

**THEMATIC SEGMENT:
MENTAL HEALTH AND HIV/AIDS –
PROMOTING HUMAN RIGHTS,
AN INTEGRATED AND
PERSON-CENTRED APPROACH
TO IMPROVING ART ADHERENCE,
WELL-BEING AND QUALITY OF LIFE**

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All case studies have been compiled as a Conference Room Paper (UNAIDS/PCB (43)/CRP2), which is available at the PCB website.

ACRONYMS

2030 Agenda	2030 Agenda for Sustainable Development
AIDS	acquired immune deficiency syndrome
ART	antiretroviral therapy
ARV	antiretroviral
CDC	U.S. Centers for Disease Control and Prevention
Global Fund	Global Fund to fight AIDS, Tuberculosis and Malaria
HIV	human immunodeficiency virus
PCB	Programme Coordinating Board
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
SDG	Sustainable Development Goal
TB	tuberculosis
UHC	Universal Health Coverage
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization

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INTRODUCTION

1. At its 41st meeting, the UNAIDS Programme Coordinating Board (PCB) agreed that the topic of the thematic segment of the 43rd meeting would be “Mental Health and HIV/AIDS—promoting human rights, an integrated and person-centred approach to improving antiretroviral therapy (ART) adherence, well-being and quality of life.” This session responds to the growing acknowledgment of the importance of addressing the intersection between mental health and HIV and of the need to adopt a human rights-based approach and to help improve the wellbeing and quality of life of people living with HIV and people with mental health conditions.
2. The focus is timely and relevant in the context of the health-related Sustainable Development Goal (SDG) target 3.3 to end the epidemics of AIDS, tuberculosis (TB), malaria and neglected tropical diseases by 2030 and the realization of the 2016 Political Declaration on Ending AIDS.
3. The focus of this session is also relevant to SDG targets 3.4, 3.5 and 3.8 to: “by 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being; strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol; and achieve Universal Health Coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all” (1).
4. More generally, the 2030 Agenda for Sustainable Development (2030 Agenda) explicitly seeks “to realize the human rights of all”. Its vision of a healthy, inclusive society means that all SDGs must be met without discrimination, including on discrimination based on HIV status or mental health conditions. In addition, the discussion comes at a time of increased demand for global action to improve responses to non-communicable diseases, including mental health conditions, across the world (1), following the adoption of the Political Declaration of the Third High-Level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases (2).
5. The thematic segment is further relevant to the implementation of the United Nations (UN) Convention on the Rights of Persons with Disabilities.¹ This convention promotes the rights, freedom, dignity and inclusion of persons with psychosocial disabilities. They include civil and political rights, the right of persons with disabilities to live independently in the community and to make their own decisions regarding health and life, the right to participation and inclusion, access to information, privacy, education, health, employment and social protection, including for people with psychosocial disabilities.
6. The Convention also notes that persons with disabilities have the same rights as other people to sexual and reproductive health and population-based public health programmes, and that health care should be provided on the basis of free and informed consent. It calls on states to prevent discriminatory denial of health care or health services on the basis of disability.
7. This session also aligns with the recommendations of:

¹ <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html>

- the 2017 report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health which focused on the right of everyone to mental health (AHRC/35/21);
 - the 2018 Report of the United Nations High Commissioner for Human Rights on Mental health and human rights (A/HRC/34/32);(3-5) and
 - the Human Rights Council Resolution on Mental Health and Human Rights of October 2017, which urged actions to address the “social, economic and environmental determinants of health and to address holistically a range of barriers arising from inequality and discrimination that impede the full enjoyment of human rights in the context of mental health” (6).
8. The thematic segment will discuss the importance of addressing the mental health needs of people living with HIV, key populations and people affected by or at risk of HIV in order to:
 - optimize HIV prevention, testing, treatment and care services;
 - reduce the suffering, disability and stigma associated with mental health conditions; and
 - increase psychosocial wellness and quality of life.
 9. The segment will also review the HIV prevention, testing and treatment needs of people with mental health conditions. It will also identify strategies for substance use and mental health and HIV programme to work better together to address the common socioeconomic, gender, stigma and human rights issues that drive these conditions and, when relevant, their co-occurrence. The session will explore how programmes can work together to identify and reach vulnerable populations with the multisectoral services they need to achieve the broader SDGs.
 10. A starting point for the thematic segment is need to reduce stigma and discrimination to achieve good health and quality of life outcomes for people living with or affected by HIV, key populations (including people who use drugs) and people with mental health conditions. The discussion recognizes the relevance of intersectionality, i.e. the relationships and interactions among the many factors that affect health inequalities (7, 8).
 11. Key populations, people living with HIV and people with mental health conditions may experience multifaceted stigma and the effects of interlocking systems of discrimination (9, 10) Stigma associated with HIV—and marginalized identities—has been linked to anxiety, depression, poor self-esteem and poor adherence to HIV care (11). Stigma also remains a barrier to accessing drug dependence treatment, mental health care and HIV services (12-14). The 2016 Political Declaration on Ending AIDS explicitly recognizes the HIV epidemic as a human rights challenge and expresses grave concern that stigma and discrimination continue to prevent people from accessing HIV services. The Declaration commits countries to promote non-discrimination in health care, workplaces, education and social services.
 12. This thematic segment recognizes that the largest generation of 10–24-year-olds in history is now growing into adulthood (11). Yet, more than 3,000 young people die every day, totalling 2 million deaths a year, from largely preventable causes (12).
 13. Adolescence is a unique developmental phase. Adolescent brain development, shaped by the social environment and experiences, paves the way for future capabilities, while the onset of sexual activity and compromised capacity for emotional control can be associated with new health and behavioural vulnerabilities (11, 13).
 14. Many of today’s adolescents face unemployment, family instability, war and conflict, mass migration and pressures to adopt unhealthy lifestyles (11). Adolescent development is marked by strong motivations to form relationships beyond the family, take risks and be guided by peer influences (11). Young people born with HIV who are entering adolescence

and considering becoming sexually active may experience particular stressors. Laws that prevent child marriage, protect against violence or reduce discrimination can promote adolescent health, as can engagement in quality education and health care that is accessible and acceptable to adolescents (11).

15. The thematic segment adopts a life-cycle approach, focusing on actions needed to promote mental health and quality of life for people living with and affected by HIV across the course of their lives.
16. The thematic segment builds on the cross-cutting principles and approaches of the UNAIDS Strategy 2016–2021(14) and the World Health Organization’s (WHO) Mental Health Action Plan 2013–2020 (15):
 - **Universal health coverage.** Regardless of age, sex, socioeconomic status, residence, race, ethnicity or sexual orientation, and following the principle of equity, persons with mental health conditions should be able to access, without the risk of impoverishing themselves, essential health and social services that enable them to achieve the highest attainable standard of health (15). People living with HIV should have access to people-centred systems for HIV care in the context of Universal Health Coverage (UHC), including treatment for tuberculosis (TB), cervical cancer and hepatitis B and C (16).
 - **Human rights.** Both HIV and mental health strategies, actions and interventions for treatment, prevention and promotion must be compliant with the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments (15).
 - **Evidence-based practice.** HIV and mental health strategies and interventions for treatment, prevention and promotion need to be based on scientific evidence and/or best practice, taking cultural and other local and community considerations into account (15).
 - **Life course approach.** Policies, plans and services for mental health and HIV need to take account of health and social needs at all stages of the life course, including infancy, childhood, adolescence, adulthood and older age, (15) supporting and strengthening factors that protect mental wellbeing, the foundation for good quality of life.
 - **Multisectoral approach.** A comprehensive and coordinated response for mental health requires partnership with multiple sectors such as health, education, employment, judicial, housing, social and other relevant sectors as well as community and private sector engagement, as appropriate to the country and local context (15).
 - **Gender equality.** Strategies should aim to eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV, key populations, people who use drugs and people with mental health conditions (16).
 - **Empowerment of people living with HIV, key populations, people who use drugs and persons with mental health conditions and psychosocial disabilities.** Persons with mental health conditions and psychosocial disabilities, including those living with or affected by HIV, should be empowered and involved in mental health advocacy, policy, planning, legislation, service provision, monitoring, research and evaluation (15). People living with HIV, key populations, people who use drugs and people at risk of and affected by HIV must be empowered to know their rights and to access justice and legal services to prevent and challenge violations of human rights (14), including criminalization and discriminatory legislation, policies and practices.
17. A number of recent initiatives have increased momentum for integrating mental health across a range of community and health-care settings and, more broadly across, the SDGs, including:
 - the recent launch of the Lancet Commission on Global Mental Health and Sustainable Development (17);
 - the convening of the first-ever Global Ministerial Mental Health Summit, by the United Kingdom; and

