Supporting mental health in South African HIV-affected communities: primary health care professionals' understandings and responses

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How do practitioners respond to the mental distress of HIV-affected women and communities? And do their understandings of patients' distress matter? The World Health Organization (WHO) along with advocates from the Movement for Global Mental Health (MGMH) champion a primary mental health care model to address burgeoning mental health needs in resource-poor HIV-affected settings. Whilst a minority of studies have begun to explore interventions to target this group of women, there is a dearth of studies that explore the broader contexts that will likely shape service outcomes, such as health sector dynamics and competing definitions of mental ill-health. This study reports on an in-depth case study of primary mental health services in a rural HIV-affected community in Northern KwaZulu-Natal. Health professionals identified as the frontline staff working within the primary mental health care model ($n = 14$) were interviewed. Grounded thematic analysis of interview data highlighted that practitioners employed a critical and socially anchored framework for understanding their patients' needs. Poverty, gender and family relationships were identified as intersecting factors driving HIV-affected patients' mental distress. In a divergence from existing evidence, practitioner efforts to act on their understandings of patient needs prioritized social responses over biomedical ones. To achieve this whilst working within a primary mental health care model, practitioners employed a series of modifications to services to increase their ability to target the sociostructural realities facing HIV-affected women with mental health issues. This article suggests that beyond attention to the crucial issues of funding and human resources that face primary mental health care, attention must also be paid to promoting the development of policies that provide practitioners with increased and more consistent opportunities to address the complex social realities that frame the mental distress of HIV-affected women.

Keywords   HIV, practitioner understandings, primary mental health care, South Africa, women's mental health

> **KEY MESSAGES**
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> - Practitioners working in a primary mental health care model account for distress using a social discourse rather than a biomedical one.
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> - To respond to the social needs of patients practitioners developed new strategies to work around the current structure of services.
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> - Practitioner strategies signal the need to expand attention to the social needs of HIV-affected women in resource-poor settings within primary mental health care services.

Introduction

It's impossible, but we are trying

Participant, psychiatric nurse

The intersection of mental ill health and HIV/AIDS presents a significant public health challenge for South Africa (Olley *et al.* 2003; Pillay and Kriel 2006; Petersen and Lund 2011; Schatz and Gilbert 2012). HIV and common mental disorders (depression, anxiety and Post Traumatic Stress Disorder (PTSD)) are more prevalent in women (Tomlinson *et al.* 2009). Both are mediated by violence, political insecurity (de Jong *et al.* 2003; De Waal 2006), poverty (Lund *et al.* 2011), food insecurity (Tsai *et al.* 2012) and the fragmentation of families by migrant labour (Schatz *et al.* 2011). When combined with limiting local gender norms such as those defining 'wife' and 'mother', these factors may lead to extreme emotional distress for some women (Burgess and Campbell 2014). Two recent studies (Petersen *et al.* 2013; Burgess and Campbell 2014) articulate that HIV-affected women's mental health problems are often anchored to the complex social realities listed above, which will carry important implications for the organization of appropriate services.

The Movement for Global Mental Health (MGMH) takes interest in scaling-up access to services for such women (Lee *et al.* 2010; Patel 2012), and identifies the expansion of primary mental health care (PMHC) services in low- and middle-income countries (LMIC) (WHO 2010; Thornicroft and Tansella 2013) as crucial to this process. It is well known that primary mental health services in many LMIC operate under severe resource scarcity (Saxena *et al.* 2007). A cluster of studies cite the value of strategies such as task shifting to support the delivery of low-cost interventions within PMHC settings (see Kakuma *et al.* 2011) and bolster services. However, these efforts alone may not tackle the wider challenges that face primary health care (PHC) service settings more broadly, such as low levels of equity, complexities arising from competing knowledge systems about care, poor collaboration across health and welfare sectors and patient and lower grade practitioner disempowerment (Lawn *et al.* 2008; Dookie and Singh 2012). There is a need to better understand the operation of PMHC systems to prepare for the increasing service demands (Patel *et al.* 2012). Such studies would also help inform planning of mental health services for HIV/AIDS-affected women in highly marginalized settings that often depend on PHC. In response to calls for such research, this article presents a case study of health practitioner efforts to deliver services to HIV-affected women within a PMHC model in a rural South African setting. It seeks to answer the following research questions:

- How do practitioners working within a primary mental health care model understand the mental health needs of HIV-affected women?
- How do practitioner understandings operate within a PMHC model?

