

INTEGRATING MENTAL HEALTH AND NCD SCREENING AND MANAGEMENT WITH HIV CARE

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I. BACKGROUND AND CASE FOR INTEGRATION

Global Impact of ART: Antiretroviral therapy (ART) has extended life expectancy for people living with HIV (PLHIV), transforming HIV into a chronic condition.¹

Emerging Comorbidities: Increased prevalence of non-communicable diseases (NCDs) (e.g., cardiovascular disease, diabetes, cancer) and mental health conditions (e.g., depression, anxiety) among PLHIV.²

Risk Factors: HIV-related inflammation, long-term ART side effects, and shared behavioural risks (e.g., smoking, alcohol use, sedentary lifestyle) elevate NCD risk.³

Health System Strain: Clustering of HIV, NCDs, and mental health issues in low- and middle-income countries (LMICs) exacerbates health disparities and burdens healthcare systems.⁴

2. PREVALENCE REPORT

Setting & design	Outcome (incidence/prevalence or control)	Effect
Pragmatic cluster RCT integrating HIV, diabetes & hypertension clinics. ¹	1. Retention in care for diabetes/HTN. 2. HIV viral suppression (<1,000 copies/mL)	1. 89% retained in both arms; no significant difference (non-inferior) 2. 97.0% integrated vs 97.3% standard at ~12 months; non-inferior—integration did not compromise HIV outcomes
IC3 fully integrated chronic care. ²	Viral suppression in PLHIV during first year	81% achieved undetectable VL; NCD outcomes improved for HTN, asthma, epilepsy; diabetes improvement not significant
Integrated HTN care within HIV clinics. ³	BP control prevalence	Successful integration with documented improvements in BP control in follow-up cohorts (e.g., 26% controlled by 6 months in one urban cohort).
Friendship Bench (Mental-health integration in HIV primary care; prospective controlled cohort and qualitative). ⁴	Viral non-suppression prevalence at 6 months (Measured effect of intervention)	1. 7.3 percentage points vs control (borderline p=0.05); among those suppressed at baseline: 2. 2.9% lost suppression vs 9.3% control (p=0.002). 3. CMD screen-positive prevalence fell -21.6 points vs control

HIGHLIGHTS FROM RECENT STUDIES

Systematic Review (38 Studies, SSA) - McCombe G et al. 2022

- **Strong evidence for integration's value** in improving access and continuity of care.
- **Different models needed** depending on facility capacity and context.
- **Key barriers:** workforce shortages, weak supply chains, stigma, and lack of standardized protocols.
- **Facilitators:** provider training, stakeholder buy-in, streamlined workflows, and patient-centered approaches

Cluster RCT on HIV + Hypertension + Diabetes Integration - Kivuyo S et al. 2023

- **Integration improved retention** in care compared to vertical (separate) services.
- **Cost savings achieved** through shared infrastructure and workforce.
- **No harm to HIV outcomes** – viral suppression rates were maintained.

Qualitative study on Mental Health Integration - Grimes KEL et al. 2024

- **Widespread support among providers** for integrating mental health into HIV care.
- **Barriers:** stigma, low resources, and inadequate screening tools.
- **Recommendations:**
 - Use **culturally sensitive, community-based approaches**
 - Adopt **simplified, validated screening tools**
 - **Train and support providers** to deliver MH services
 - Ensure **institutional and system-level commitment**

OBSERVABLE PATTERNS FROM PREVALENCE STUDIES

Cardiometabolic NCDs (HTN/diabetes):

- **Increase in detection and treatment coverage** and can **raise the prevalence of controlled hypertension** at the population level, though effects on **glycaemic control** are less consistent.
- **No harm to HIV viral suppression or patient retention** (large pragmatic trials) meeting non-inferiority benchmarks.

Mental health

- **Reduction in the prevalence of depression/CMD** using brief, task-shared psychological care and this **helps maintain viral suppression** among already-suppressed patients.
- **Large depression reductions and better adherence**, with **good cost-effectiveness** in broader RCTs.

Implementation matters

- **NCD control indicators sometimes stagnated or dipped** where integration was rolled out without adequate resourcing or workflow redesign.
- **Highlights** need for:
 - Medication supply,
 - Staffing
 - Protocols tailored to chronic multimorbidity.

