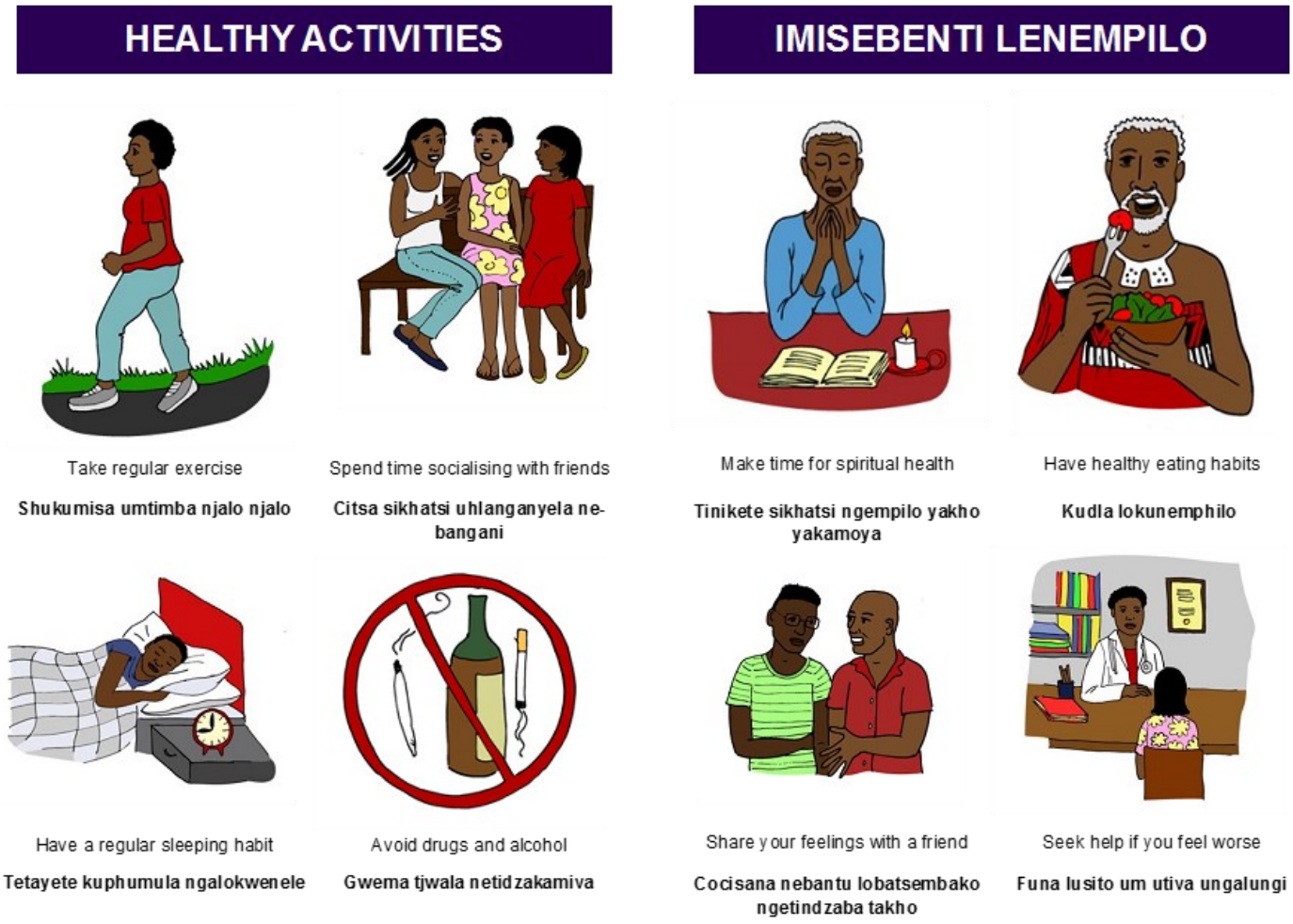
Expanding mental health care in the Kingdom of Eswatini: Successes, challenges and recommendations from initial experiences in Lubombo Region

POLICY BRIEF



Leaflet highlighting healthy activities used in psychosocial counselling intervention

Background

In 2017, in collaboration with the Eswatini Ministry of Health, the National Psychiatric Hospital and other regional stakeholders, COMDIS-HSD developed a brief psychological intervention for people living with depression to be delivered by nurses in primary care in Eswatini.

Our aim was to improve accessibility of support for depression for all those in need living in Eswatini. This 1-year initial phase assessed the feasibility and acceptability of this mental health programme for people living with HIV/TB accessing care in nurse-led primary care in Eswatini.