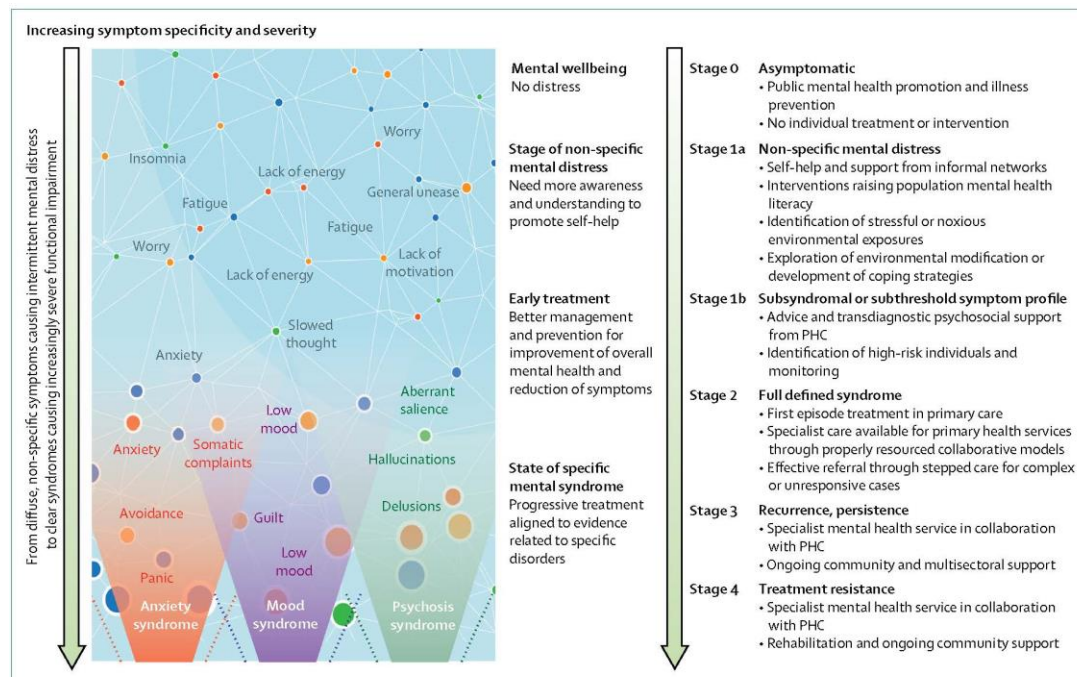
- the commitment from the Netherlands to host the second Global Ministerial Mental Health Summit in 2019 with a focus on mental health and psychosocial support in emergencies (18-20).