3. DEFINITIONS

➤ **What are NCDs (Non-communicable disease)?**

- Chronic conditions
- Not spread from person to person
- Require long-term care.

Examples; Cardiovascular diseases, cancers, diabetes, chronic respiratory diseases, and mental and neurological disorders. ¹

- This presentation refers to Hypertension, Diabetes Mellitus, Epilepsy, Cancers, Chronic respiratory disease and Mental health conditions (mainly Depression and anxiety)

➤ **What is Integration?**

The act or process of forming, coordinating, or blending into a functioning or unified whole.²

4. RATIONALE FOR INTEGRATION

WHY INTEGRATE CARE?

Global Advocacy

WHO's Integrated People-Centred Health Services (IPCHS) and UNAIDS promote combining communicable and non-communicable disease care.¹

Move Beyond Silos

Shift from vertical programs to comprehensive care reduces duplication, optimizes resources, and improves outcomes.²

Funding Disparities

HIV programs receive more global funding (e.g., PEPFAR) compared to NCDs and mental health, leading to under-prioritization.³

Opportunity

Established HIV care infrastructure can integrate NCD and mental health screening, improving ART adherence, reducing stigma, and lowering costs.⁴

5. INTEGRATIVE MODELS FOR NCDS

Model 1

- NCD services integrated into HIV care.
- HIV services integrated into NCD care at primary healthcare (PHC) level.
- Simultaneous introduction of integrated HIV and NCD services.

•Duffy Hawkins et al. (2017)

Model 2

- Community-based screening for HIV and NCDs in the general population.
- Screening for NCDs and risk factors among HIV patients in care.
- Integration of HIV and NCD care within clinics.
- Differentiated care for patients with HIV and/or NCDs (DMOC).
- Population-wide healthcare for all.

•Njuguna et al. (2018)

SUMMARY OF INTEGRATIVE MODELS FOR NCDS

Model A

**NCD Services
Integrated into HIV
Care Platforms.**

4 studies

Model B

**HIV Services Integrated
into NCD Settings.**

3 studies

Model C

**Simultaneous Provision
of HIV & NCD Care
(Shared Clinics).**

4 Studies.

Model D

**Integrated Community-
Based Screening.**

4 Studies.

Model E

**Population Health /
Differentiated Care.**

3 Studies.

6. MENTAL HEALTH (MH) INTEGRATION

➤ Considerations & Challenges

Prevalence: Depression and anxiety 2–4 times more common among PLHIV.¹

Impact: Poor mental health linked to lower ART adherence, faster disease progression, and higher mortality.

Challenges: Shortage of mental health specialists.

Persistent stigma.

Lack of policy frameworks.²

South Africa Example: Integrated Chronic Disease Management (ICDM) model piloted to co-manage HIV, NCDs and Mental Health.³