Our methods

This programme is not specific to HIV/TB patients and can be used for anyone with depression. However, we decided to start with this group, because:

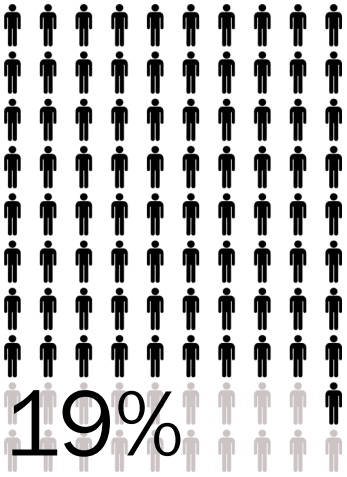
- We know this group have a risk of depression/anxiety, due to the condition, the medication, socioeconomic impacts of the condition (such as an inability to work or the cost of travel to clinics), and social impacts (such as on family life and stigma and discrimination)
- We know also that depression/anxiety can affect treatment adherence, which affects the individual's prognosis, increases the risks of transmission and interferes with national goals such as '90-90-90'
- Both international and Eswatini national guidance for these groups advocates for the inclusion of mental health support for this population.

16 nurse counsellors were trained from 8 sites across Lubombo. They received training from the National Psychiatric Hospital on the Eswatini Ministry of Health Mental Health Desk Guide, providing a comprehensive background on mental health conditions, as well as specific training developed for Eswatini on our psychosocial intervention: a counselling intervention based on the WHO-supported Behavioural Activation method, called the 'Healthy Activity Programme' (HAP). This is specifically aimed for non-specialist heathcare staff working in primary care.

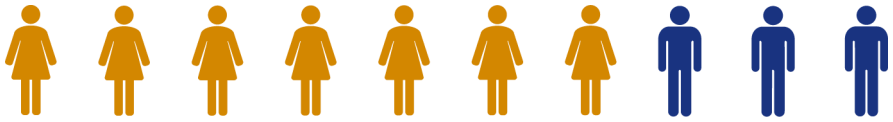
We asked the participating clinics to screen as many of their HIV/TB patients as possible, using a screening tool called the PHQ-9, which asks 9 questions about the patient's mood and wellbeing and is scored out of 27. If the patient scored greater than 10/27, meaning they have moderate depression, we advised the nurse offer a course of 5-8 counselling sessions. If they scored greater than 15, meaning they have severe depression, we advised the patient also be referred to a doctor.

We trained doctors on our mental health programme. Each clinic was given clinic and patient-held cards to record information. We used this monitoring information to evaluate the first 7 months of this programme. We also interviewed 21 patients and counsellors.

In under 2 months, 324 HIV/TB patients were screened in 7 sites. 62 patients screened positive for depression



of these patients suffered from depression



70% of those with depression were female

While this is just a rough estimate, if this number were applied to people living with HIV (not including TB) in Lubombo only, over 7,500 people living with HIV could be living with depression[1].

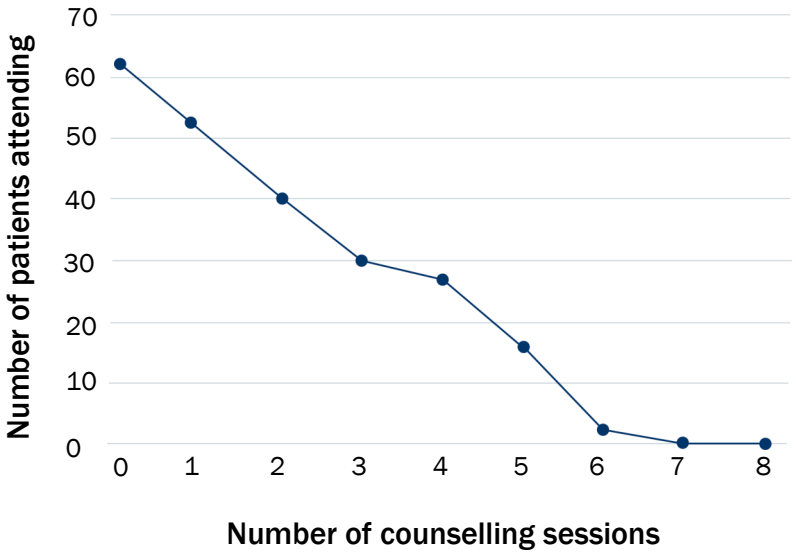
[1] Population of Lubombo from the 2017 Census (211, 191) x proportion aged >15 years (0.62) x proportion adults HIV positive from SHIMS2 study (29.4%) x number scoring >10 on PHQ-9 in the pilot (19%)—note that the eligibility for the study was >18 years and these statistics relate to >15 years, meaning this is likely an underestimation.

Map of sites that initiated counselling

Of the 8 sites that were initially involved, 7 screened for depression and 6 sites initiated counselling. The counselling service was offered to 60 patients.