The study is contextualized within two bodies of literature: studies exploring practitioner understandings of patient needs and practitioner efforts to deliver services in line with primary mental health services in resource-poor settings.

Why do practitioner understandings of patient distress matter?

Bloom *et al.* (2008) assert that 21st century health systems in LMIC settings are best understood as knowledge economies: where engagement with health information is governed by social contracts influenced by dynamics of trust and power. As such, pathways to care are often determined by the outcomes of dialogue between opposing knowledge and belief systems about causes of illness (van Rensberg 2009) that converge during encounters between patient and practitioners.

Health professionals' understandings of patient realities or the 'problem' to be tackled have been linked to the effective delivery of mental health services and patient compliance (Kleinman 1980; Kirmayer 2006). There is a long history of practitioner understandings existing at 'odds' with patient realities, resulting in obstacles to mental health treatment, in both high-income (Laing 1961; Mishler 1984; Barry *et al.* 2001; Rose 2008), and low-income settings (Swartz 1996).

A minority of studies have explored practitioner understandings of HIV-affected patients' mental distress in African settings. For example, Ofori-atta *et al.* (2010) reported that while practitioners in Ghana recognized similar social drivers of mental distress as their patients did, some held negative representations of women as genetically predisposed to mental illness due to their 'weaker' constitution, shaped predominantly by negative cultural framings of women. In Zambia (Aidoo and Hall 2001) urban practitioners' understandings of their patients' mental distress acknowledged the role of psychosocial factors such as poverty and marital problems. In both studies, the value of identifying shared understandings was linked to improving the ability of diagnostic procedures to account for culturally bound idioms of distress.

In South Africa concern with minimizing the gap between practitioner and patient models of mental ill health is driven by

a desire to improve cultural dynamics of care. This is part of a process seeking to etch out a middle ground where aspects of traditional cultural frameworks are maintained (Swartz 1996; van Rensberg 2009). However, integration of biological and traditional treatment practices is complicated by the negative health outcomes that are often linked to certain aspects of traditional healing (Campbell-Hall *et al*. 2010).

Current recommendations for the provision of culturally competent and congruent care, which is defined as the ability to provide care within service users' cultural frameworks and social realities as a part of ensuring adherence to treatment (Petersen *et al*. 2013), attempts to acknowledge the value of community understandings. However, an emphasis on cultural narratives may overshadow the need to attend to broader structural conditions that also heavily shape patient experience. The degree to which this occurs within the delivery of mental health care to HIV-affected patients needs further attention—a gap this study seeks to contribute to.

PMHC in South Africa

In South Africa, PHC is anchored to the Alma-Ata comprehensive PHC approach (Department of Health 1997). This approach is delineated from other models (i.e. 'primary care'), through an interest in patient empowerment (Rifkin and Walt 1986) and assertion of the importance of social development and patients' cultural understandings to health and well-being (Lawn *et al.* 2008). Conversely, 'primary care' models are anchored to priorities such as first-contact care (at general practitioners or community clinics that are responsible for subsets of a population) and treatment that is continuous, comprehensive and co-ordinated across various levels of services (Rittenhouse *et al.* 2009). The application of a comprehensive PHC approach in South Africa was linked to the need to counteract the history of segregation and poor health access institutionalized during Apartheid.

A district health model is the core of South African PHC. District hospitals form hubs of services and support, providing bridges between specialized centres of care at regional and tertiary levels, and more accessible primary health clinics (satellite clinics). Recent WHO guidelines on the treatment of mental health in low-income settings argue for services that balance treatment at the community level (satellite clinics) with hospital settings (WHO 2010). In a balanced care model (Thornicroft and Tansella 2013) general hospitals—such as district hospitals—are supported by more specialized centres given the absence of mental health specialists in most communities. The South African model for PMHC involves the engagement of multi-sector health care professionals, including nurses, occupational and physical therapists, social workers and medical practitioners. The co-ordination of differing paradigms of care could potentially increase difficulties in delivering services, but this is an area of interest that has rarely been explored in low-income settings.