Definitions

18. WHO defines mental health as the state of wellbeing that enables every individual to realize their own potential in relation to their developmental stage, to cope with the normal stresses of life, to study or work productively and fruitfully, and to contribute to their community (21).
19. Mental disorders are commonly defined as disorders of thought, emotion, behaviour and/or relationships with others that lead to functional impairment in one or more major life activities (22). Psychosocial difficulties include a broad range of psychological and social factors that can also influence quality of life for people with HIV such as unemployment, social interaction problems and social stigma, as well as psychological experiences such as sadness or poor concentration, which may overlap with symptoms of mental health conditions (23). The term “mental health conditions” is used throughout this text to represent diagnosed disorders as well as states of mental distress.
20. The WHO Quality of Life Group defines quality of life as “an individual’s perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards, and concerns” (24).
21. WHO defines substance abuse as harmful or hazardous use of psychoactive substances, including alcohol and drugs. Psychoactive substance use may lead to dependence. This refers to a cluster of behavioural, cognitive and physiological phenomena that develop after repeated substance use. They typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance and sometimes a physical withdrawal state (25). Throughout the present document, the following terms are used: “substance use”, “drug use”, “drug dependence”, “harmful use of alcohol” and “alcohol dependence”. It should be noted that, while there are links between mental health and substance use, not all substance use is associated with a mental health condition.
22. The Lancet Commission on Global Mental Health and Sustainable Development proposes a reframing of global mental health that is informed by three guiding principles (17). The first is a broader conceptualization of mental health which recognizes that mental wellbeing and mental disorders lie along a continuum that extends from no distress to persistent and severe symptoms. Applying this dimensional approach underscores that mental health promotion and the prevention and treatment of mental health conditions are crucial (Figure 1).
23. The second principle calls for the alignment of evidence from the diverse disciplines that contribute to our understanding of mental health (17). This approach recognizes that factors such as social disadvantage and childhood adversity (or other social and economic conditions) confer risk or resilience for mental health outcomes through their influence on brain development and function from infancy to old age (11). Their impact is greatest during sensitive periods of development in early life and adolescence.
24. The third principle positions approaches to mental health within a human rights framework, noting that mental health is a universal human right and that some people are at elevated risk of having their rights neglected or abused (17). Engagement of persons with mental

health conditions should be central to the development and implementation of promotion, prevention and care activities.

Figure 1. Example of a dimensional approach to mental health



A staging approach to the classification and treatment of mental disorders
PHC=primary health care. Adapted from McGorry et al.²³ and McGorry and van Os.²⁴

Note: Reproduced from the Lancet Commission on Global Mental Health and Sustainable Development (17).

