as “running as parallel services” (Mangezi 2012; Sithole 2012). However, discussions surrounding integrating these strategies and services are occurring, and steps to proceed in coordination are anticipated.

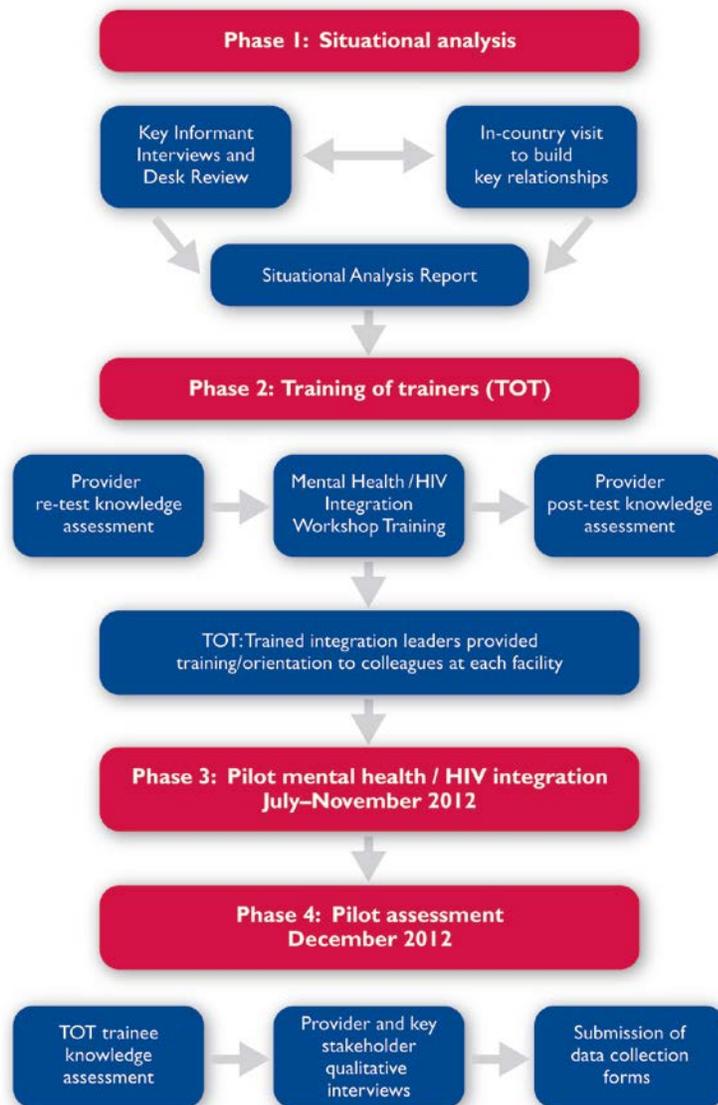
## **MENTAL HEALTH AND HIV INTEGRATION: PILOT ACTIVITY**

In collaboration with the MOHCW and the PEPFAR Care and Support and Treatment Technical Working Groups, AIDSTAR-One implemented an integrated mental health and HIV pilot activity in Zimbabwe that aimed to promote integration of basic mental health services into existing HIV services. The integrated pilot was implemented in four phases. In Phase 1, AIDSTAR-One facilitated the situational analysis report of mental health and HIV service systems in Zimbabwe. An AIDSTAR-One team member visited Zimbabwe in April 2012 to initiate discussions and develop relationships with key stakeholders to move the activity forward. Site selection that followed was based on concurrence with key stakeholders, during which the MOHCW selected five urban clinics and the Zimbabwe Association of Church-Related Hospitals (ZACH) selected four rural facilities to participate in the pilot integration process in Phase 2. ZACH is a not-for-profit member-based organization supporting 126 hospitals and clinics. As an association, ZACH supports the planning and coordination of training programs in medical services of its members. Through further discussions with the Traditional Medicine Department within the MOHCW and the Traditional Medicine Practitioners Council (TMPC), TMPs were also invited to participate.

AIDSTAR-One, with support of the MOHCW, Harare City Clinics, and ZACH, facilitated a TOT workshop in July 2012 for select staff from participating sites on integrating mental health services into HIV care. The MOHCW and ZACH collaborated with pilot sites to select staff who then received a formal invitation from AIDSTAR-One, in collaboration with the MOHCW to participate in the workshop, which included roles and responsibilities that participants were expected to agree to. Specifically, participants were trained on implementing validated mental health and substance use screening tools that included: 1) the SSQ for health care providers; 2) the CAGE-AID for health care providers; and 3) the Abbreviated Community Screen for CHWs and TMPs. The SSQ is an indigenous tool and has been validated in Zimbabwe. While not formally validated in Zimbabwe, the

CAGE-AID is a widely accepted tool that has been used globally for substance use. The Abbreviated Community Screen was adapted from a mental health and HIV integration program in Vietnam<sup>2</sup>, with the most sensitive screening question for substance and alcohol added to the tool. The tools were all made available in Shona and English for the pilot. Participants were also trained to provide basic counseling services and referral for more in-depth services when necessary. The team provided supportive follow-up visits immediately after the training to all participating sites to ensure the cascade training and pilot were scheduled. Phase 3 involved pilot implementation that was conducted from July 2012 to November 2012. Lastly, Phase 4 describes the pilot assessment, which is the focus of this report. The pilot phases are summarized in Figure 1.

**Figure 1. Integrated HIV and Mental Health Pilot Phases**



<sup>2</sup> This program was implemented by FHI with support from USAID and the Centers for Disease Control and Prevention. For more information, please refer to the relevant AIDSTAR-One's case study here: [http://aidstar-one.com/focus\\_areas/care\\_and\\_support/resources/case\\_study\\_series/mental\\_health\\_vietnam](http://aidstar-one.com/focus_areas/care_and_support/resources/case_study_series/mental_health_vietnam).

## **TRAINING OF TRAINERS ON INTEGRATION TOOLS AND PROCESS**

In July 2012, with support from the MOHCW, AIDSTAR-One facilitated a two-day TOT workshop on implementing a stepped-care model of mental health and HIV integration, which focused on screening clients for mental health problems, providing basic counseling and therapeutic communication, and referring clients to a higher level of care, as needed. Specifically, applying a stepped-care model initially uses simple interventions; more time- and resource-intensive interventions are reserved for clients who have not improved or who are experiencing acute alcohol withdrawal or suicidal ideation. A total of 16 health care providers from five urban facilities, four rural hospitals, and one traditional medicine practitioners' organization participated based on direction from the MOHCW, ZACH, and the TMPC. The workshop's training modules included: 1) Welcome/Pre-Test, 2) Basics of Mental Health, 3) Screening Tools Introduction, 4) Linkages for Community-based Support, 5) Preparation for Co-facilitation Session, 6) Therapeutic Communication Skills, 7) Logistics for Integration, 8) Practice Co-facilitation Session, and 9) Wrap-Up/Post-Test.

As stakeholders in this activity and in Zimbabwe's health care system, the staff was trained as integration leaders to help ensure commitment and roll-out of the integration pilot activity at their respective sites. Integration leaders were also responsible for providing supportive supervision to their colleagues and community partners that they trained at their facilities. Participants who attended the training sessions were expected to agree and accept responsibilities as integration leaders, including training their colleagues and community partners through the cascade approach, ensuring screening, collecting screening and referral data, and following the mental health and HIV integration standard operation protocol, which delineated roles and responsibilities. Integration leaders were provided with a participant's manual that included site-staff training materials, data collection materials, job aids, an emergency action template, MOHCW guidelines, supportive supervision tools, and the screening tools. The referral protocol for positive screens is described in Figure 2.

For the integration pilot activity, integration leaders were trained to use three screening tools, which varied for level of provider. Findings from the situational analysis assisted in the process to select appropriate screening tools for this pilot. For instance, the WHO self-report depression questionnaire was used during the 1980s. This screening tool was translated and adapted into Shona as the SSQ to diagnose depression (Patel et al. 2001). Key informants from the 2012 situational analysis reported that the SSQ was often used in Zimbabwe. The SSQ, developed by nurses and TMPs (Patel et al. 1995), is the first indigenous screening tool in Zimbabwe to detect depression and anxiety. In addition, the SSQ was selected due to its cultural relevance and validated ability to pick up common mental health problems in 14 questions, whereas other validated mental health screens are much more extensive and less "integration friendly." The SSQ was intended to be used at the health facility level to identify common mental health problems (Annex A). The SSQ is a 14-item tool, requiring "yes" or "no" responses that indicate whether the client has experienced the symptom in the past week. All "yes" responses should be tallied, and a score of eight or greater indicates that the client may be experiencing depression or anxiety and is in need of a referral (Patel et al. 1995). A score of 10 or greater warrants a same-day immediate referral for additional mental health screening.