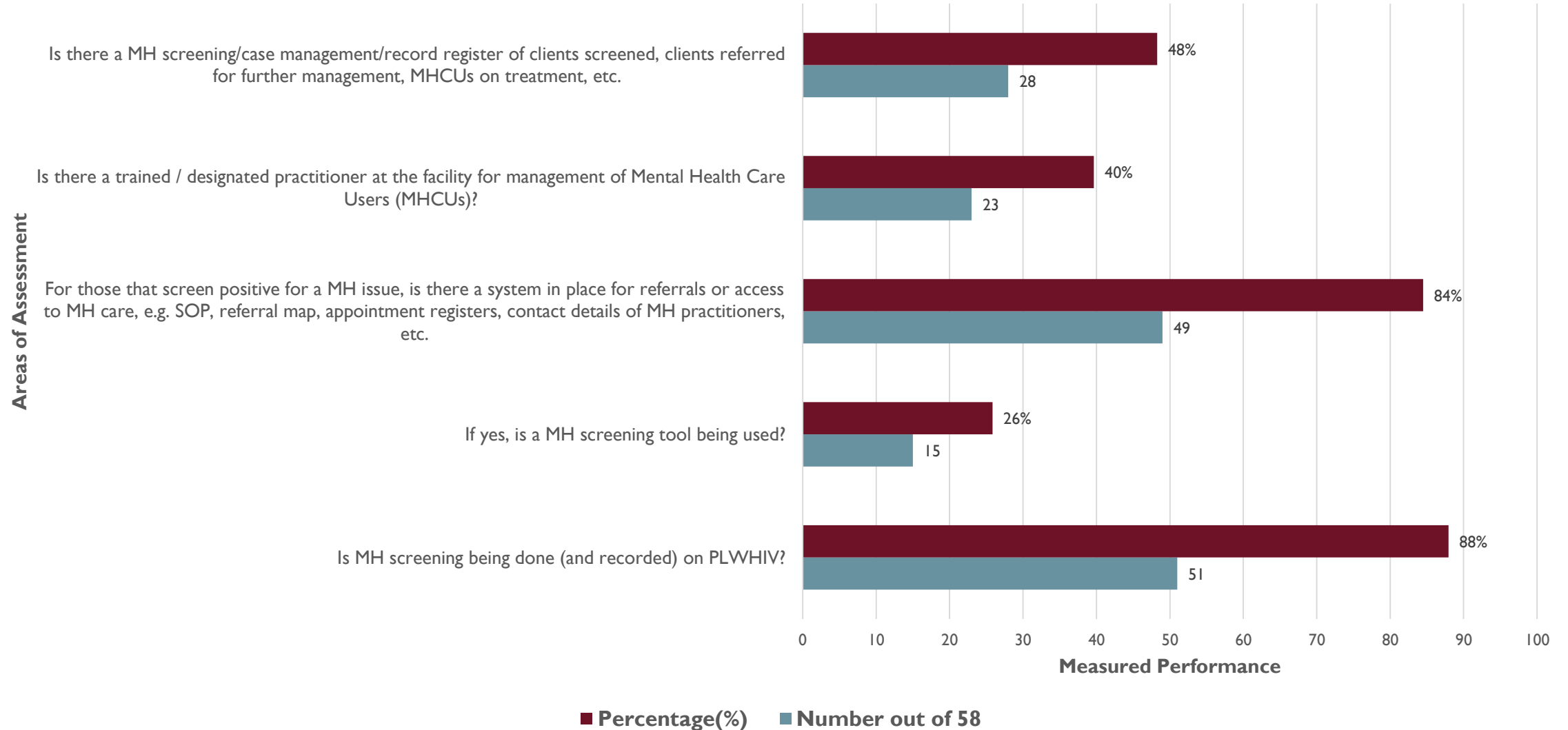
1-Collins et al., 2006; WHO, 2019; UNAIDS, 2022. 2- Sikkema et al., 2015; WHO & UNAIDS, 2021

3- Mahomed et al., 2015; SA NDoH, 2011

7. MH ASSESSMENT ACROSS 58 AHF SUPPORTED FACILITIES

OCTOBER 2024

Analysis of MH assessment



KEY FINDINGS (58 FACILITIES AHF SUPPORTED SITES)

➤ **Mental Health Screening for PLWHIV**

- **88% (51/58)** of facilities reported conducting and recording mental health (MH) screening for people living with HIV (PLWHIV).
- This is the strongest area of performance, indicating widespread MH screening integration into HIV services.

➤ **Referral Systems for Positive Screens**

- **84% (49/58)** of facilities had a referral system or access mechanism for MH care (e.g., SOPs, referral maps, appointment registers, or contact lists of MH practitioners).
- This shows a relatively well-established referral network for clients who screen positive.

➤ **Designated Practitioners for MH Care**

- **40% (23/58)** had a trained or designated practitioner specifically for managing Mental Health Care Users (MHCUs).
- This indicates that more than half of facilities lack designated staff for mental health management.

➤ **MH Screening/Case Management Register**

- **48% (28/58)** maintained a MH screening or case management record/register for clients screened and referred.
- This shows gaps in documentation and case follow-up systems.

➤ **Use of MH Screening Tools**

- Only **26% (15/58)** used a formal, standardized MH screening tool.
- This is the weakest area, suggesting a lack of standardized tools across most facilities.