DETERMINANTS OF MENTAL HEALTH AND HIV

Prevalence and co-occurrence of mental health conditions and HIV

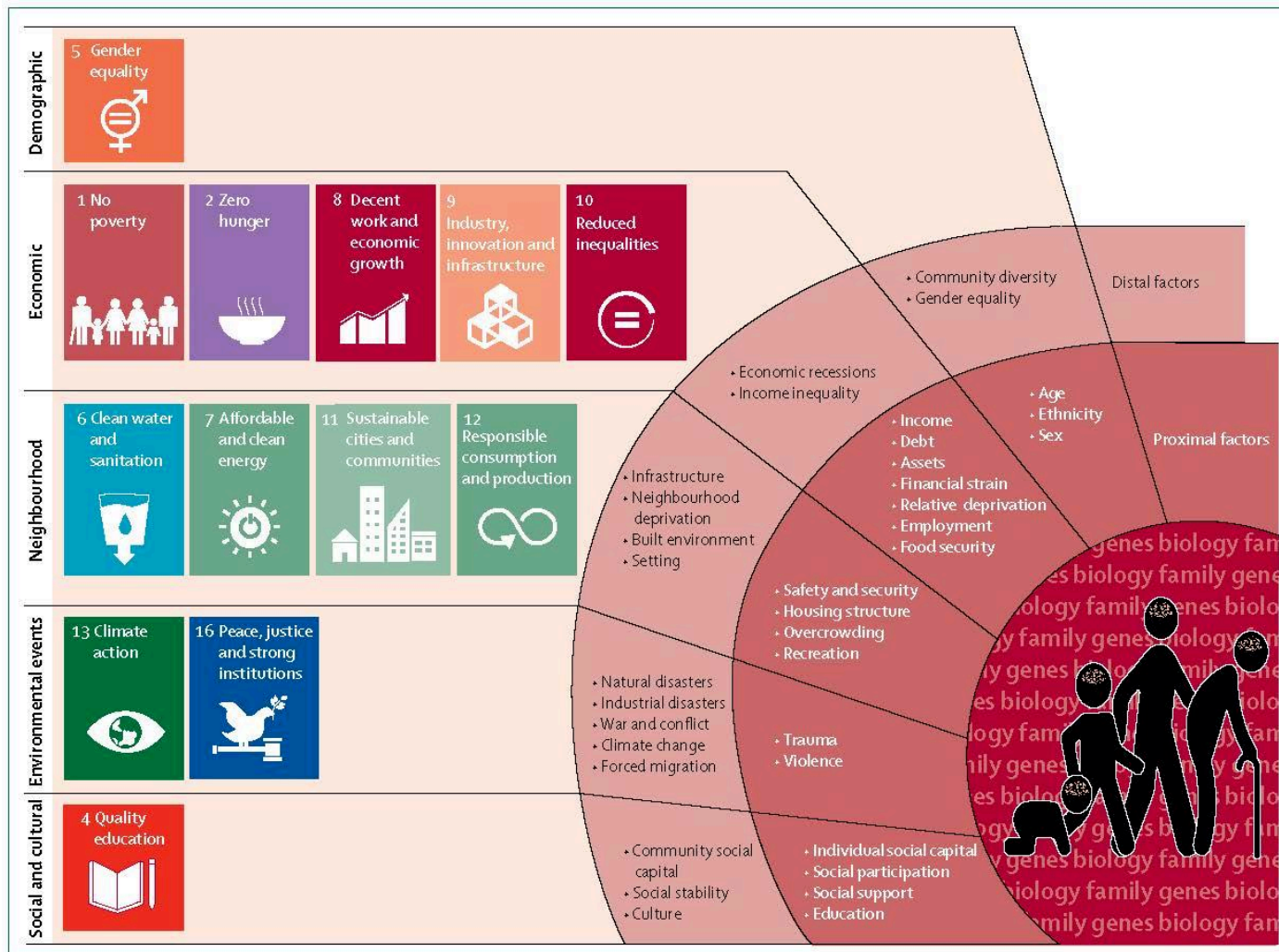
25. A synthesis of 155 epidemiologic surveys from 55 countries has shown that 18% of people reported having had symptoms of a mental health condition, alcohol use disorder or a substance use disorder in the past year and that nearly 30% of people experienced at least one of these conditions over the course of their life (26).
26. In 2016, according to the Global Burden of Disease Study, approximately 950 million people around the world experienced a mental health condition, and over 162 million – drug or alcohol use disorders – an estimated total of more than 1 billion people or 16% of the global population . About 268 million people suffered from depression and an estimated 100 million had alcohol use disorders (27). Approximately 50% of mental health conditions present in adulthood begin by age 14 and 75% begin by age 25, affecting adolescents and young adults as they enter school, transition to work, experience sexual debuts and start families (Figure 2) (28).
27. In addition to compromised wellbeing, mental health conditions are associated with increased risk of mortality (29, 30). Close to 800 000 people die from suicides annually, a majority of which are associated with mental health conditions. Suicide is now the second largest killer of older adolescent girls worldwide, following maternal mortality. Suicide is the second-leading cause of death among young people aged 15–29 years globally (31).