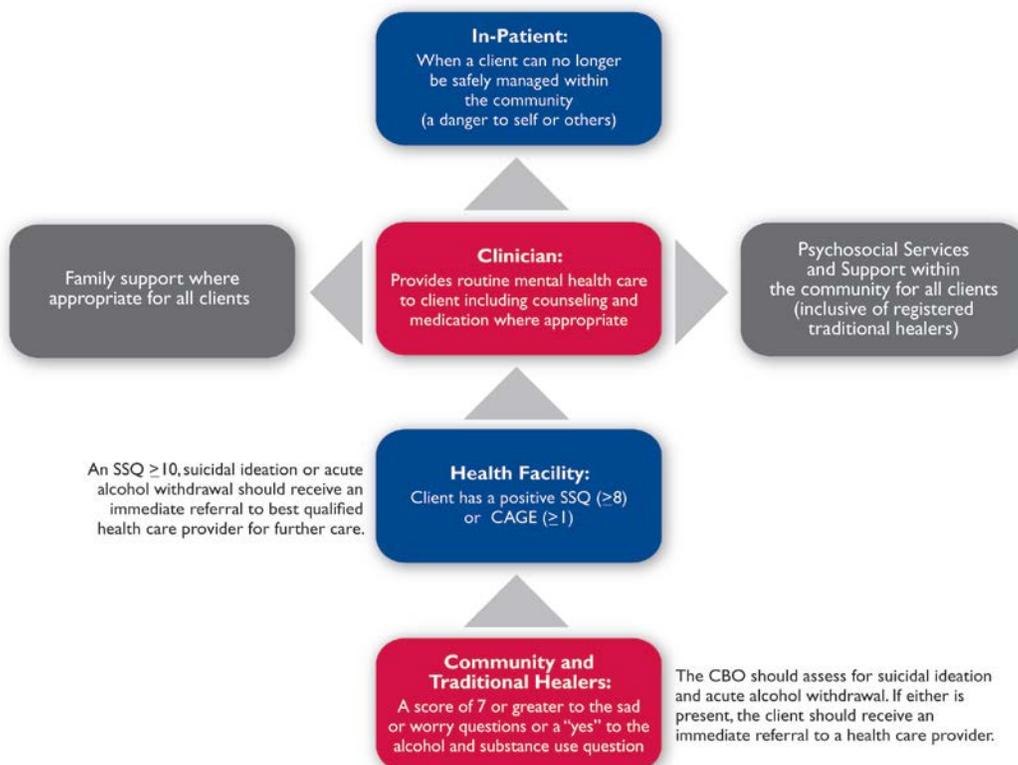
In terms of substance use screening tools, the WHO's Alcohol, Smoking, and Substance Involvement Screening Test has also been implemented in Zimbabwe (MOHCW 2012a); however,

it was described by community health care workers as cumbersome and time consuming. The CAGE-AID screening tool for substance use chosen for this pilot activity, although not formally validated in Zimbabwe, has wide international use (Mangezi 2012). The CAGE-AID was also intended to be used at the health facility level to screen clients for alcohol and substance use problems (Annex B). The CAGE-AID is a four-item tool, requiring “yes” or “no” responses about alcohol and substance use. Any “yes” response warrants further investigation and referral; and a score of three to four indicates alcohol or substance use dependence unless proven otherwise (Lanier 2008).

The final tool, the Abbreviated Community Screen, consists of three questions to screen for mental health and substance use issues (Annex C). For this pilot, the Abbreviated Community Screen was intended to be used by trained community partners (e.g., village health workers and TMPs), which requires strong linkages and bidirectional communication between the community partner and health facility. All of the tools were made available in English and Shona. The Abbreviated Community Screen consists of three questions to screen for both mental health and substance use issues. The first question refers to feelings of “sadness,” and the second question asks clients to rate their feelings of worry. The last question refers to harmful alcohol or substance use. A rating of seven or greater to the first two questions or a positive response to the third question warrants a direct referral to a health facility.

Immediately following the training, AIDSTAR-One provided follow-up site visits at each of the participating facilities to ensure the cascade training was scheduled, to finalize referral directories, and resolve any issues or answer any immediate questions. Following the on-site trainings, the intervention period began. AIDSTAR-One conducted a pilot assessment beginning in December 2012 to understand the feasibility of integrating the tools and the stepped-care approach into routine services. One of the findings from this assessment was the need for a more streamlined protocol tool for a positive screen. Recommendations adapting this tool included clearly indicating the type of specialist and level of care needed (e.g., primary, secondary, specialist services, etc.).

**Figure 2. Protocol for a Positive Screen**



## **ASSESSMENT OBJECTIVES**

AIDSTAR-One conducted the pilot assessment from December 10 to 14, 2012, visiting all facilities that participated in the pilot activity. The objectives were to:

- Assess feasibility of the integration tools through provider acceptability, satisfaction, and feedback
- Assess “what worked well” and challenges to integrating mental health services into HIV services
- Identify potential recommendations to inform a standard operating procedure for mental health integration in Zimbabwe.



# METHODOLOGY

AIDSTAR-One conducted a mixed-methods assessment with the support of the MOHCW to determine the feasibility of integration of mental health services in HIV care and support. The assessment goal was to outline the process (what worked well, what could be improved, and what challenges were encountered), document lessons learned, and understand implications for future planning of integrating the services in Zimbabwe. The assessment team included Dorcas Sithole, Deputy Director of Mental Health Services (MOHCW), Ilana Lapidos-Salaiz, USAID/Washington, Thomas Kresina, Substance Abuse and Mental Health Services Administration, two AIDSTAR-One researchers, and two local consultants who assisted with logistical arrangements.

During the July 2012 workshop, participating health workers took a 10-item pre-test before the training. The short pre-test was designed to assess knowledge level of mental health and HIV integration. The test was then administered as a post-test at the conclusion of the training to reassess knowledge after participation in the workshop. During the follow-up assessment, a sample of health care providers, trained by the integration leaders through the cascade TOT training, were also administered the knowledge assessment to assess transfer of knowledge as well as six additional questions on outcomes related to the integration. (Refer to Annex D for the Knowledge Assessment.)

During follow-up, semi-structured qualitative interviews were conducted with 12 health care providers, including integration leaders who attended the July 2012 training as well as other facility- and community-based nurses, psychiatric nurses, mental health nurses, counselors, health promoters, and traditional medicine practitioners utilizing a semi-structured interview guide. The qualitative interview questions focused on the providers' experiences with the cascade TOT training model, integrating mental health screening post-training, their use of and perception of the screening tools, the mental health referral process, documentation, challenges encountered, and recommendations for other facilities interested in integration. (Refer to Annex E for the Interview Guide.)

The data collection forms used during the pilot implementation period were also reviewed. These forms included data on the sex of the clients, their SSQ or CAGE-AID scores, whether they were referred for follow-up, and whether the referral was completed.

## FACILITIES

All sites that participated in the pilot integration training in July 2012 were assessed. Urban sites were selected by the MOHCW. In Harare, TMPs were also included because of their integral role in health care, particularly mental health care, in Zimbabwe. Table 1 provides a list of facilities that participated in the pilot.

**Table 1. Facilities Participating in the Integration Pilot and Assessment**

Harare City Clinics	ZACH Mission Hospitals	Traditional Medicine Practitioners
Budiriro Polyclinic	Howard Mission Hospital	Ruwa/Zimre Traditional Healers Association
Kambuzuma Polyclinic	Nhowe Mission Hospital	
Kuwadzana Polyclinic	Nyadire Mission Hospital	
Mufakose Family Health Services	St. Paul's Musami Mission Hospital	
Rujeko Polyclinic Dzivaresekwa		

# RESULTS

The mental health and HIV integration assessment team visited all sites that were engaged in the pilot activity over a one-week period (December 10–14, 2012) to facilitate the assessment. The assessment team divided into two teams to implement most site visits. A total of nine sites and one TMP were visited within Harare and surrounding rural areas. Semi-structured interviews were conducted with the integration leaders or other key staff involved in the integration pilot, in addition to facilitating post-test survey assessments to staff or community-based partners who were trained as part of the cascade training and actively involved in the pilot. Table 2 describes the data sources from the assessment visits.

**Table 2. Assessment Data Sources**

	Urban (n 5)	Rural (n 4)	TMP (n=1)
# of pilots visited	5	4*	1
# of interviews	6	4	2
# of post-test surveys	13	12	4

## FEASIBILITY AND RESULTS OF CASCADE TRAINING

All sites involved in the pilot activity participated in the cascade training following the TOT training of integration leaders in July 2012. A dominant theme that emerged from the analysis was that the cascade training component of the pilot activity was feasible for the trained integration leaders to implement. However, one site was unable carry out training for all modules according to the protocol due to unforeseen community unrest that disrupted hospital functions.

The cascade trainings involved a variety of facility-based staff, community-based partners, and TMPs. Facility-based staff trained during the cascade trainings included nurses (e.g., opportunistic infection nurses, maternal and child health nurses), doctors, primary care counselors, technicians, and rehabilitation assistants. Community partners that were trained included CHWs, home-based caregivers, and health promoters. In some instances, interviewees mentioned certain community partners were invited to the training but did not attend the training due to staff shortages. Detailed results of the cascade trainings are depicted in Tables 3 and 4. Most of the cascade trainings were facilitated within one to two weeks following the July 2012 TOT. While data was not available for all sites, the on-site trainings ranged in length from three hours to two days.