The 2 sites that withdrew did so due to logistical problems, but they are interested to start this programme in the next phase.

Number of patients attending counselling sessions



Most patients did not attend the planned 5 sessions; however, as of the end of September 2018:

- 85% participants attended at least one counselling session
- 48% attended 3 sessions and 44% attended 4 sessions (a number most counsellors felt was sufficient for most patients)
- 26% had attended at least 5 sessions.

Patients attended sessions approximately once/month, coinciding with collecting their medication refills.

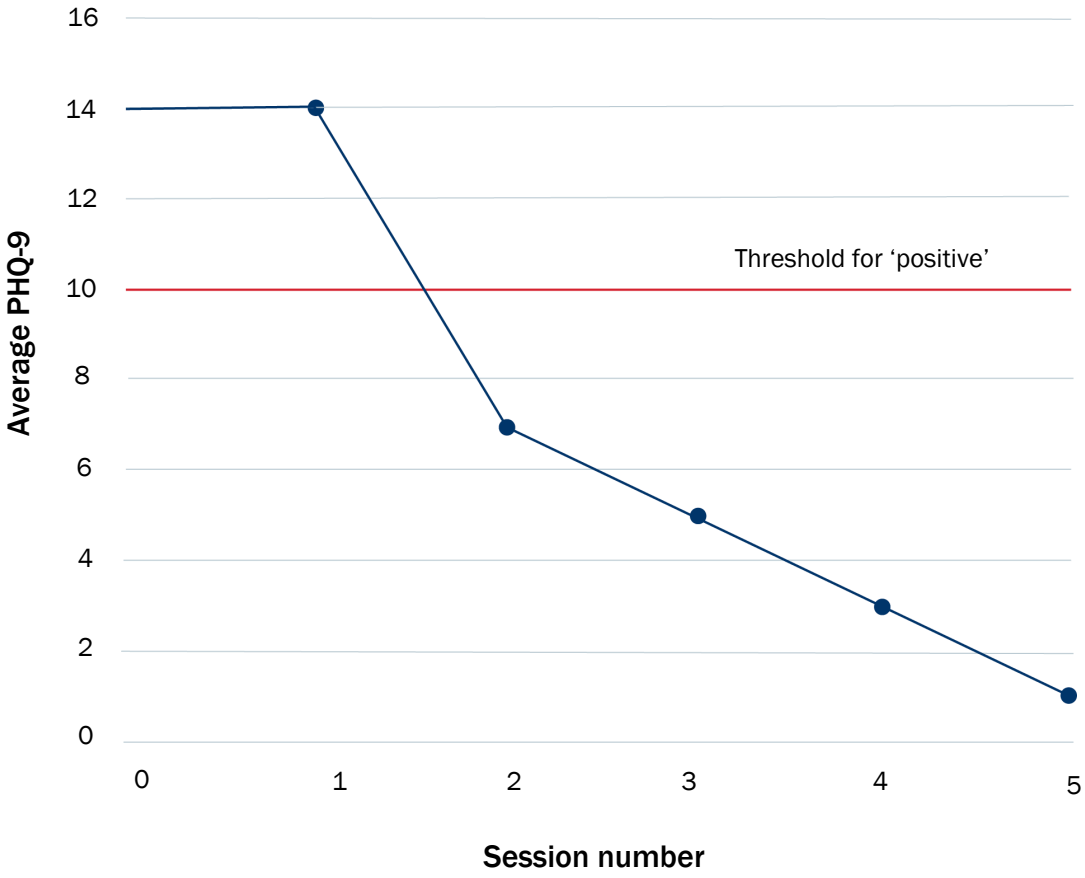
Outcomes

The HAP was **acceptable** to counsellors and patients and, with adjustments, **feasible** to be delivered in primary care and antiretroviral therapy (ART)/TB clinics in Eswatini. Extensive feedback from clinics, counsellors and participants was sought to make improvements and adjustments to the programme to make this service more feasible in the Eswatini setting.

Did patients improve?

Participant mental health was monitored using the PHQ-9 tool at every session. The average PHQ-9 dropped sharply after each session. While the reasons behind this are complex, it is likely that patients' mood is improving after counselling.

PHQ-9 Scores



In their own words, patients state that HAP counselling made them feel happier, made them feel like living, and made them more likely to take their antiretrovirals:

'I found that my heart feels free ever since I got counselling. I am so free and happy in my heart. There is no worries.'

'It has helped because before HAP my lifespan was shortened, but this getting into HAP my life span has extended. Now I am able to plan for the future and ensure the legacy of my children in case I pass away.'

'It has positively touched me. It was educated and changed my perception towards the pills, and I feel well.'