South African mental health services are co-ordinated through national and provincial government collaborations to implement the National Mental Health Care Act (2002). The act focuses on the integration of previously institutionalized services within a PHC model, clarifies the rights of service users and established 72-h emergency observation points at district hospitals. In KwaZulu-Natal—the province of focus in this study—three additional policy documents detail day-to-day service delivery (see Table 1). The strategic implementation plan (Department of Health KwaZulu-Natal 2003) outlines the PHC model for mental health services, detailing flows of power and resources from tertiary centres through to primary care clinics, who are also supported by partnerships with NGOs, community actors, volunteers and other social welfare sectors. The standard treatment guidelines for common mental health conditions (Department of Health KwaZulu-Natal 2006) details procedures of treatment, largely focusing on drug therapies. Finally, the policy for mental health on psychosocial rehabilitation (2010) details multidisciplinary care at district level and guidelines for providing vocational and life skills training as part of rehabilitation services in communities.

Although the PHC model has improved access to basic mental care in many parts of the country, reports of inequity across districts and provinces remain (Lund *et al*. 2010) with recent evidence citing KwaZulu-Natal as particularly under resourced

Table 1 Key policy documents driving PMHC services, KZN, South Africa

Document (year)	Aim of policy/document
South African mental health care act (2002)	• Integrates MH services into PHC services • Seeks to clarify rights and obligations of MH users • Establishes 72-h observation points (district-level care)
Strategic implementation plan for delivery of mental health care services (Department of Health KwaZulu-Natal **2003**)	• Outlines how national policy is to be implemented at local level outlines framework for delivery of care • Seeks to attend to continuity of care across service levels with attention to community level actors
Standard treatment guidelines for common mental conditions (Department of Health KwaZulu-Natal **2006**)	• Delivery of psychopharmacological interventions for common mental disorders most often seen in primary care/psychiatric practice • Disorders identified: schizophrenia, depression, anxiety, phobia disorders, substance abuse disorders
Policy for mental health psychosocial rehabilitation (Department of Health KwaZulu-Natal **2010**)	• Introduction of a comprehensive psychosocial rehabilitation programme to support mental health care users to optimize their quality of life • Promotion of multi-disciplinary approaches to mental health services in daily service delivery

(Burns 2010). A recent review of mental health services and policy (Petersen and Lund 2011) cites successes in the decentralization of care and the establishment of 72-h emergency care at district-level hospitals to manage acute cases. First-line psychotropic medications are available at most clinics. To address issues of inequity between rural and urban services, the community service programme which mandates a year of rural service for early career health professionals like psychologists (see Pillay and Harvey 2006) has extended mental health services to rural districts that often face staffing difficulties.

The PHC model acknowledges the importance of shared understandings through its inclusion of lower tier service providers. In South Africa, community health care workers are viewed as appendages to the PHC model, and hoped to reduce the gap between the knowledge systems of practitioner and patients 'because they are part of the community, experience the same health problems and can promote community organization to confront the basic causes of ill health' (Department of Health KwaZulu-Natal 2003).

There are a limited number of studies that report on practitioner understandings and efforts to work within a PMHC model in low-income settings. Existing studies of PMHC have focused on either a specific dimension of the model, such as the success of task shifting strategies (see Padmanathan and De Silva 2013) or financing (see Petersen *et al*. 2012), or a particular cadre of practitioner (i.e. nurses).

For example, Jenkins *et al.* (2012) highlighted general health professionals' understandings of patients' mental distress as being related to issues such as abandonment, infertility and relational problems among female patients. Muga and Jenkins (2008) reported that in the 3 years following the initiation of PMHC in 1994, nurses continued to believe that patients were best managed by specialists, and adhered to a medical model that emphasized traditional sick roles and contradicted the PHC emphasis on patient agency and empowerment. Petersen (2000) found that South African PHC nurses had a tendency to distance themselves from the mental health needs of patients despite understanding the need for holistic care that acknowledges the biological, social and cultural needs of patients. Instead, they delivered biologically focused care, sometimes completely avoiding discussion of psychosocial problems identified by patients. Nurses often cited resource constraints and their inability to treat social and cultural concerns as justification for their avoidance. In a more recent study of task shifting in South Africa, Petersen *et al.* (2011) report that primary care nurses felt more comfortable with the use of mental health specialists or community mental health volunteers to support patients, citing workload and resource burdens as limiting their ability to manage mental health patients. Although these studies provide a partial picture of various aspects of the PMHC model, explorations of the day-to-day realities of different types and levels of practitioners working within and across levels of care within the PHC model are scarce—a gap this study seeks to fill.