\* Although all sites were visited, one ZACH site was unable to implement the pilot activity due to unforeseen events. The cascade training was carried out by the trained integration leaders at this site, but no formal assessment was conducted.

**Table 3. Cascade Training Results for Clinics and Traditional Medicine Practitioners**

Site	Type of Staff	# Trained	Level of Staff
Kuwadzana Polyclinic	Clinical staff (not specified)	9	Facility
	Community partners (including health promoters, police)	20	Community
	HIV support groups leaders (PLHIV)	10	Community
Kambuzuma Polyclinic	Primary care counselors (PCC)	2	Facility
	Health promoters	7	Community
	Community trust workers	3	Community
Rujeko Polyclinic	Nurses	20	Facility
	Community partners	25	Community
Budiro Polyclinic	Nurses	8	Facility
	PCCs	2	Community
	Community partners	21	Community
Mukafose Family Health Services	Staff (including 1 PCC)	5	Facility
	Community partners	8	Community
Ruwa/Zimre Traditional Medicine Practitioners (TMPs)	TMPs	40	Community
	Community partners	6	Community
	<b>Total facility staff trained</b>	<b>44</b>	
	<b>Total community partners trained</b>	<b>102</b>	
	<b>Total TMPs trained</b>	<b>40</b>	
	<b>Total trained</b>	<b>186</b>	

**Table 4. Cascade Training Results for Zimbabwe Association of Church-Related Hospitals**

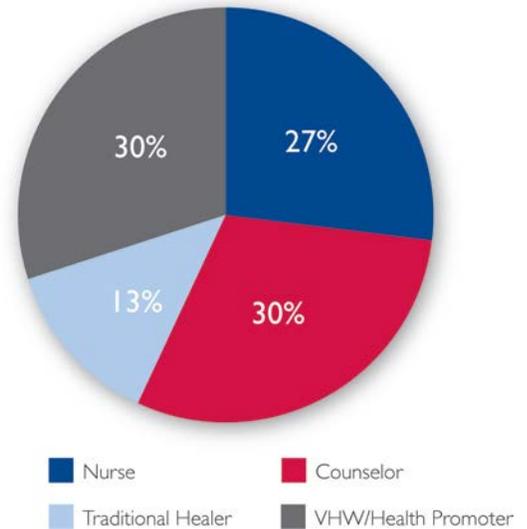
Site	Type of Staff	# Trained	Level of Staff
Nhowe Mission Hospital	Nurses	12	Facility
	Technicians	8	Facility
	Community health workers (village health workers, home-based caregivers)	10	Community
Howard Mission Hospital	Maternal and Child Health nurses	2	Facility
	Opportunistic Infection (OI) nurses	2	Facility
	Counselors	4	Facility
Nyadire Mission Hospital	Nurses	11	Facility
	Nurses (from rural health centers)	4	Community
	Home-based care givers	10	Community
	Traditional medicine practitioners	4	Community
St. Paul's Musami Mission Hospital	Nurses	9	Facility
	Primary care counselors	2	Facility
	Rehabilitation assistant	1	Facility
	Village health workers	14	Community
	<b>Total facility staff trained</b>	<b>51</b>	
	<b>Total community partners trained</b>	<b>38</b>	
	<b>Total TMPs trained</b>	<b>4</b>	
	<b>Total trained</b>	<b>93</b>	



# PRE-POST TESTS

Mental health knowledge was assessed through a pre- and post-test. The integration leaders' average score on the knowledge assessment during the July 2012 TOT workshop increased slightly from 79 percent pre-training to 82 percent post-training. During the assessment, a sample of trainees who participated in the cascade training were administered the knowledge assessment as well to assess transfer of knowledge. In total, a sample of 30 staff who received training by the integration leaders at the 10 facilities assessed received an average score of 80 percent on the knowledge assessment. Figure 3 provides the various cadres of staff who completed the knowledge and attitude assessment during the December 2012 assessment.

**Figure 3. Provider Level of Knowledge Assessment Respondents**



## MENTAL HEALTH SCREENING

### FEASIBILITY AND USABILITY OF TOOLS

Overall, the majority of interviewees responded positively in regard to the feasibility of integrating the screening tools. Specifically, once health care providers became familiar with the tools, the tools were considered easy to understand. For example, one interviewee described the SSQ as “clear and elaborate.” As a result, the use of the screening tool increased over time. The tools were also generally perceived to be understood by clients. A mental health nurse explained, “The tools were easily understood by our clients and easy for staff to use.” Although the tools were feasible overall, a respondent at one site indicated that the SSQ question related to hallucinations (question five) was interpreted in different ways culturally and could lead to a misdiagnosis. Also noted, one interviewee suggested that the CHWs had some challenges comprehending the tools. Nevertheless, the screening tools were being used at all sites visited. At the community level, the Abbreviated Community Screen, and in some cases the CAGE-AID, were applied.

Results from the interviews suggested that the SSQ was the most often used screening tool and was deemed beneficial. The screening tools helped trained staff become more aware of mental health issues, and the tools, particularly the SSQ, were perceived to be useful in identifying mental health problems. For instance, one interviewee indicated that, “The SSQ is very beneficial in exploring client problems.” The TMPs were also open to the SSQ and CAGE-AID, wherein the latter tool was useful and complemented their practices and remedies for alcohol dependency. However, challenges to implementing the protocol were encountered, as discussed below. The CAGE-AID also appeared to be less often used than the SSQ at the facility level, but reasons for this are unclear.

## **SCREENING PROTOCOL AND OUTCOMES**

The integrated mental health and HIV pilot activity's screening protocol was designed to screen all HIV-positive clients for mental health and substance use issues as a baseline. Based on the results, clients with a positive screen would be managed or referred for care, and clients with a negative screen would be reassessed after one year or sooner, depending on the provider's judgment. However, results from the interviews indicated variations in the screening protocol implemented during the pilot. The screening process varied by which clients were screened. More specifically, at some sites only HIV clients were screened, whereas at other sites non-HIV clients were included in the screening process. For instance, one interviewee described the screening process as, "[we] screen HIV-positive clients, initiated through PITC (provider-initiated testing and counseling) or clients on ARVs." However, another interviewee suggested, "the SSQ is used on all clients in the OI (opportunistic infection) and outpatient clinics." Additionally, the screening process was applied differently across sites and among community-based partners; e.g., some sites screened all clients, whereas other sites screened clients selectively after informally "pre-screening" clients for signs of distress or symptoms of depression or took a medical history before use of the tools. In implementing a "pre-screening," the tools were often used as diagnostic measures. The latter approach was often implemented at both facility and community levels.

Interviewees described perceived client acceptability of screening as generally favorable; however, some clients were more responsive and willing than others to participate. One respondent suggested that the clients were "grateful" for the screening. Further, another key theme that emerged from the interview data was that the screening tools helped identify mental health problems that would have otherwise been overlooked. For example, one interviewee commented, "[the screening tools] helped identify clients with problems we didn't know before." Before this pilot, clients may have only been referred for exhibiting violent behavior. Some respondents indicated the most important aspect of the pilot intervention was identifying clients who have mental health issues and need treatment. Many respondents indicated that they were not aware of the risks for mental health problems. Depression was the most common mental health issue found. Some suicidal cases were identified, and those clients were referred for treatment. The interviewees generally reported fewer clients with harmful substance use but did not specify why.

## **SCREENING AND REFERRAL DATA**

At the pilot training workshop in July 2012, integration leaders were provided with data collection forms and asked to record data on the sex of the clients, their SSQ or CAGE-AID scores, whether they were referred for follow-up, and whether the referral was completed. (See Annex F.)

Due to limitations in staff time and loss of records in some places, not all facilities provided complete data. The screening and referral data that was analyzed included nine facilities because one site did not carry out the activities. A total of 703 SSQ screenings were reported, of which 159 clients (23 percent) screened positive, with a score of eight or higher. The facilities reported that 136 clients (86 percent) that screened positive on the SSQ were referred for further evaluation or treatment. Of the referrals made, including internal and external referrals, 83 (61 percent) were reported as completed.