28. Early life adversity (neglect, abuse) and a family history of suicide deaths increase risk, as do other risk factors such as alcohol and substance misuse. Symptoms of mental health conditions, such as major depression, are frequent precipitating risk factors for suicide (32). Within countries, suicide rates may vary considerably among different demographic groups. High rates of suicide among Indigenous people have been attributed to the intersections of poverty, disruption of traditional cultures and livelihoods, displacement, marginalization and increased prevalence of alcohol and drug use (32-36).
29. Elevated suicide rates are also associated with a variety of chronic, life-threatening medical conditions, including cancer and HIV (37-41). A South African study found a 24% prevalence of suicidal ideation among people seeking HIV testing (37). Rates of suicidal ideation or attempts ranged from 13–17% among people living with HIV in three African studies (42-44). In a study sample of gay and bisexual men living with HIV, suicidal ideation and suicide attempts were associated with social exclusion for living with HIV, rejection as a sexual partner and being verbally or physically abused (45). Importantly, community, health system and interpersonal factors associated with suicide risk can accumulate in communities vulnerable to HIV or living with HIV (46). Those factors include stigma associated with help-seeking, limited access to mental health services, living in the context of war or displacement, acculturation pressures, experiencing discrimination, isolation, poor social support, punitive laws and discriminating policies and practices (46).
30. Severe mental health conditions are associated with HIV mortality in some studies (47). Depression has also been associated with HIV mortality(48-52). In a study of nearly 1,500 Tanzanian women receiving ART, rates of death were higher among depressed women (6.6% vs 3.7%) and 36% of deaths that occurred over 2 years were associated with attributable to depression (51). The harmful use of alcohol was linked to approximately 3 million deaths globally in 2016, approximately 5% of all deaths that year (53). Harmful use of alcohol is associated with hepatitis and TB infection (54): Consumption of alcohol is estimated to have been associated with 22 new cases of TB and 2.35 deaths per 100 000 people living with TB (55).

Social determinants of mental health and HIV

31. The social, cultural, economic, legal and physical environments in which people live play significant roles in mental health. Social inequalities, discrimination and human rights violations are associated with increased risk of many common mental health conditions (56), as well as poor health-related quality of life for people living with HIV (57). There is a two-way relationship between mental health conditions and socioeconomic status: mental health conditions can lead to reduced income and employment, and chronic poverty (58). Poverty, in turn, increases the risk of mental health conditions (56).
32. Clustering of social determinants or syndemics (e.g. displacement, poverty, exposure to intimate partner violence etc.) occurs in vulnerable populations, leads to poor health outcomes and can increase risk of mental health conditions or HIV (17, 59). Acting to improve living conditions across the course of a life provides opportunities to both improve population mental health and reduce the risk of mental health conditions that are associated with social inequalities (56). These actions align with the 2030 agenda (Figure 2) (56).

Figure 2. SDGs and social determinants of mental health



Social determinants of global mental health and the Sustainable Development Goals⁹⁰

Note: Reproduced from the Lancet Commission on Global Mental Health and Sustainable Development (17).

33. Multiple social determinants influence HIV risk and those factors can cluster to create a “context of vulnerability” that must be considered for effective HIV prevention and care (60, 61). There are links between cycles of social vulnerability, exposure to trauma and adversity, and HIV risk behaviours. This underscores the value of trauma-informed services (62). Social and sexual networks that reinforce social norms can either facilitate or protect against HIV risk (63). Community environments can similarly promote health or increase risk.
34. Social stigma impacts on mental wellbeing and can limit provision and uptake of HIV prevention, treatment and care services. Laws and policies also shape risk and protection for marginalized populations. For example, criminalization of homosexuality, sex work and/or drug use, and the refusal to sanction prevention practices, such as needle exchange or condom provision in prisons, all hinder HIV prevention (63).