Furthermore, despite widespread agreement in the combination of HIV/AIDS treatment and mental health services in South Africa (Kelly *et al*. 2008; Freeman 2004), the bulk of supportive evidence is epidemiological in scope, reporting on high levels of CMDs associated with HIV (Tomlinson *et al*. 2009; Pappin *et al*. 2012). Given that the delivery of integrated services will occur within a PHC model (Hanlon *et al*. 2014), understanding the challenges facing practitioners working in these settings is crucial.

Research context

The study site is located in northern KwaZulu-Natal. At the time of research, it was one of the most rural, under-resourced areas of the province for mental health services (Area Three Psychiatrist, personal communication, KZN December 2011). The site is typical of a rural South African setting; high unemployment, exposure to violence and high levels of HIV and AIDS—37% (Burgess and Campbell 2014). The district hospital at the heart of this study is one of five in the region, responsible for supporting 11 satellite (community) clinics. A recent cross-sectional health survey in the region identified high levels of common mental health problems among HIV/AIDS-affected carers in the community, with 44% of AIDS-affected caregivers meeting criteria for depression, anxiety or PTSD (Kuo *et al*. 2011).

Conceptual framework

The study is guided by a social psychological interest in the bridge between understandings and action. The theory of social representations (Moscovici 1984) asserts that understandings—which are framed by a series of symbolic and structural constraints in a given environment—are crucial to understanding the 'how' and 'why' of action in social settings (Jovchelovitch 2007; Bauer and Gaskell 2008). This platform provides a useful starting point to link practitioner understandings of patient emotional distress—argued to heavily influence patient treatment outcomes—to the daily practice of delivering treatment in resource-poor settings.

Methods

Data were collected as part of a larger qualitative study of mental health needs and services within rural HIV/AIDS-affected communities (Burgess and Campbell 2014). The local district hospital formed the hub of the investigation. Interviews (semi-structured) with 14 health professionals supporting mental health inpatients, outpatients and community clinics on a daily basis were conducted during November 2010 and January 2011. Interview schedules focused on two areas: (1) their understandings of the explanatory models used by patients—specifically HIV-affected women and (2) informants' daily activities related to patient care. Interviews were conducted by the author in English, averaged 1 h in length, and were transcribed verbatim with the assistance of a professional transcription company. The order and shape of questions were driven by each informant's account, in order to allow for a more natural and conversational flow during interviews. Interviews were contextualized by approximately ∼80 h of ethnographic observation of hospital and satellite clinic settings. Findings from analysis of ethnographic observations

are reported in detail elsewhere (Burgess 2013), and the below analysis reports only on themes from interview data.

Although this study reports on a small sample size, it accessed the individuals most actively engaged in delivering PMHC services to the community at the time of the study using a combination of purposive and snowball sampling methods (see Table 2 for participant demographic details). The sampling procedure was informed by a grounded theory approach (Glaser 1991). Preliminary interviews with the district hospital medical manager informed initial recruitment of participants who were identified as having direct or daily involvement with delivery of mental health services to HIV-affected women (HIV-positive, or managing HIV-related loss/care-giving responsibilities) in the community. Each participant was asked to identify other salient actors across the full PMHC model (community, district, regional and tertiary tiers), who were subsequently contacted for interviews. The grounded approach to sampling was devised to establish a picture of the reality of the system as it operated on a daily basis—or the reality of policy implementation. Nurses at satellite clinics—who are often viewed as the backbone to a PHC model were not indicated by any staff as potential participants, and as such, not interviewed. Their absence was confirmed by ethnographic observations where nurses at satellite clinics did not engage with patients, often telling them to wait to visit with a staff member from the district-level hospital (see Burgess 2013).

Ethical clearance came from three sources: (1) the London School of Economics, (2) University of KwaZulu-Natal and (3) the KwaZulu-Natal Department of Health. Data were analysed using grounded thematic analysis (Glaser 1991; Attride-Stirling 2001), involving multiple readings of interviews to identify data-driven themes related to the 'social field' of interest, namely the delivery of mental health services within a PMHC model. The first reading generated descriptive codes which were progressively clustered into basic themes. These were organized into a global thematic network, which was progressively refined to highlight the central areas of concern underpinning inform-ants' accounts of service delivery: (1) professionals' under-standings of women's distress (2) challenges faced and (3) successes achieved in delivery of care. Coding was validated by

a researcher familiar with the project, who reviewed the coding framework and excerpts from interview transcripts.