**Table 5. Shona Symptom Questionnaire Data Collection Results  
SSQ Screenings – Facility Level**

Facility	SSQ screenings	SSQ > 8	Referred	Referral completed
Kuwadzana Polyclinic	96	Not reported	49*	Not reported
Kambuzuma Polyclinic	174	27	22	12
Rujeko Polyclinic	205	55	55	38
Budiriro Polyclinic	52	33	19	12
Mufakose Family Health Services <sup>3</sup>	Missing	Missing	Missing	Missing
<b>Clinic subtotal</b>	527	115	96	62
Nhowe Mission Hospital	48	10	9	9
Howard Mission Hospital	—	—	—	—
St. Paul's Musami Mission Hospital	12	2	2	Not reported
Nyadire Mission Hospital	91	19	19	12
<b>Rural Hospital Subtotal</b>	151	31	30	21
Traditional Medicine Practitioners	25	13	10	Not reported
<b>Total</b>	<b>703</b>	<b>159</b>	<b>136</b>	<b>83</b>

While the actual number of CAGE-AID screenings for harmful substance use is not known, the facilities reported 55 cases of CAGE-AID scores equal to or greater than one. Of these clients, 20 (36 percent) were reportedly referred for follow-up.<sup>4</sup> Of those referred for follow-up, nine clients (45 percent) reportedly completed the referral.

\* Screenings reportedly conducted; however, data collection forms were lost.

<sup>3</sup> Not added to the total because the number of positive screens is unknown.

<sup>4</sup> Rujeko Polyclinic did not report the number of clients referred for follow up of the 26 positive screens they reported, lowering the referral rate. If the 26 positive screens are removed, the referral rate increases to 69 percent.

**Table 6. CAGE-AID Data Collection Results:  
CAGE-AID Screenings – Facility Level**

	CAGE AID screenings $\geq 1$	Referred	Referral completed
Nhowe Mission Hospital	8	3	3
St. Paul's Musami Mission Hospital	8	7	Missing
Nyadire Mission Hospital	6	4	0
Budiriro Polyclinic	1	Missing	Missing
Rujeko Polyclinic	26	Missing	Missing
Kambuzuma Polyclinic	6	6	6
<b>Total</b>	<b>55</b>	<b>20</b>	<b>9</b>

Community-based partners conducted 182 screenings using the Abbreviated Community Screen. In total 58 (32 percent) clients screened positive with a score of seven or higher to the “sad” or “worry” questions. Of the 58 clients that screened positive, nearly all were referred for follow-up (93 percent). A total of 41 clients (76 percent) completed the referral. The screening data from community-based partners were only submitted by the rural sites indicated below.

**Table 7. Abbreviated Community Screening Data Collection:  
Community Screenings**

	Screenings	$\geq 7$	Referred	Referral completed
Nhowe Mission Hospital	48	3	3	3
St. Paul's Musami Mission Hospital	119	40	36	34
Nyadire Mission Hospital	15	15	15	4
<b>Total</b>	<b>182</b>	<b>58</b>	<b>54</b>	<b>41</b>

Although determining health outcomes was not an objective of this pilot assessment, more in-depth data our team collected at a few sites suggested some clinical trends that may have implications for future programming. (See “A Snapshot of Preliminary Health Outcomes: Comparison of Three Sites” on the following page.) These preliminary observations are based on a small sample of health facilities and would need further evaluation with a larger number of sites to determine whether they hold true.

## **A Snapshot of Preliminary Health Outcomes: Comparison of Three Sites**

*Pre-screening may be useful for identifying clients at higher risk of mental health issues.*

At one urban facility, clients were “pre-screened” based on signs of distress, e.g. crying, short answers, etc., by health care staff and then selected to be assessed with the SSQ and/or the CAGE-AID. At another urban facility, clients were given the SSQ and the CAGE-AID according to protocol (no “pre-screening”), with screenings conducted sometimes in a group format, wherein clients listened to instructions/questions and completed the screening tool individually. At the site employing a “pre-screening” approach, 39 percent of clients (n=161) screened positive for mental health issue; at the second site 23 percent of clients assessed without a pre-screen (n=233) were positive for a mental health issue. Both sites show a need for mental health screening, but “pre-screening” may increase the efficiency of identifying clients in need of mental health services.

*The combined use of the CAGE-AID and the SSQ may be useful in identifying co-occurrence of mental health and harmful substance use issues in clients at both the facility and community level.*

In one urban community-based setting, 55 percent of clients who screened positive on the CAGE-AID, also screened positive for mental health problems; 40 percent of those who screened positive on the SSQ for mental health issues also screened positive for alcohol or other substance use issues. Further, at another urban site, 40 percent of clients were screened as having co-occurring mental health and alcohol issues. Both of the sites suggest high rates of co-occurrence, and should be considered in future programs.

## **CLIENT MANAGEMENT AND REFERRAL**

### **THE “STEPPED-CARE” MODEL**

A key theme that emerged from the interview data was the application of the stepped-care model, wherein simple interventions are first used in client management, and more time- and resource-intensive interventions are reserved for clients who have not improved through simple interventions or who are experiencing acute alcohol withdrawal or suicidal ideation. Results indicate that most providers used the stepped-care model by utilizing on-site counseling and referral resources as a first step, and then referring more difficult or serious cases to higher levels of care. Thus, providers typically managed clients at lower levels of care during the pilot activity.

Most interviewees discussed referring to a mental health nurse or doctor on-site, and CHWs referred to the facility level. For example, one interviewee suggested, “[I] try to manage [clients] at the primary care level first”; similarly, another stated, “Generally, first referral is to the mental health nurse or PCC (primary care counselor), then to Harare Hospital if additional care is needed.” Clients that needed further, advanced care or treatment (i.e., clients experiencing suicide ideation or harmful substance use) were referred to a skill health facility or psychiatric hospital. Counseling was often provided by on-site staff, e.g., a mental health nurse or PCC. Some interviewees indicated that counseling, including peer support groups, at the lower levels was the most important component of the pilot activity and that all staff should be trained in basic counseling skills. For instance, one interviewee commented, “‘continuous counseling’ is important and helps with coping.” In some cases, health care providers would involve family members and relatives, especially regarding HIV disclosure issues.

## COMMUNICATION AND STRATEGIES FOR CLIENT FOLLOW-UP

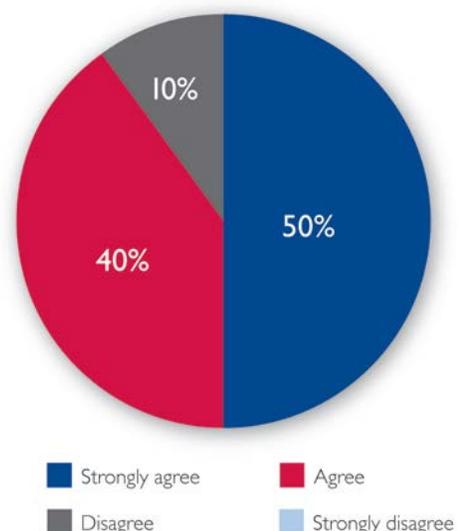
Regarding client management and referral, a key theme that emerged from the interview data is that communication between the CHWs and health facilities was viewed as important to implementation of the pilot activities. Regular, bidirectional communication was particularly useful, and this was more often discussed at the rural hospitals. While communication was an important factor, follow-up and referral issues remained as challenges. For example, one site informed community stakeholders (e.g., the TMP council, hospital department directors, and village chiefs) of the pilot activity before initiating the activity, and this was found beneficial in facilitating the rollout of the activity. In terms of client follow-up, interviewees identified that clients are often the source of referral feedback when they returned to their local facilities. At most sites, interviewees explained that the screening score was recorded in the clients' record booklets, which they would bring with them. However, follow-up on referrals remains a challenge, particularly at rural sites. In some cases, CHWs assisted with follow-up activities, and at one urban site cell phones were used to contact clients and referral sites for follow-up.

## PERCEIVED BENEFITS/“WHAT WORKED WELL”

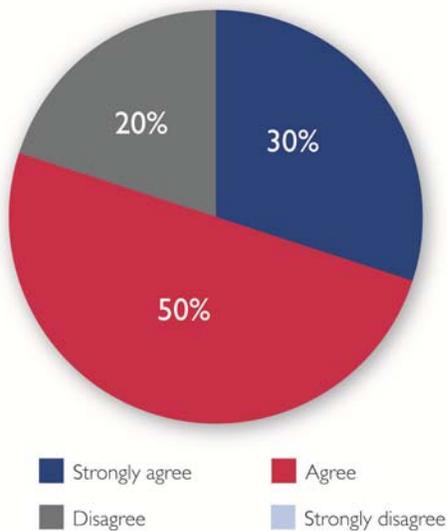
One of the most important perceived benefits of the screening and integration protocol was the identification of mental health problems that might otherwise have been missed. The screening process “opened the door” to discussing mental health problems and helped in making decisions about client care (general nurse). (One clinic reported that before the pilot activity only clients who became violent were referred for psychiatric services.) Additionally, the use of the screening tools improved the patient-provider relationship and enhanced engagement of patients in care. It also raised staff awareness of mental health issues and gave them a better understanding of mental health issues, which was a new area of focus for some staff. (See Figure 4.)

Results from the post-test survey indicated that overall, providers agreed that the training increased their understanding of mental health integration issues. Of the 30 providers trained by the integration leaders, 90 percent either agreed or strongly agreed.