Threats to psychosocial wellbeing and quality of life

35. Stigma and discrimination are associated with poorer health outcomes, health disparities and quality of life for people living with HIV, key populations, people who use drugs and people with mental health conditions (64, 65). Stigma is a complex process which involves labelling, stereotyping, separation and loss of status and which typically also fuels discrimination (66).
36. Stigma associated with HIV or mental health conditions can occur simultaneously and may interact with other forms of stigma related to social identities such as race, gender and sexual orientation. The discrimination that results from layered stigma can create barriers to social and structural supports as well as to quality health care (67). For example, social stigma, discrimination and exclusion associated with HIV may also hinder provision and care-seeking for other medical conditions, including noncommunicable diseases. For example, studies have found that some women are reluctant to be screened for cervical cancer for fear of its association with HIV (68).
37. Policies and legislation that violate human rights also contribute to poorer quality of life for people living with HIV and key populations, and may also contribute to poor mental health (20, 69-72). A Canadian review has shown that criminalization of HIV non-disclosure creates barriers to engagement and retention across the cascade of HIV care (73).
38. UNAIDS guidance expresses concern about the “overly broad application of criminal law to HIV non-disclosure, exposure and transmission” given the risk of human rights violations and interference with public health efforts. The guidance urges states to: “a) concentrate their efforts on expanding the use of proven and successful evidence-informed rights-based public health approaches to HIV prevention, treatment and care, and b) limit any application of criminal law to truly blameworthy cases of HIV-transmission where it is needed to achieve justice”(74).
39. Criminalization of drug use in the context of HIV can also impede access to and use of evidence-informed care. A recent systematic review of 106 studies found that 80% of them found evidence of negative effects of criminalization on HIV prevention and care. Other studies have shown that punitive drug laws do not achieve reductions in drug use frequency or injection, nor do they support cessation of drug injecting (75).
40. Few national HIV prevention strategies make provision for harm reduction services and diminishing funding has led to the closure or reduction of such services in some settings (76). Criminalization of key populations functions as an additional driver of stigma and source of psychosocial stress for affected individuals and communities.

WHY A FOCUS ON PSYCHOSOCIAL WELLBEING, MENTAL HEALTH IS IMPORTANT FOR AN EFFECTIVE AIDS RESPONSE

Quality of life and psychosocial wellbeing

41. Health is a state of physical, mental and social well-being and not merely the absence of disease (77). Interventions to promote wellbeing and quality of life, implemented in collaboration with people living with and affected by HIV, are therefore needed alongside HIV testing and treatment. Access to HIV care and treatment as well as access to quality mental health services play central roles in supporting quality of life. Yet, even when viral suppression is achieved, people living with HIV may continue to report lower quality of life than the general population, with depression and anxiety significantly contribute to those

outcomes (78). It is important to acknowledge the interrelationship of quality of life with psychosocial wellbeing, mental health and HIV-related outcomes and to tailor care, support and treatment interventions accordingly (78-80).

Mental health consequences of HIV

42. People living with HIV are at increased risk of developing mental health conditions (69, 81), which can undermine health-seeking behaviours, reduce adherence to treatment (82) and lead to higher rates of mortality (48, 51, 52).
43. HIV is associated with an array of neurocognitive disorders (e.g. HIV-associated neurocognitive disorder, or HAND), including asymptomatic neurocognitive impairment, mild neurocognitive disorder, and HIV-associated dementia. Symptoms include cognitive changes, dementia and motor disorders. HAND has been linked to poorer quality of life, unemployment, poor medication adherence and reduced survival in studies in high-income countries (19). Use of ART is associated with improvement in neurocognitive status and the incidence of HAND has decreased where care is accessible.
44. Depression and anxiety are the most common mental health conditions that co-occur with HIV. A recent meta-analysis of studies from sub-Saharan Africa found a 24% prevalence of depression among people with HIV (69). People with HIV may suffer from depression and anxiety as they adapt to life with a chronic condition, experience or anticipate stigma, or manage ongoing life stressors (19). Predictors of depression include female gender, older age, unemployment, negative life events, childhood trauma, greater number of HIV-related physical symptoms, low CD4 counts, impaired function and poor social support (51, 83).
45. While HIV treatment reduces the risk of some mental health conditions (19, 84), some commonly prescribed antiretroviral (ARV) medications can also result in neuropsychiatric side effects for up to half of those using them (85, 86). People living with HIV who receive mental health care may also receive psychotropic medications. When used with ARV medications, this may lead to drug interactions that affect the metabolisms of both types of medication. Clinically, this means that patients' sensitivity to side-effects of medications may increase and that providers must be aware that modified doses of psychotropic drugs or the ARV medications may be required (87).
46. ARV side-effects can also include psychiatric symptoms. Zidovudine and abacavir have been associated with mania and psychosis, while nevirapine and efavirenz have been associated with mood changes and vivid dreams (85). Poor adherence to ART has been linked to efavirenz use in some settings (88).