RECOMMENDATION FROM MH ASSESSMENT RESULT

Area of Focus	Gap Identified	Recommendation
Strengthen Use of Standardized Screening Tools	Only 26% of facilities use formal MH screening tools.	<ul style="list-style-type: none">• Train staff on validated MH screening tools (e.g., PHQ-9, GAD-7).• Integrate screening tools into routine HIV consultations and clinical stationeries.• Monitor compliance through periodic audits.
Improve Documentation & Case Management	48% of facilities maintain screening/case management registers.	<ul style="list-style-type: none">• Develop a standard MH case register template.• Digitize registers where possible to ensure continuity of care and data tracking.• Assign staff responsibility for updating records.
Build Human Resource Capacity	Less than half (40%) of facilities have trained/designated practitioners.	<ul style="list-style-type: none">• Expand training for nurses, social workers, and lay counselors on MH management and referral protocols.• Consider task-shifting and mentorship models to increase MH capacity in primary care

RECOMMENDATION FROM MH ASSESSMENT RESULT(CONTD)

Area of Focus	Gap/ Strength Identified	Recommendation
Strengthen Referral Pathways	84% have referral systems in place — but coverage is not universal.	<ul style="list-style-type: none">• Standardize referral SOPs across all facilities.• Develop a district-level directory of MH services and practitioners.• Use community health workers to support linkage to care and follow-up
Scale Up Routine MH Screening for PLWHIV	High coverage (88%) — but should be universal.	<ul style="list-style-type: none">• Aim for 95-100% routine screening of PLWHIV at every visit.• Include MH indicators in performance monitoring frameworks.• Provide supportive supervision to ensure quality screening.

8. RECOMMENDATIONS FOR MENTAL HEALTH INTEGRATION

Scale up evidence-based, non-pharmacologic interventions (e.g., CBT, counselling) within HIV care.

Expand task-shifting models, training non-specialist health workers to increase access.

Prioritize culturally relevant interventions tailored to community needs.

Increase implementation research in under-represented SSA countries to guide scale-up

9. PROMISING MODELS FOR INTEGRATION

SHORT TERM

- **Stepped Care/Trans-diagnostic Models**
 - Scalable interventions using basic screening, triage and referral systems.
 - Utilizing a tiered approach
 - Treatment models - Multiple mental health disorders simultaneously,

SHORT TO MEDIUM

- **Task Shifting**
 - Use of non- professionals HCW such as Nurses, CHWs and Lay counsellors.

MEDIUM TO LONG TERM

- **One-Stop Clinics**
 - Single-visit with comprehensive package of care within the same structure and system.
- **Digital Health**
 - E-health/mHealth apps and electronic medical records enhance patient tracking and workflows.

10. BARRIERS TO INTEGRATION & RECOMMENDATIONS

Challenges	Recommendations
Workforce Constraints	<ul style="list-style-type: none">• Task-shifting and sharing.• Training, mentorship, and capacity building.
Inadequate Health Information Systems	<ul style="list-style-type: none">• Data systems with streamlined indicators and digital tools• Information sharing and referrals• Quality Improvement Mechanism
Poor Financing	<ul style="list-style-type: none">• Cost-effective interventions with high return on investment• Sustainable funding through joint budgeting and resource mobilization• Addressing Vertical funding disparities

BARRIERS TO INTEGRATION & RECOMMENDATIONS

Challenges	Recommendations
Policy Misalignment (Lack of clear national directives or guidelines)	<ul style="list-style-type: none">• Clear National guidelines• Multi-sectoral approach• Create enabling environment – Culture and stigma• Authorize task sharing multi-month policies
Evidence limitations (No Long-term outcomes and few RCTs)	<ul style="list-style-type: none">• Design economic workstreams into scale-up• Use pragmatic & hybrid trials
Sustainability concerns	<ul style="list-style-type: none">• Phased, risk-stratified integration• Domestic financing & benefit packages

II. CONCLUSION & KEY TAKEAWAYS

Integration is Critical: Combining HIV, NCD, and mental health services is essential for chronic disease management in high HIV-burden LMICs.

Evidence of Success: Integrated models are feasible, acceptable, and effective, improving outcomes and reducing costs.

Public Health Priority: Advances universal health coverage by addressing comorbidities holistically.

Next Steps: Address barriers through workforce training, policy alignment, and scalable, culturally sensitive models, systems integration, and adequate funding.

Address research gap on prevalence and incidence data for HIV and NCD comorbidity.

• THANK YOU

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