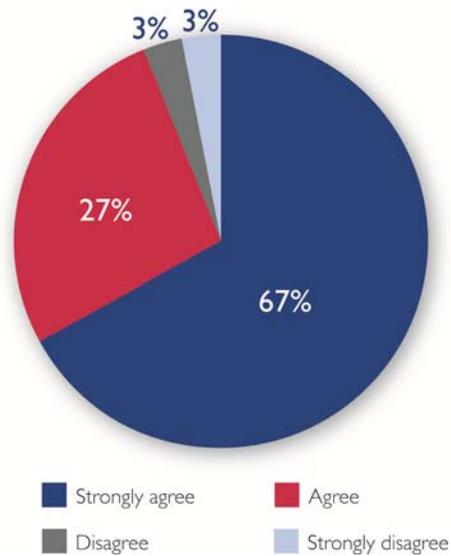
In total, post-test survey results indicated that 80 percent of the respondents agreed with the statement that mental health stigma was reduced in their facilities following the training provided by integration leaders. Interviewees also reported a change in staff attitudes toward clients with mental health issues as a result of the pilot activities. (See Figure 5.)



**Figure 5. Mental Health Stigma Reduction**



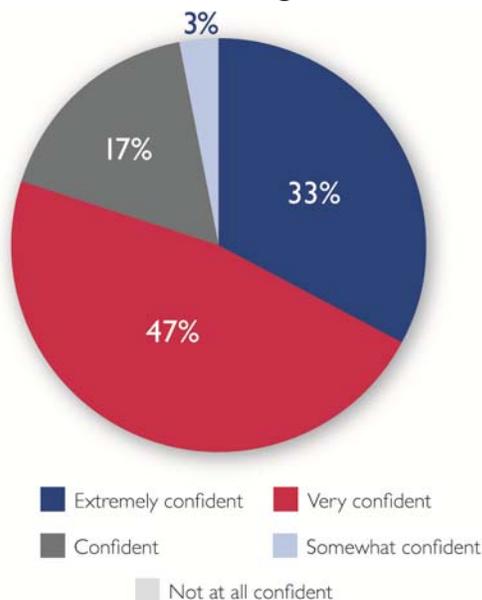
**Figure 6. Comfort in Discussing Mental Health Issues**



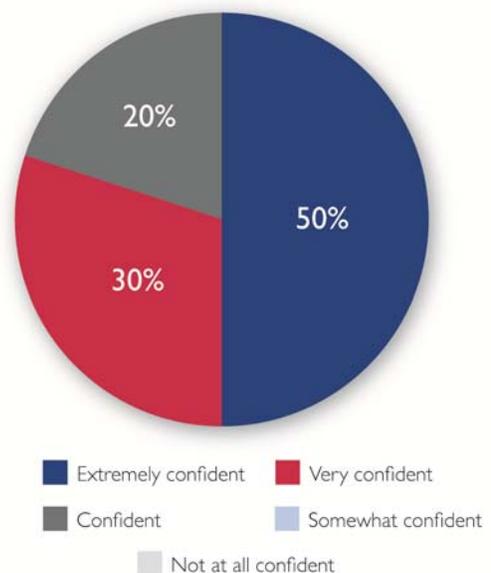
Interview results and the post-test survey indicated that providers who participated in the cascade training expressed a greater confidence in their ability to integrate mental health screening and referral into routine client care and were more comfortable discussing mental health issues with clients. (See Figure 6.)

Integration leaders' confidence in their ability to integrate mental health screenings and make appropriate referrals based on the screening increased post-training. On a scale of one (not at all confident) to five (extremely confident), the average score was 3.8 before training and 4.7 post-training. The providers who received cascade training from the integration leaders at their facilities reported similarly high levels of confidence in their ability to integrate mental health screenings into their routine care (on a scale of one to five average: 4.1) and confidence in their ability to make appropriate referrals based on mental health screens (average: 4.3). (See Figures 7 and 8.)

**Figure 7. Confidence in Integrating Mental Health Screenings**



**Figure 8. Confidence in Making Referrals for Mental Health Issues**



The ability to identify mental health problems, improved use of referrals, and increased staff confidence in the integration of mental health services into routine care were deemed to be some of the most important benefits of the integration pilot. This was especially true of the SSQ screening, which facilitated the use of a stepped-care approach to addressing mental health issues. Results of the post-test survey indicated that two-thirds (20) of the respondents trained by the integration leaders strongly agreed that they were more comfortable discussing mental health issues post-training.

## **CHALLENGES IN IMPLEMENTATION**

Interviewees mentioned a number of challenges to implementing the integration protocol. The challenges primarily fell into two categories: those related to system issues and those related to perceived client barriers. In terms of system issues, the most common challenge was related to staff workload and time constraints. Chronic staff shortages and a high volume of clients limited the staff's ability to administer the screening tests or provide basic counseling. One clinic saw more than 100 clients per day, allowing only a few minutes per client. The nurse interviewed indicated that she used her spare time to administer the screening tools to clients. Lack of space and privacy in the clinic environment also interfered with screening and counseling of clients with mental health issues. Given these constraints, staff indicated that they lacked incentives for integrating mental health screening, which they perceived as “extra work,” into their routine care. Some clients were also reluctant to participate in screening, although staff was able to counsel some of them about their concerns. Some clinics noted a shortage of screening forms and a lack of resources to print more forms as deterrents to further screening. Additional staff training was recommended on both the use of screening tools and counseling skills.

Based on available information, 61 percent of referrals for mental health services were completed. Important to note, the percentage of referrals that was derived from the data sheets was not corroborated with other information or with interviewees. One of the major challenges discussed by all interviewees was that clients lacked the money and means for transportation to the referral site. Lack of means or money for transport to referral facilities was perceived as a major barrier for clients at most sites. Further, some clients will seek care with local providers but may be reluctant to go to a hospital or referral site for additional care and treatment. As reported by one TMP, “People come to us, but do not want to go to referral.”

Interviewees also indicated that they did not know where to refer clients with certain types of problems identified through screening (i.e., financial problems, need for food and shelter, and domestic violence). For instance, one interviewee explained, “[I am] unsure of how to handle some client issues...not being able to refer for financial issues.” However, as screening tools uncovered other client issues that are associated with stress or anxiety, one site mentioned referring patients to social workers or scheduled home visits to try to address some of these identified needs.

## **CONTINUATION AND SCALE-UP**

Most participating facilities indicated that they would continue the integration protocol and were in favor of scaling up to other sites. As stated by a staff member at a Harare city clinic, “Mental health is as good as ARVs (for HIV clients)... it was a big omission (in standard care).” However, to continue the integration protocol, they would need additional screening forms, resources to follow up on referrals, more training, and on-the-job supervision and support. Community health workers and TMPs interviewed also think highly of the program and wish for it to continue.

## **RECOMMENDATIONS FROM INTERVIEWEES**

Several interviewees suggested that screening should be “routine” for all clients, not just HIV clients. However, staff should be given adequate time and training on the use of the tools, and if possible, incentives for integrating the screening tools into their routine care, according to some respondents. The tools could also be revised to correct areas of misunderstanding (e.g., question five on the SSQ) and made easier to use (e.g., shorter questionnaire, group questions into categories such as depression, suicide ideation, psychosis, etc.). One suggestion was to attach a carbon copy (duplicate) to the tools that can be filed in the clients chart to facilitate follow-up. Most important, client names, gender, and dates should be included on all tools.

Interviewees also suggested that training in basic counseling should be required of all staff. Mental health is a new topic for many staff and CHWs, and “upskills” training could be made available for those who received the basic training. Creating wall charts that illustrate the screening protocol and referral process would also facilitate implementation.

The general recommendation is that financial, material, and staff support are needed to continue or scale-up implementation of the integration protocol, including staff time to conduct follow-up visits and work with CHWs to sustain the benefits. In addition, continued involvement of TMPs is seen as a very important part of a community-based approach to integrating mental health and HIV care and support.



# LIMITATIONS

The assessment results are based on a small sample size as this was a pilot activity that served primarily as a feasibility study, not a formal evaluation of the integration process. Thus, the results may not necessarily be applicable to other settings.

The integration protocol was not uniformly implemented at all sites. Participating sites varied in their use of the screening tools and referrals, depending on local resources and needs. One site was only able to implement the cascade training but not the screening or referral processes due to local unrest that disrupted clinic operations. Therefore, results cannot be compared across sites or be used to evaluate a systematic approach to integrating mental health services in HIV care and support. However, the results did demonstrate that on-site training, mental health screening, and referral is feasible under varying conditions with different client populations.

The level of data collection varied across sites. The data analyzed in the report only accounts for the data sheets that were physically collected; therefore, additional screenings may have been carried out that were not recorded or recorded properly. Some sites were unable to complete data sheets for various reasons, or the completed sheets were lost. Further, results from the knowledge survey were self-reported.

During the assessment, not all integration leaders who attended the July 2012 TOT were present for interview. Therefore, the experiences of the integration leaders were not represented at all sites, which further limited the comparisons across sites.

