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Letter

Scaling up mental health interventions for people living with HIV in Zimbabwe: evidence for integration into differentiated service delivery programmes

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Mental health services.

The presence of HIV infection is a well-established risk factor for significant psychological distress. These mental health challenges require ongoing, dedicated attention, as they can independently affect a person's quality of life and adherence to medical treatment.[1] Syndromes of depression, anxiety, stress and substance misuse associated with HIV infection require continued rigorous recognition and appropriate treatment. The psychosocial context of treatment is also an important factor in HIV care.[2]

Zimbabwe has an estimated 1.3 million individuals who are people living with HIV (PLHIV). The 2020 Zimbabwe Population-Based HIV Impact Assessment (ZIMPHIA 2020), a large-scale survey that included 2958 PLHIV, employed a standardised serological testing

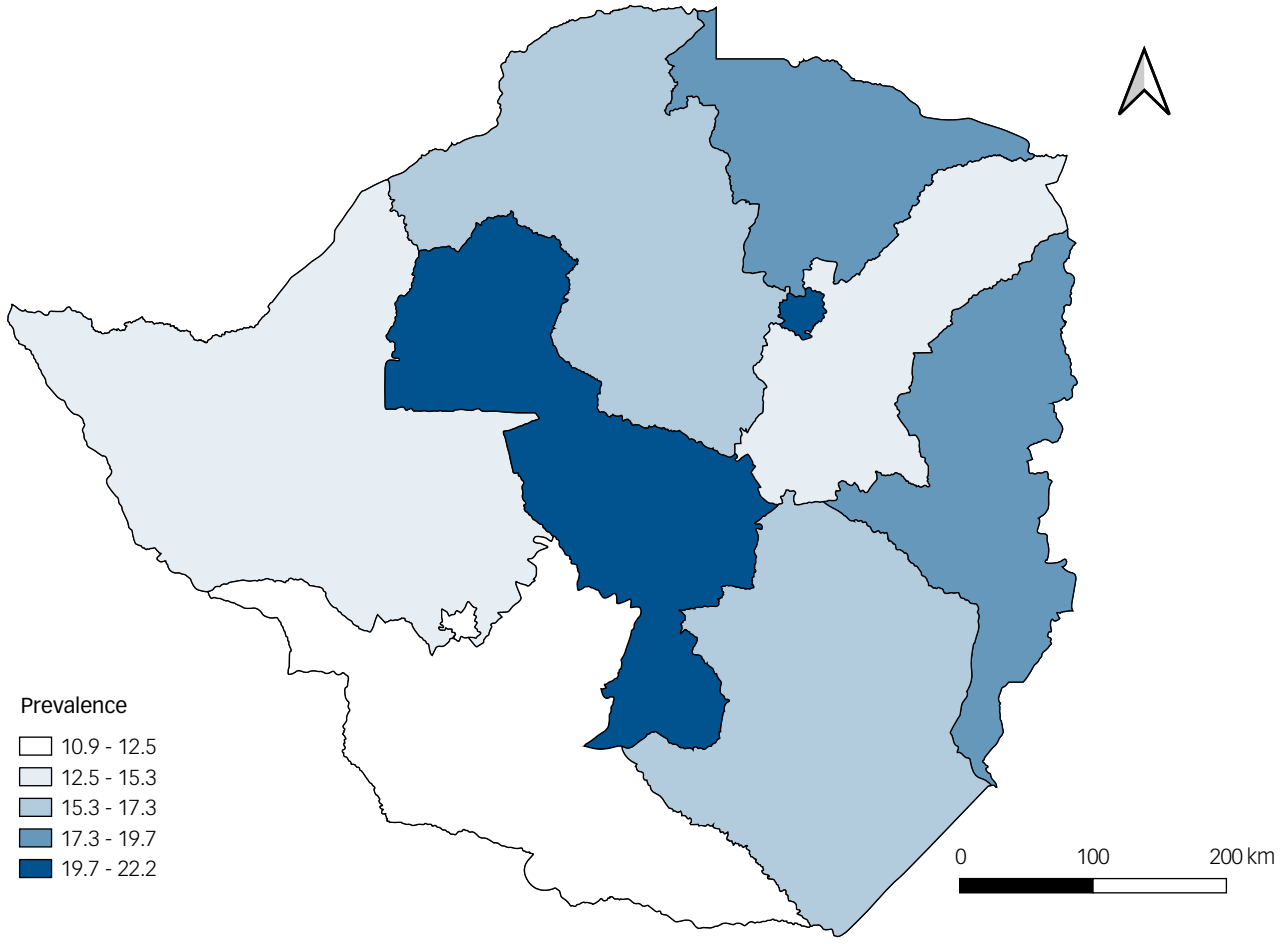

Fig. 1 Provincial distribution of PLHIV reporting being nervous, worried, anxious or depressed for more than 7 days. There was a statistically significant difference between the prevalence among PLHIV (16.3%) and in HIV-negative individuals (12.3%); $P < 0.001$.

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algorithm for HIV infection according to national guidelines. In addition, individual interviews incorporated questions to assess mental health and depression. Participants reported on their recent experiences with mental health and depressive symptoms.[3]

According to our analysis of the ZIMPHIA 2020 data, 28–37% of PLHIV reported experiencing symptoms of mental health problems or depression for varying lengths of time. This prevalence is significantly higher than the global average of 4.7% observed in the general population (Fig. 1).

In Zimbabwe, and probably throughout southern Africa, most PLHIV who experience mental health conditions such as depression and anxiety lack access to appropriate effective care and treatment.[4] To bridge this substantial care gap and achieve progress towards universal health coverage, a multifaceted approach is necessary. Although traditional psychotherapy delivered by specialists remains valuable (only 18 psychiatrists are practising in the country, which has a population of 16 million), a more scalable solution lies in implementing low-cost psychological interventions. The Tendai project, where trained lay health carers deliver a stepped-care intervention for treating depression to improve adherence to antiretroviral therapy, and the friendship bench model, where trained and supervised lay providers deliver mental health support, exemplify a scalable approach.[5] Collaboration with the Zimbabwe Network of People Living with HIV, the national umbrella organisation for PLHIV, is crucial, as it is currently implementing initiatives for both self-stigma and internalised stigma.

In conclusion, Zimbabwe has successfully implemented differentiated service delivery (DSD) models, with more than 60% of stable HIV treatment clients enrolled in one of these programmes. DSD represents a patient-centred approach to HIV prevention, testing and treatment. However, Zimbabwean policy makers must re-evaluate their DSD models. This ensures that mental health screening and appropriate referrals for care and treatment are integrated into the programmes, particularly for clients with infrequent facility visits.

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