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A Narrative Review of Mental Health and Human Immunodeficiency Virus

Nyondo Susan*

Department of Clinical Medicine, Malawi College of Health Sciences – Lilongwe Campus, Malawi

***Corresponding author:** Symon Nyondo, Malawi College of Health Sciences, E-Mail: snyondo@yahoo.com

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Description

Globally, the mental health of people living with HIV (PLHIV) is of increasing concern. Compared to people who are HIV negative, PLHIV are twice as likely to experience common mental disorders (CMDs) such as depression, anxiety and substance use disorders (SUDs). It has been proposed that CMDs negatively impact on progress towards achieving the 90-90-90 targets by 2020 as set by the Joint United Nations Programme on HIV and AIDS (UNAIDS). The three targets are as follows: 90% of all PLHIV should know their HIV status, 90% of all people diagnosed with HIV should receive sustained antiretroviral therapy (ART), and 90% of all people receiving ART will have achieved viral suppression.

There have been several calls for effective care models such as single-facility, multiple-facility and case-manager service integration models to combine services for HIV and mental health. The World Health Organization (WHO) guidelines on the use of ART recommend PLHIV are screened for depression, the presence of which has been associated with poorer health outcomes, reduced quality of life, and suboptimal adherence to ART. In many settings, international guidelines have not necessarily translated into national policies and plans to address the mental health of PLHIV.

In Malawi, the 2015 to 2020 National HIV & AIDS Strategic Plan and the 2018 HIV Clinical Guidelines guide the delivery of HIV services. The National HIV and AIDS Strategic Plan are aligned to the 90–90–90 targets. To reach these targets, the Malawi HIV & AIDS Strategic Plan and Guidelines focus primarily on integrating tuberculosis and HIV care, with limited coverage of mental health care. In this paper, we consider the potential impact of CMDs on progress towards the 90-90-90 targets, and identify potential intervention approaches to integrate mental health and HIV care in Malawi.

Four electronic databases (Medline, PsycInfo, Embrace, Global Health) were searched between May and June 2019. Search terms covered the following domains: common mental disorders, HIV, and sub-Saharan Africa (search terms for Medline are presented in Web Appendix 1).The search was limited to English-language texts published between January 2002 and June 2019, to identify the most up-to-date information. We conducted this narrative literature review following guidelines outlined by Green et al. (2006).

In another study, Lancaster et al. (2017) evaluated the association between alcohol and marijuana use and sub-optimal HIV treatment engagement outcomes among HIV-infected FSWs in Malawi. It was found that FSWs with harmful drinking or alcohol dependency were

1.9 (95% CI: 1.0, 3.8) times as likely to not use ART compared to FSWs without harmful or dependent drinking. Among FSW swath increased alcohol use while on ART, 14% were virally non-suppressed. In addition, marijuana-using FSWs were 1.9 (95% CI: 0.8, 4.6) times as likely to not use ART compared to FSWs who were not using marijuana. Kim et al. (2017) Explored factors contributing to high levels of self-reported non-adherence to antiretroviral therapy amongst adolescents living with HIV (ALHIV) in Malawi. Feeling depressed and alcohol use were both among the reported barriers to ART adherence among ALHIV in Malawi. Of the 519 participants, 153 (30%) reported having missed ART doses within the past week, and 234 (45%) in the past month. Alcohol use in the past month was one of the factors found to be independently associated with missing a dose in the past week.

Models of service integration

A previous review by Chua et al. (2017) identified three models of service integration which could be used to address the negative impact of CMDs on the 90-90-90 targets. Firstly, single-facility integration that works as a one-stop center where multidisciplinary teams provide HIV and mental health services within one facility, and where care is coordinated through internal referral systems. Secondly, multiple-facility integration where services are integrated through collaborations between different agencies by use of external referral systems to a network of providers. Lastly, service integration using case-managers, which involves an integration of services facilitated by a nurse, physician assistant or social worker in a case management role. In this model, the case manager sits in an HIV clinic, plans and implements integrated care for each individual, making referrals to other services as needed. We found examples of each type of integration in our review.

Multi-site integration

The advantages of a multi-site integration model include the possibility of service integration occurring through established referral systems between participating facilities or agencies that provide separate services. However, splitting services over different locations can result in patients receiving different health services from different providers, resulting in fragmented, inconsistent, and sometimes poorly coordinated care.