However, while these limitations are present, the variety of staff interviewed, including CHWs, enriched the qualitative data and provided a wider perspective on the pilot activity.



# LESSONS LEARNED

- The role and responsibilities of the integration leader need to be more clearly defined and included in any “contractual” agreement with participating sites to ensure that the integration protocol is followed and quality data collected for evaluation. Ownership of and commitment to the pilot were important factors to adopting and integrating mental health services. Many integration leaders were passionate about the program and seek to continue the services.
- Follow-up staff training, support, and supervision may be needed to fully implement, strengthen, and sustain the integration process. Dealing with mental health issues may be new to many health care providers (both facility- and community-based), and the provision of on-site coaching, mentoring, and supervision by qualified professionals may be essential for building motivation and capacity to sustain the integration effort.
- The screening protocol implemented on-site at many of the clinics varied from the standard screening protocol that integration leaders learned during training. In most cases, informal “pre-screening” was facilitated, wherein health providers looked for clients exhibiting symptoms of depression (e.g., crying). The self-determining pre-screening was often related to limited staff time and heavy workloads; yet this process may miss clients with mental health or substance use issues who do not physically express symptoms. Although most health care providers responded positively to the screening tools, they encountered some challenges implementing the full protocol.
- The pilot assessment demonstrated that the integration protocol can be used in different ways to address different needs at different sites, and therefore the facility context will influence the integration protocol. The integration protocol should be flexible enough to accommodate different clinical environments and needs, but common elements are the importance of building strong linkages and communications between community and referral sites for optimal client care and follow-up. If the protocol is scaled up throughout Zimbabwe, a toolkit applicable to different clinical and community settings may be useful, which could, for example, include revised tools that are appropriate for a family clinic population. Currently, no systematic means exists for communications between different levels of care, and clients appear to be the main source of information on the outcome of referrals. Whereas the training included a referral protocol, the actual means of communication between different levels of care was not systematic.
- The role of community-based health care providers (e.g., health promoters, CHWs, TMPs) is critical for an integrated approach to mental health and HIV care. The pilot has shown the feasibility for these providers of using the Abbreviated Community Screen effectively to identify mental health issues and refer to facility-level care for further evaluation and treatment. In addition, follow-up at the community level can involve family and other support systems to provide a more holistic model of care.

- More needs to be done to integrate the screening and management of harmful substance use. Why the CAGE-AID was not used more often for screening for substance use problems is unclear. Providers were also not convinced that clients would answer honestly to the questions, and other means may need to be developed to identify potential substance use problems. Currently, substance use problems are typically referred to psychiatric facilities. Without separate services to address substance use issues, this serves as a barrier to client follow-through due to stigma surrounding psychiatric services. Understanding the client perspectives on substance use and other issues is critical.
- A well-constructed, systematic approach with a true cascade of service delivery of pilot sites is needed to formally evaluate the integration process. This should include selection of participating sites through a consultative process with key stakeholders and include a formal performance management plan as part of the integration protocol to enable a systematic and rigorous evaluation of the effectiveness and cost-benefit of integrating mental health services into HIV care and treatment. Ultimately, evaluating the effects of mental health integration on client care and outcomes in HIV care and treatment will also be important.

# RECOMMENDATIONS

1. *Scale-up mental health and HIV integration to the community level.* Integration of the screening tools and stepped-care approach was found to be feasible within the nine pilot sites. Scaling up this approach to additional sites within each catchment area will serve to increase awareness surrounding mental health problems and harmful alcohol and substance use, increase identification and treatment for these issues at the community level, and serve to decrease stigma among health care providers, community care providers, and TMPs.
2. *Clarify the role and emphasize the importance of the integration leaders.* Ownership of and commitment to the pilot were important factors to adopting and integrating mental health services. The role and responsibilities of the integration leader need to be well defined and included in any “contractual” agreement with participating sites to ensure that the integration leader is aware of the responsibilities associated with the position and carries them out in a timely manner. These responsibilities include ensuring that site staff trainings are carried out, that the integration protocol is followed, that strong community linkages are in place, and that quality data is routinely collected for evaluation. Integration leaders should also be available to colleagues as a resource for mental health integration when questions arise during implementation. Future work with integration leaders should build their capacity for leadership among their peers.
3. *Build the capacity of integration leaders to provide further trainings on mental health care and counseling skills for the initial pilot sites.* Further equipping providers who are delivering integrated mental health services with increased skills on mental health screening and counseling will be critical, as mental health care is a new area of service provision for many health care providers in Zimbabwe. The use of on-site cascade training appears to be an effective way to train facility-level and community health care providers on mental health integration processes. Advanced training and mentorship on the stepped-care approach should be implemented, in line with the National Mental Health Policy and MOHCW’s Mental Health Program.
4. *Build strong bidirectional communication and referral pathways between different levels of health care providers.* Regular, clear, and documented referral and follow-up protocols should be developed and integrated at all sites. Use of a bidirectional client referral form will provide information to the organization receiving the referral and will provide a means for the originating organization to receive follow-up information including that the client completed the referral.
5. *Explore cultural or contextual issues about substance use and routes to increase screening and management.* Identification of cultural taboos or other contextual issues about discussing alcohol or other substance use issues should be carried out to develop better screening, referral, and management approaches for these clients.
6. *Develop a more robust data monitoring and evaluation system, particularly during supportive supervision.* Data collection methods, as well as the importance of accurate data collection, should be further emphasized during future trainings, pilot preparation, and supportive supervision.

7. *Identify and overcome logistical challenges to ensure sustainability of the integrated program.* Issues surrounding availability of screening tools and data collection forms should be explored with support identified at the country level to ensure a continuous supply is in place. Identification and problem solving for other logistical challenges including privacy, referral completion, and transport for referred clients should also be resolved.
8. *Consider routine mental health and substance use screening at the primary health care level in addition to HIV-positive clients.* All clients can be screened with the SSQ, CAGE-AID, or the Abbreviated Community Screen tools as part of routine care, especially to reduce stigma. However, where time is limited, HIV-positive clients could be prioritized.

# CONCLUSION

In collaboration with the MOHCW and the PEPFAR Care and Support and Treatment Technical Working Groups, AIDSTAR-One implemented an integrated mental health and HIV pilot activity in Zimbabwe that aimed to promote integration of mental health and HIV care and support services. In December 2012, AIDSTAR-One conducted a small, mixed methods assessment to understand the feasibility of integrating the mental health and substance use screening tools and the stepped-care approach into routine services. Results demonstrated that integrating mental health care services was feasible and generally found beneficial in identifying and managing mental health needs of PLHIV, as well as the general client population. The overall attitude toward implementing the mental health and substance use screenings was positive and beneficial to holistic care of clients, as without the integration, the mental health issues would have been overlooked. While strengthening the areas mentioned above, continued support of and further roll-out of mental health and HIV integration will support improved health outcomes for PLHIV.



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**ANNEX A**

**SHONA SYMPTOM  
QUESTIONNAIRE**

# Shona Symptom Questionnaire

Client Name: \_\_\_\_\_ Client ID: \_\_\_\_\_ Date: \_\_\_\_\_

Musvondo rapfuura...	Ehe	Aiwa
<i>During the course of the past week...</i>	Yes	No
1. pane pamaimboona muchinyanya kufungisisa kana kufunga zvakawanda here? <i>did you have times in which you were thinking deeply or thinking about many things?</i>		
2. pane pamaimbotadza kuisa pfungwa dzenyu pamwechete here? <i>did you find yourself sometimes failing to concentrate?</i>		
3. maimboshatirwa kana kuita hasha zvenhando here? <i>did you lose your temper or get annoyed over trivial matters?</i>		
4. maimborota hope dzinotyisa kana dzisina kunaka here? <i>did you have nightmares or bad dreams?</i>		
5. maimboona kana kunzwa zvinhu zvanzvisinga onekwe kana kunzwikwa nevamwe here? <i>did you sometimes see or hear things which others could not see or hear?</i>		
6. mudumbu menyu maimborwa dza here? <i>was your stomach aching?</i>		
7. maimbovhundutswa nezvinhu zvisina maturo here? <i>were you frightened by trivial things?</i>		
8. maimbota dza kurara kana kushaya hope here? <i>did you sometimes fail to sleep or lose sleep?</i>		
9. pane pamaimbonzwa muchiomera neupenyu zvekuti makambochema kana kuti makambonzwa kuda kuchema here? <i>were there moments when you felt life was so tough that you cried or wanted to cry?</i>		
10. maimbonzwa kuneta here? <i>did you feel run down (tired)?</i>		
11. pane pamaimboita pfungwa dzekuda kuzviuraya here? <i>did you at times feel like committing suicide?</i>		
12. mainzwa kusa fara here mune zvamaita zuva nezuva? <i>were you generally unhappy with things you were doing each day?</i>		
13. basa renyu raive rave kusarira mumashure here? <i>was your work lagging behind?</i>		
14. mainzwa zvichikuomerai here kuti muzive kuti moita zvipi? <i>did you feel you had problems deciding what to do?</i>		
<b>Scoring: Add together the number of questions to which the client responded "yes".</b>	<b>TOTAL SCORE:</b>	

## Scoring Information

Negative Score 0-7: Rescreen in one year.