Results

How do professionals understand HIV-affected women's distress?

PHC professionals' accounts reflected biomedical understand-ings through their use of diagnostic category labels such as depression and psychotic episodes, cited in relation to demographic variables such as age and gender. However, practitioners anchored these labels to their understandings of HIV-affected women's daily lives in relation to four themes: poverty and deprivation, family and social relationships, HIV/AIDS and limiting social norms.

Poverty and related conditions of unemployment, food and housing insecurity were described as integral to their patients' experience of emotional distress. For example:

> *"Socioeconomically driven psychotic episodes are prevalent in women…unemployment that leads to poverty is still the biggest cause of depression. If the husband or woman is employed, then her emotional condition improves, if not, it evolves into a pattern like major depression where they don't respond to meds."*—Psychiatric nurse 1

Family disputes were seen as critical to understanding women's mental health problems. Accounts framed distress resulting from disputes to the intersection of gender norms governing women's behaviour, poverty and violence:

> *"You find that people are depressed because of the things that happen to them socially. With some women there is a family conflict with their husband, for some it is because of abuse, like the other [woman] we saw in the[hospital] ward, her kids were being sexually abused by the husband, and then mom ends up depressed. The other thing is depressing [women] is when their kids are being abused, the family likes to say 'no, you mustn't take this to [the police] you mustn't report it - this is a family thing" and when it's*

Table 2 Participant demographics

Position	Duration in local post	Place of birth
Doctor—district level	8 years	South Africa (KZN)
Doctor—district level (mental health doctor)	1 year	England
Doctor—regional level	5 years	South Africa (KZN)
Doctor—tertiary level	10+ years	South Africa (KZN)
Therapy department assistant manager, Physiotherapist—district level	6 years	South Africa (Gauteng)
Jr. Physiotherapist (community service)—district level	1 year	South Africa (Western Cape)
Sr. Occupational therapist (Chief)—district level	3 years	South Africa (KZN)
Occupational therapy assistant—district level	7 years	South Africa (KZN—Manguzi)
Nurse (psychiatry)	4 years	South Africa (KZN—Manguzi)
Nurse (psychiatry)	5 years	South Africa (KZN)
Social work	3 years	South Africa
Voluntary counselling and testing (VCT) programme co-ordinator	4 years	South Africa (KZN—Manguzi)
NGO home-based care co-ordinator (nurse)	5 years	South Africa (KZN—Manguzi)

a family thing, that means that a mother can't do what she needs to do – protect her children.''—Occupational therapy assistant

Accounting for distress among HIV/AIDS-infected women was linked to one of two categories: (1) discovering they were infected by a husband or partner or (2) managing the complex social needs of inpatients:

''With [depression related to] HIV, it starts with the husband who will not disclose his status to his partner. Or, he has disclosed the status, but there is this stigma attached, you know this feeling of guilt, and others think they are going to die. But HIV dementia has dropped since 2005, because of ARV's (Anti-retroviral treatment). Previously it was very hard to access ARV's, and because of this you used to see lots of depressed and suicidal women.''—Psychiatric nurse 2

''When you see psychotic or depressive symptoms on the [HIV/TB] ward, it's usually related to life at home, or isolation at the ward. One woman was flailing about displaying psychotic symptoms, and [upon further examination] it turned out that she was upset because of issues about her lobola and her husband.''—Mental health doctor

Practitioners' representations of the 'problem' differed from women's own understandings of their distress in one dimension: the acknowledgement of the impact of negative social norms regarding women and mothers on mental distress (see Burgess and Campbell 2014 for details of women's understandings).

''. . . you have so much responsibility to be the makoti [daughter-in law] in the household: to make sure everyone is looked after; the mother in law, whoever lives on that homestead is your responsibility. You have to cook, you have to clean, you have to make sure your kids are at school - you have to do everything, and who is your sounding board? Who do you chat to? I think this place works because of women, but they don't have anywhere to have their say, and to let go of their frustration with all of the things they have to deal with.''—Senior occupational therapist

Practitioner understandings identified in this analysis seem to contradict a body of evidence that places understandings of mental health practitioners and patients in oppositional life worlds (Barry *et al*. 2001; Appignanesi 2009). In further contrast to findings from aforementioned African contexts, practitioners' in this study understandings of the psychosocial concerns of their patients resulted in a scepticism about the value of biomedical responses or categories in addressing the needs of patients:

''[community definitions of mental illness] is around being mad, their definition is not like any of the other [categories], it's not mood disorders . . . .and the other thing is, that if you tell them that they have mental illness, well if you're doing all these surveys and you tell them they're mentally ill, and they think 'hey my life really is shit' do you really want to be telling people that? they're so tough and they're so admirable and they're just bumbling along and trying to do the best that they can, on a day to day basis, and to

suddenly, go there . . . when someone tells you that you have something, then it's actually on your mind a lot and it's not helpful, particularly when its social problems and there's nothing that they can do about it . . . . I mean I'm sure [mental illness] still needs to be addressed, but the poverty first perhaps, because . . . that would be like opening Pandora's box.''—Mental health doctor

Findings described above highlight a group of practitioners who held an understanding of their patients' mental health as socially constituted—inexorably linked to challenging the social settings that shaped the everyday experiences of women. The following section reports on how the above understandings were enabled or limited by the current scope of the PMHC system.

Understandings in practice: supporting women's mental health needs within the PMHC system

Practitioner accounts identified barriers to mental health services in three areas that confirmed recent country evidence (Burns 2010; Petersen and Lund 2011): Resource constraints in areas of human resources and funding; environmental constraints, such as structural barriers to follow-up leading to the loss of patients, and spaces incongruent to the delivery of counselling; and bureaucratic constraints, such as complicated referral pathways created by insufficient bed spaces at regional and tertiary hospitals.

Although accounts of barriers were linked to the biomedical logic of the system, accounts of every day practice highlighted practitioner efforts to target the psychosocial issues they cited as driving women's mental distress.

Participant accounts are based on encounters with women in district hospitals or during their visits to satellite clinic settings. Wider failures in the operation of the PMHC system as a whole were noted, indicated by the absence of screening, treatment and follow-up delivered at satellite clinics (driven by stigma and disengagement from primary care nurses—see Burgess (2013) for a full description of these findings). The result was that most mental health patients were seen via one of two routes: attendance at general health clinics (open clinics) or emergency admissions into 72-h observation at the district hospital.

Practitioner accounts identified various strategies that resulted in adaptations to the existing PMHC model, which were organized under three themes: creating new systems to increase access and engagement with women; working within current systems; and strategic counselling practices, such as identifying verbal cues among general patient discussions.

Creating new systems to increase access and engagement with women was driven largely by efforts of district-level occupational and physical therapists. These staff encountered women during their general clinics, and felt that delivering appropriate treatment and assessment at these times was impossible. Given the low likelihood of follow-up to the hospital or satellite clinics for financially constrained women, informants developed a new schedule to increase their presence at satellite clinics.

''At general clinics often times there's no privacy, there's someone sitting beside you screaming, they can hear everything, people

screaming teeth extraction, babies crying during immunization...here we have OT and PT in the same room – it's not a counselling environment. There's no time at clinic to do a proper counselling session...so a lot of time, we identify a walking social problem and tell them to come back – and never see them again, so we started (additional) twice a month visits to some of the residential clinics, hoping that we can catch and sort out some of these cases better.''—Therapy department assistant manager

The labelling of women as 'walking social problems' was linked to practitioners' understandings that social issues resided at the heart of many patients' depression and anxiety symptoms.

An interpreter programme was also developed to support visiting specialists from tertiary settings and non-local staff who were employed on placements. The programme—which relied on volunteers due to a lack of funding—enabled more effective engagement with women during assessments. However, the quality of translators varied, leaving practitioners to rely on the strategy of patient advocacy by postponing assessments, counselling sessions and treatment planning to prevent mismanagement.

''Just a little patient advocacy...Because this system is so dysfunctional you're not going to find the patient again. If he gets mismanaged by that doctor, they're going to get mismanaged for the next 20 years. If the translator puts the wrong diagnosis down on that card, every tom dick and harry nurse at the clinic is going to follow through with that diagnosis and the same meds and no one is going to review that patient for the next twenty years. You're not going to follow that patient up unless you're lucky. Because the translations are difficult, you need a translator who understands the point of a counselling session...so often I'll give them some exercises to practice at home for the (psychosomatic) pain, and just try to get them back another day.''—Therapy assistant manager

Some practitioners viewed general clinic sessions as opportunities to identify the women's social and relational 'time bombs' for later mental health problems: abusive husbands, abandonment and extreme poverty. To conduct these sessions in contexts unfit for counselling, practitioners drew on the second strategy for improving engagement with women: strategic counselling practices. Practitioners agreed on the need to observe women's body language and other verbal cues to overcome a cultural framing that valued women who stayed strong and didn't complain.