7 recommendations for policy and practice

1 Focus on mental healthcare

There should be continued focus on mental health care in Eswatini, including improving access to basic management of common mental health conditions in non-specialist primary care, such as counselling and medication, given the significant need.

2 HAP counselling

HAP counselling should be developed as a first-line option for non-specialist nurse-led primary care for moderate depression.

3 Sensitisation

All healthcare workers require sensitisation on mental health conditions and the value and importance of counselling and other treatments.

4 Routine screening

HAP counselling can be provided through routine screening of a patient group, for example people living with HIV/TB, and/or when there is clinical signs or symptoms of depression in any patient attending the health facility. The first 2 PHQ-9 questions are sufficient in a routine HIV-ART or TB follow-up. This decision should be made regionally or nationally, based on capacity and funding.

5 Good referral systems

Even with HAP counselling, some patients will need referral for further counselling, psychotherapies or medication. It is essential that good referral systems exist to the regional referral hospitals, where doctors are trained to assess, prescribe and have access to anti-depressants. Good links are also required to the National Psychiatric Hospital, both for advice and referrals.

6 Mentoring and supervision

Counsellors need regular mentoring and supervision from the Mental Health Team at their regional referral hospitals.

7 Monitoring and evaluation

There is a need for ongoing monitoring and evaluation of mental health care. Data on HAP counselling, referrals and quality of mental health care should be collected on the Eswatini electronic health record system: Client Management Information System (CMIS).

6 challenges to consider for the future

1 Mental health care need

The extent of need for basic mental health care is not known for Eswatini. Our crude estimates indicate that there could be many thousands of individuals in need of this care. This makes service preparation difficult.

2 Counselling capacity

Nurses in primary care provide many essential services to the people of Eswatini and sometimes may lack the capacity to take time for counselling. It is important that other services are not negatively affected by this, and that nurses get the necessary support and time.

3 Incomplete counselling courses

Most patients did not complete a full HAP course (designed to be 5-8 sessions, ideally 2-weekly). This was sometimes due to 3-month medication refills, with patients unable to attend in the interim due to time or finances, sometimes because the counsellor was too busy or not aware the patient was there and sometimes because patients did not want to continue with the course. Some nurses felt that 3-4 sessions was enough for their patients to benefit.

4 Treatment for severe depression

HAP counselling can only give support for moderate depression. Severe depression, those at risk of suicide and serious mental illness such as psychosis requires doctor and specialist input and access to psychiatric medication. Access to quality mental health care in secondary, tertiary and specialist care requires additional and sustained focus and development concurrently.

5 Social barriers

Stigma, discrimination and misunderstandings remain significant barriers to prevention and care of mental health conditions, both in the community and in healthcare settings.

6 Multi-agency support

Our results indicate that traumatic experiences, such as sexual violence, domestic violence and bereavement are common in patients experiencing depression. This requires multi-agency focus in terms of both prevention and care for these individuals.

7 successes of the psychological intervention

Our psychological intervention, delivered on HIV/TB patients in the Lubombo region, demonstrates that it is feasible to improve accessibility of support for depression in community clinics through HAP counselling.

1 Patient benefit

Nurse counsellors report that this service has helped their patients, changed their understanding of patient behaviour, and enhanced and improved adherence to their HIV/TB care.

2 Patient support

Patients report feeling relieved by having someone to talk to and supported and cared for by their nurse counsellors. They report learning new skills and undertaking healthy activities to help them with their mood. Patients that had suicidal thoughts prior to counselling reported feeling better.

3 Establishing good links

Good links have been built between the Good Shepherd Hospital mental health department and the community clinics, allowing for ongoing support and mentoring.

4 Successful referrals

Most patients with severe depression and/or suicidal thoughts have been appropriately referred to doctors, with most of these patients being prescribed appropriate medication, indicating functional community-hospital linkages.

5 Adequate record keeping

Record keeping in community clinics was generally good, allowing for good monitoring of results.

6 Using feedback

Extensive feedback has been sought from all study participants, including counsellors, clinic supervisors, regional matrons and patients. This is to improve the counselling, training, guidance and advice, and to ensure that this package is contextualised and appropriate for our Eswatini setting.

7 Transferable guidance

This package is in line with international guidance on the management of common mental health conditions in primary care.

Contact

Good Shepherd Hospital
P.O. Box 2
Siteki
Eswatini (Swaziland)

Dr Nina Putnis
Telephone: +268 7835 3940
Email: gshpublichealth@gmail.com

Ministry of Health Eswatini
P.O. Box 5
Mbabane
Eswatini (Swaziland)

Telephone: +268 2404 5514 / 2404 2431
Fax: +268 2404 74 20
Email: mohswaziland@yahoo.com

11/18

This project was funded with UK aid from the UK government

UKaid from the British people