Positive Score 8-14: Provide brief counseling intervention; refer to for further health assessment, and to a CBO for psychosocial services.

*If a client scores a 7 or less, but is still suspected of mental health symptoms, they should be considered to have a positive score and receive a brief counseling intervention and referrals.*

## Action Taken:

Brief counseling intervention provided: (circle one)      YES                      NO

Referred: (circle one)                      YES                      NO

Referred to: \_\_\_\_\_

Additional notes: \_\_\_\_\_

## **ANNEX B**

# **CAGE-AID SCREENING TOOL**

# CAGE-AID Screening Tool

Client Name: \_\_\_\_\_ Client ID: \_\_\_\_\_ Date: \_\_\_\_\_

<b>Pindurai ehe kana aiwa pane mibvunzo inotevera:</b> <b>Please answer yes or no to the following questions:</b>	<b>Ehe Yes</b>	<b>Aiwa No</b>
<b>1.</b> Unombonzwa here kuti unofanirwa kudzikisira manwiro aunoita doro, uye maputiro kana mashandisiro aunoita zvinodhaka? <i>Have you ever felt you should cut down on your drinking or drug use?</i>		
<b>2.</b> Pane munhu kana vanhu vanombokushatirisa here nekushoropodza kwavanoita manwiro ako edoro, uye maputiro kana mamwe mashandisiro aunoita zvinodhaka? <i>Have people annoyed you by criticizing your drinking or drug use?</i>		
<b>3.</b> Unombozvitongesa here pamusoro pekunwa doro, kuputa kana kushandisa kwaunoita zvinodhaka? <i>Have you ever felt bad or guilty about your drinking or drug use?</i>		
<b>4.</b> Wakambotanga nekumwa doro, kuputa kana kushandisa zvinodhaka uchangobva mukumuka mangwanani kuti unzwe zvakanaka kana kuti upedze bhabharasi? <i>Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover (an "eye-opener")?</i>		
<b>Scoring: Add together the number of questions to which the client responded "yes".</b>	<b>TOTAL SCORE:</b>	

**Scoring Information**

Negative score: zero. Re-screen in one year.  
 Positive score: 1 or greater. Provide brief counseling intervention; refer to for further health assessment, and to a CBO for psychosocial services.

*If a client scores a zero, but is still suspected of harmful alcohol and substance use, they should be considered to have a positive score and receive a brief counseling intervention and referrals.*

**Action Taken:**

Brief counseling intervention provided: (circle one)      YES                      NO

Referred: (circle one)    YES                      NO

Referred to: \_\_\_\_\_

Additional notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## **ANNEX C**

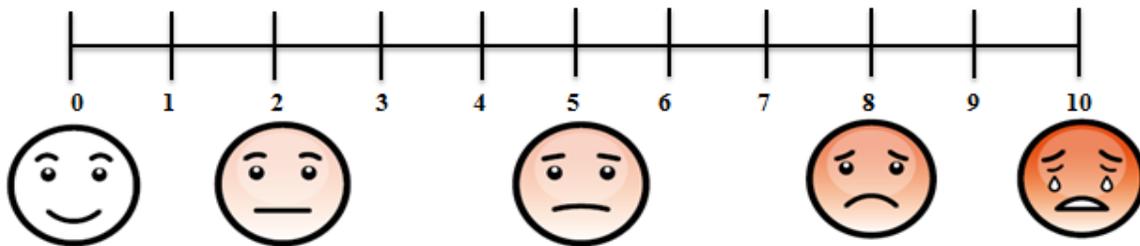
# **ABBREVIATED COMMUNITY SCREEN**

# Abbreviated Community Screen

Instructions: Ask the client the following questions. The client should be referred to the health facility if: They answer  $\geq 7$  to questions 1 or 2 or if they respond "yes" to question 3.

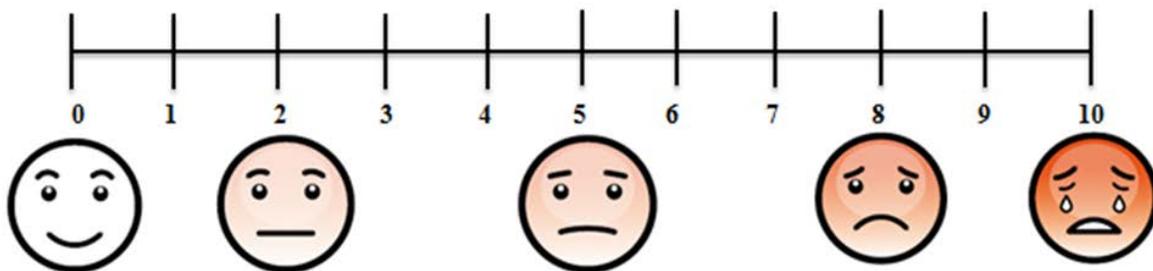
1. **Wakambonzwa kusuwa here musvondo rapfuura?**

*Have you been feeling sad over the past 7 days?*



2. **Wakambonzwa kushushikana here musvondo rapfuura?**

*Have you been worried over the past 7 days?*



3. **Wakambotanga nekumwa doro, kuputa kana kushandisa zvinodhaka uchangobva mukumuka mangwanani kuti unzwe zvakanaka kana kuti upedze bhabharasi?**

*Have you ever had a drink or drug first thing in the morning to steady your nerves or get rid of a hangover (an "eye-opener")?*

Ehe *Yes*

Aiwa *No*

Action Taken:

Referred: (circle one)      YES      NO

Referred to: \_\_\_\_\_

Additional notes:

\_\_\_\_\_

# ANNEX D

## KNOWLEDGE ASSESSMENT

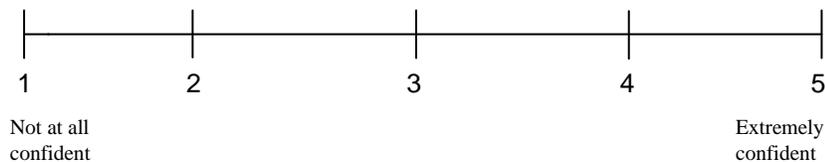
Did you attend the AIDSTAR-One Mental Health/HIV Integration workshop in July 2012?

- Yes
- No

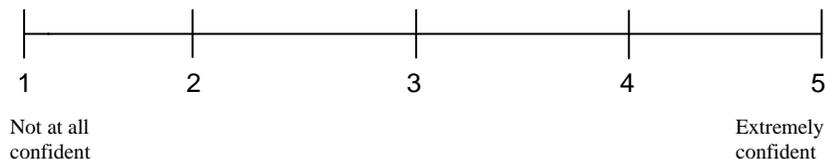
If no, did you receive training from a colleague who did attend the AIDSTAR-One Mental Health/HIV Integration workshop?

- Yes
- No

On a scale from 1 to 5, how confident are you that you are able to integrate mental health screenings into the routine care that you provide, 1 being “Not at all confident” and 5 being “extremely confident”?



On a scale from 1 to 5, how confident are you that you are able to make the appropriate referrals based upon the results of a mental health screening, 1 being “Not at all confident” and 5 being “extremely confident”?



1. The connection between HIV and mental health problems is:
  - a. Those with mental illness and substance use are more likely to contract HIV.
  - b. An HIV diagnosis poses a significant psychological burden.
  - c. Adherence to treatment is decreased in the presence of mental health problems.
  - d. All of the above

2. Depression is best characterized as:
  - a. Persistent sad or anxious mood, “thinking too much,” and multiple vague physical symptoms
  - b. Persistent auditory and visual hallucinations lasting over a period of 12 months
  - c. Multiple physical symptoms with a clear biologic cause
  - d. Screened for by use of the CAGE-AID
  
3. A positive screen on the Shona Symptom Questionnaire:
  - a. Indicates the presence of depression, anxiety, psychosis, and substance use
  - b. Warrants a direct referral to an in-patient psychiatric facility
  - c. Indicates that mental health problems may be present
  - d. Is not something that warrants further investigation
  
4. Acute Alcohol Withdrawal:
  - a. May cause vomiting, hand tremors, hallucinations, seizures, and death
  - b. Is not cause for concern; clients should be sent home to rest
  - c. Should be managed by providing foods high in sodium
  - d. None of the above
  
5. Effective interviewing techniques include:
  - a. Use of close-ended questions
  - b. Limiting discussions surrounding difficult topics for the client
  - c. Reflective listening and use of open-ended questions
  - d. Only discussing the client’s emotional status if they bring up the subject
  
6. A client who screens “positive” in the Abbreviated Community Screen should be:
  - a. Monitored only at the community-based organization (CBO)
  - b. Referred to a traditional healer for further screening
  - c. Referred to the health facility for further screening
  - d. Initiated on medication immediately
  
7. A client who screens “positive” on the CAGE-AID with the traditional healer should be:
  - a. Immediately managed for Acute Alcohol Withdrawal
  - b. Encouraged to cut down on their substance use to help improve their health
  - c. Referred to a health facility and CBO for further support
  - d. Answers B and C

8. A client who screens “positive” on the Shona Symptom Questionnaire at the health facility should:
  - a. Receive an immediate referral to a psychiatric hospital
  - b. Be referred to a health care professional (HCP) who is qualified to provide counseling interventions and medicine; they should also be referred to a CBO for psychosocial services.
  - c. Be immediately referred for an alcohol and drug detoxification program.
  - d. Receive another screen in one week to make sure that they are improving.
  