''You can identify these women because they come in with a certain expression on their face- they don't meet your eyes, tone of voice, posture...patients will often use cues to point to the problem – a little emphasis on stress, money matters and lack of support and you think – ahh, yes, now I have to unpack that.''—Therapy assistant manager

Social work referrals were the main outlet for responding to the immediate social needs framing HIV-affected women's mental health problems. In the PMHC system, social work referrals enable more holistic supports including: access to income (via welfare grant support); management of family disputes (via trauma counselling delivered by social workers), and referrals to the local NGO for additional social support or access to food parcels. However, social workers acknowledged that women's access to these services was often complicated and required advocacy to achieve success:

''S: Yes, where the cause [of depression] is poverty, we recommend food parcels, or DG (disability grants). We also check for identity documents, because most women don't receive grant assistance because they don't have the necessary documents. But the problem is the working relationships because if you refer a patient to home affairs to get these documents,...they [home affairs staff] will ignore the patient and tell them to wait...so they wait wait...but ultimately, it's a waste of time for us to go with them, because other patients are waiting here to see us (laughs).''

''So you often will just attend with the patient, because when [SASSA staff] see a social worker, they say you can just go through...we've done many workshops, even with the central office of home affairs...but they don't understand this and I don't know – they just – (sigh) home affairs is the biggest problem.''

The inclusion of NGOs and community service staff within the PMHC model is a strategy that attempts to fill gaps in services. However, by linking the few services that target survival needs to junior and temporary staff resulted in a discontinuity of key services such as support groups.

''....we used to have support groups in this area. The one mental health care user group we used to have started a chicken project, they sold chickens they had money, they came together and were treatment supporters for each other...that all fell to pieces when the CRF [community rehabilitation facilitator] who was working here left...It was one of his projects...he did really well, and it fell apart.''—Chief occupational therapist

At the time of the study, there were no official mental health support groups for HIV-affected individuals available. Only five satellite clinics were supported by the local NGO in delivering general HIV support groups. However, the occupational therapist assistant described her efforts in developing a new informal support group for HIV positive women to respond to this gap:

''...there is one group that I had just around here, we started that group because I was supervising their [HIV] medication, and through that supervision, we ended up having a group. As a support group, they started selling, few things, fruits so they could generate income, because when you are unemployed you sit alone and you will feel depressed, and will think about your sickness. They were sitting along the road selling...and they have started selling their own things now, and even though they were depressed, they are now ok.''

Discussion

This case study draws attention to practitioners' understandings of HIV-affected women's mental health, and efforts to support

them within a PMHC model in a highly marginalized setting. Findings challenge assumptions of a gulf between professionals' and patients' understandings of the problem as impacting on service outcome. In this study, the obstacle to care was not so much professionals' understandings of the problem, but the gaps in services created by policy frameworks that do not adequately target the social concerns of patients, and a background of massive under resourcing.

It is worth noting that this study is limited to an in-depth exploration of one small community, making generalizations to other settings limited. Further limitations reside in the absence of direct accounts from particular actors within the model—such as nurses working in primary care/satellite clinics. However, their absence despite the use of a snowball sampling strategy where staff members implicated practitioners most relevant to the daily delivery of mental health services is telling in its own right. This disengagement of nurses highlights a need for increased sensitization among lower cadres of professionals about mental health issues in communities such as this.

Despite the presence of a range of health professions (nurses, occupational therapy and psychiatrists), all practitioners acknowledged and prioritized the social needs of patients' lives within treatment plans. Limitations they faced in delivering care highlights a need to provide practitioners supporting HIV-affected women's mental health with additional tools to respond to the basic survival needs of their patients. Current reliance on social workers is a limited strategy, as social workers often faced limitations of their own, which hindered the contributions they could make to helping women navigate bureaucratic systems. Current recommendations for interventions to address women's psychosocial needs are largely psychological in nature, such as cognitive behavioural therapy (CBT) or other group-based counselling (see WHO 2010).

Evidence from small trials in Southern Africa highlight that psychological interventions such as interpersonal therapy (IPT) (Petersen *et al.* 2012a, b, 2014) and problem-solving therapy (PST) (Chibanda *et al.* 2011) for treatment of common mental disorders such as depression and anxiety among vulnerable and HIV-affected women provide some space for patients to begin to tackle some of the economic, relational and food security challenges women reported in sessions, often through peer support. However, gains from such small-scale local collaborations are often piecemeal, and as findings from previous studies indicate, are insufficient strategies to effectively ameliorate the long-term impacts of social challenges on mental ill-health (Burgess and Campbell 2014). This suggests that whilst community mental health groups as outlined in the aforementioned studies may be a step in the right direction, there remains a need to further extend the reach of PMHC interventions so they can tackle the more systemic social issues that reside at the heart of women's distress. A recent trial from Uganda highlighted that when HIV-affected communities were involved in the design of such mental health groups, they articulated for the inclusion of income-generating activities to increase relevance of such groups to their daily lives (Nakimuli-Mpungu *et al.* 2014).

Current primary mental health policy in South Africa is underpinned by the discourse of culturally competent and congruent care, defined as the ability to provide treatment within service users' cultural frameworks and social realities to ensure treatment adherence (Petersen *et al.* 2013). Participant acknowledgement of the role of cultural norms in shaping HIV-affected women's experiences of distress in this study highlights the achievement of these aims to some degree. However, to a much larger extent, problems facing the delivery of services—and as such, the implementation of policy—were less related to cultural incongruences and more to the inability for current service pathways to also respond to the complexities of systemic social concerns facing patients—particularly poverty.

Accounts of adaptations to the PMHC model described by practitioners in this study highlight the need for interventions that target complex community issues such as disempowerment (among women who are reluctant to speak up about concerns), service access (to target structural barriers to patient follow-up), and household poverty. Findings from this article ultimately suggest the need to expand our attention to delivering 'socially competent care' which would establish a call for governments to develop further policies and contribute resources towards services that are also able to help HIV-affected women in South Africa tackle the systemic social issues that drive their common mental distress (Burgess and Campbell 2014; Petersen *et al*. 2013).

Conclusions and policy recommendations

This study has provided insights into the importance of and continued limits facing a PMHC service model in resource-poor settings. It suggests that beyond addressing the crucial issues of funding and human resources, equal attention must be paid to promoting the development of policies that provide practitioners with increased opportunities to address the complex social realities that frame the mental distress of HIV-affected women.

As part of a scaling-up agenda, particularly one that seeks to combine mental health and HIV-related services, it would be useful to implement permanent posts and funding to deliver services that tackle psychosocial needs. Beyond this, there is a need to work on promoting 'long-term' strategies to help women tackle systemic social issues—such as limiting gender norms and poverty—that impact on mental well-being. Although one route to this may include funding ear-marked to facilitate treatment programmes that are linked to income generating programmes, it need not end there.

Given the pervasiveness of social and economic challenges in the country, which carry well-acknowledged impacts on mental health, there is a need to consider the role that health professionals can also play in helping patients mediate distress, outside of current channels such as social welfare grants. All of the practitioners in this study were committed to securing better livelihoods for their patients, and there is a need for future studies to explore what shape future engagement could take. Evidence suggests the value of partnerships between communities and more powerful agents to improving mental health (Campbell and Burgess 2012) as a valuable starting point. This would involve a widening in the remit of mental health practitioners to enable them to also support patients in non-health interventions that would reap positive benefits for

health. The practice of social medicine could be one avenue to support the efforts of practitioners like those in this study. Popular in Latin American countries, social medicine requires practitioners and policy makers give equal attention to the political and economic factors that produce health inequalities, as part of treatment practices (see Briggs and Martini-Briggs 2009). To be successful however, improved communication and partnerships between PMHC actors and other social sectors in the country, which has already been championed in South Africa (Skeen et al. 2010) is required. Though this is not a short order, small-scale steps in this direction would make invaluable contributions to promoting lasting change in the mental health outcomes for HIV-affected women, and communities in low-income settings.

Ethical approval

This research was approved by the following research ethics committees: Department of Social Psychology, London School of Economics and Political Sciences; University of KwaZulu-Natal, South Africa (HSS/0794/010D); Department of Health, KwaZulu-Natal, South Africa (HRKM-166/10).

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