9. Suicide attempts are most common:
  - a. During crisis such as initial diagnosis, declining CD4 count, rejection and loss of a loved one
  - b. When a client has stopped using alcohol and other substances
  - c. Once they have become accustomed to their diagnosis and are clinically stable
  - d. Once they have built a strong support system within the community
  
10. I have a better understanding of mental health integration issues following the training that I received.
  - Strongly agree
  - Agree
  - Disagree
  - Strongly disagree
  
11. I feel more comfortable discussing mental health issues with my clients after receiving training.
  - Strongly agree
  - Agree
  - Disagree
  - Strongly disagree
  
12. As a result of the training, mental health stigma has reduced in my facility.
  - Strongly agree
  - Agree
  - Disagree
  - Strongly disagree

13. Challenges I experienced in implementing mental health/HIV integration in my facility included:  
(Check all that apply.)

- Lack of human resources/staff
- Lack of private space
- Difficulty with finding time to record data
- I need more training related to mental health.
- Clients are not comfortable discussing mental health issues.
- I don't feel comfortable discussing mental health issues.
- Other \_\_\_\_\_

## **DEMOGRAPHIC INFORMATION**

14. What is your provider level? Check one.

- Doctor
- Clinical officer
- Nurse
- Counselor
- Traditional healer
- Other: \_\_\_\_\_

15. How many years have you been working as a health provider?

- Less than 1 year
- 1-3 years
- 4-6 years
- 7-10 years
- 10-15 years
- Over 15 years

16. What is your gender?

- Male
- Female

## ANNEX E

# INTERVIEW GUIDE

1. Please describe your experience with integrating mental health services post-training.
2. Did the training lead to improvements in mental health services? (If so, please describe how so.)
3. Please describe the training you provided to your colleagues on integration of mental health.
  - How many staff did you train? \_\_\_\_\_
  - How many staff from CBOs in your catchment area were trained? \_\_\_\_\_
  - How well did the AIDSTAR-One training prepare you to train your colleagues?
  - What challenges did you encounter? Suggestions for replicating this TOT model?
4. Please describe your experience using mental health screening tools in your facility post-training.
  - Which screening tools are being used? (Were any used before the training?)
  - How did clients respond to the tools? (Responsive? Hesitant?)
  - How have the tools affected counseling/screening?
  - What challenges (if any) have you encountered using the tools?
5. What feedback have you received from other staff about use of the screening tools?
  - Staff comfort level utilizing the screening tools
  - Staff comfort level carrying out basic mental health interventions post-training
  - How well are the screening tools integrated into providers' daily routine (time management, adequate space, and privacy)?
6. Please describe your experience providing supportive supervision to other providers.
  - How often were you able to provide supportive supervision?
  - What type of support did the providers need? Please describe.

- What types of opportunities for improvement did you identify for staff members?
7. Due to use of the screening tools, were any clients recognized to be acutely suicidal?
- If so, how many? \_\_\_\_\_
  - What actions were taken?
8. Approximately how many mental health referrals have you made:
- In the past 30 days? \_\_\_\_\_
  - In the past 90 days? \_\_\_\_\_
9. Approximately how many substance use referrals have you made:
- In the past 30 days? \_\_\_\_\_
  - In the past 90 days? \_\_\_\_\_
10. Were any clients identified as experiencing an acute drug or alcohol emergency?
- If so, how many? \_\_\_\_\_
  - What actions were taken?
11. Has the mental health referral process changed since the pilot training? How?
- Have you created a standardized referral pathway? Please describe.
  - How has your communication with referral organizations changed?
  - Has your facility been able to determine if clients have followed through on referrals? How?
  - What do you think can be done to ensure that clients follow through with their referrals?
12. Please describe your experience with the documentation and using the data collection forms.
- Are data collection responsibilities realistic? If not, describe why/how it may be improved.
  - Has data collection improved? If so, how?
  - What challenges have you experienced with data collection?
13. Have you observed behavior change among PLHIV as a result of mental health integration?
- Improved adherence?
  - Improved retention?
  - Improved/timely attendance?

14. How has your knowledge or attitudes toward mental health changed by participating in the mental health/HIV integration pilot?
  - How have the knowledge/attitudes of staff in your facility changed?
  - How have the knowledge/attitudes of clients changed?
15. Have you observed any changes in mental health stigma?
  - Have you observed any change in clients' willingness to discuss symptoms?
  - Have you observed any changes in providers' willingness to discuss mental health symptoms?
16. What were the challenges (if any) that you encountered after integrating mental health post-training?
  - What was the biggest challenge that you experienced during the pilot?
  - Lack of mental health services to make referrals?
  - Lack of understanding of the tools?
  - Were you able to resolve this challenge? How?
17. What do you consider the most important change you have observed during the pilot mental health/HIV integration?
18. Based on your experience, what recommendations would you offer to facilities interested in integrating mental health and HIV?
19. What additional recommendations do you have to offer ministries of health and program planners when considering implementing a similar mental health and HIV integration program?



## **ANNEX F**

# **DATA COLLECTION SHEET AT HEALTH FACILITY (WITH TIP SHEET)**

Name of Facility:

Name of Provider:

Mental Health/HIV Integration Pilot Activity Data Collection Sheet									
	Client MR#	Gender (M or F)	Date of Assessment	SSQ Score	CAGE-AID Score	Referral (Y/N)	Person or Organization receiving Referral	Referral completed (Y/N)	Comments
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									

## The Mental Health/HIV Integration Pilot Activity Health Facility and Traditional Healer Tip Sheet

**Screening Protocol:** All clients: screen at baseline. Clients with positive screen: Re-screen at 3 month intervals until negative. Clients with negative screen: Re-screen annually or sooner based upon provider's judgment and the client's changing status.

### **A Positive SSQ (score 8 or greater):**

#### **1. Determine if the client is suicidal by asking:**

- Are you thinking of hurting yourself?
- Have you ever attempted suicide in the past?
- Do you have a plan? If yes, what is it?

*If the client is actively suicidal or has an SSQ score  $\geq 10$  seek immediate medical attention per protocol.*

#### **2. Tell the client that:**

- depression is common, treatable and temporary
- coping can sometimes be more difficult if someone is experiencing depression, but this is only temporary
- it is normal to experience difficulties and feel depressed, but there are things that you can do to help yourself feel better

#### **3. Give advice:**

- helping the client to identify stressors in their life
- encourage a healthy diet, regular exercise, social activities and a routine sleep schedule
- discourage alcohol and drug use
- encourage the client to follow through on referrals for community-based support and talk with trusted family and friends about their feelings

**4. Refer the client to a health care provider** for further counseling and medication management.

**5. Refer the client to CBO services** for supplementary care

**6. Record the information** on the Data Collection Sheet.

### **Data Collection Tips**

- Record data after each client encounter.
- Place screen in client record after the visit.
- At the client's next visit, utilize the screen in the chart as a reminder to inquire if the client followed through on any referrals.
- Notify the Integration Leader if you are running low on Data Collection Sheets.

### **Counseling Tips**

- Maintain the client's confidentiality at all times.
- Open the visit with a general greeting, "How have you been?"
- Make sure that the client feels comfortable prior to beginning the screen
- Do not judge
- Express empathy
- Let the client know that you are interested in what they have to share
- Actively listen
- Thank the client for sharing

### **A Positive CAGE-AID (score 1 or greater):**

- #### **1. Assess for Acute Alcohol Withdrawal** symptoms through determining if the client is tremulous, sweating, nauseous, vomiting, has a headache, is irritable and smells of alcohol.

*If Acute Alcohol Withdrawal is suspected the client should receive immediate medical attention per protocol.*

#### **2. Tell the client that:**

- It would be better if you cut down or abstained from using
- I understand the difficulty of cutting down or quitting, but I am optimistic that you will succeed
- I am willing to help you make plans
- I am willing to help you think about where this falls in relationship to your other goals and priorities

**3. Utilize the Readiness to Change Ruler** to assist in carrying out an assessment of the client's readiness to quit the behavior and to guide the discussion with the client.

**4. Refer the client to a health care provider** for further counseling.

**5. Refer the client to CBO services** for supplementary care

**6. Record the information** on the Data Collection Sheet.



For more information, please visit [aidstar-one.com](http://aidstar-one.com).

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