Mental health and HIV-related risk factors

47. There is a bidirectional relationship between HIV and mental health. People with severe mental health conditions are often at greater risk for HIV infection, and are less likely to access education, prevention methods, testing and treatment (90). A synthesis of 44 prevalence studies conducted in 5 regions showed that the estimated mean prevalence of HIV among people with severe mental health conditions was 6% in the North American studies, 2.7% in those from central and South America, 1.5% in Asia-Pacific and 19% in the studies from Africa (90).
48. Risk for HIV infection among people with severe mental health conditions may be associated with poverty or financial instability, transactional sex, sexual violence, sharing

drug injection equipment, inconsistent condom use or with psychiatric symptoms that can impair cognition and judgment (89, 91). Stigma, limited social support, apathy associated with active symptoms of a mental health condition, poor quality or inhumane care, medical staff who exhibit unprofessional behaviour, and limited clinic hours are all factors that can limit access to health services (89).

49. Adherence to care is crucial for good treatment outcomes, but adherence can suffer in the presence of a mental health condition. A synthesis of 125 studies across 38 countries showed that 15% of adults and 25% of adolescents with HIV reported that depression or feeling overwhelmed was a barrier to adherence to ART (89). A recent meta-analysis showed that depression treatment improves adherence to ART (90). Non-adherence was 35% greater among people who did not receive depression care and the odds of adhering to care were 83% higher for people receiving depression care or interventions for psychological distress. However, poor mental health is associated with HIV disease progression independent of its effects on adherence to care (91).
50. Numerous studies have demonstrated the adverse impact of trauma on the health outcomes of people living with HIV. For example, a study from the United States of America found that among 490 HIV-positive women and men, those who had experienced more categories of lifetime trauma had almost twice the all-cause death rate than those below the median levels of trauma. The same study also found that trauma was associated with more rapid onset of opportunistic infections and of AIDS-related death. Another study among HIV-positive women in clinical care found that recent trauma (defined as being abused, threatened, the victim of violence or coerced to have sex in the previous 30 days) was the single, statistically significant predictor of ART failure. Participants reporting recent trauma had more than four times the odds of ART failure than those not reporting recent trauma (92).

Drug and alcohol-related risk factors for HIV and their relationship to mental health

51. According to UN Office on Drugs and Crime, about 275 million people worldwide—roughly 5.6% of the global population aged 15–64 years—used drugs at least once during 2016. Some 31 million people who use drugs suffer from drug dependence, i.e., the drug use is harmful to the point where they may need treatment. Opioids cause the most harm and account for 76 per cent of deaths attributable to drug use. An estimated 10.6 million people worldwide injected drugs in 2016 (93).
52. It is estimated that more than half of people who inject drugs are living with viral hepatitis C and 1 in 8 (around 1.3 million) are living with HIV (93). Sharing of injection equipment, use of stimulants and chemsex confer risk (94). Approximately 20% of new HIV infections that occurred outside of sub-Saharan Africa in 2015 were associated with injection drug use (93, 94). In addition to opioids, methamphetamine can be injected (95), and stimulant use has been linked in some settings to earlier age of sexual initiation and less consistent condom use (96).
53. Alcohol consumption is also associated with HIV risk. One meta-analysis found that consuming any alcohol increased the risk of becoming infected with HIV, while binge drinking doubled the risk and drinking before or during sex led to an 86% increase in risk of acquiring HIV (97). One review notes: “Past and present alcohol consumption directly influences HIV progression and survival by altering timing of and adherence and response to medication designed to minimize levels of HIV in the body. Alcohol use also influences health outcomes by increasing the risk for HIV and HIV-related comorbidities, including liver disease, cardiovascular and cerebrovascular disease, pulmonary disease, bone disease,

and cancer”(98). Alcohol dependence further increase risk of HIV infection as well as associated TB and viral hepatitis.

54. Prevention, testing, treatment and care services therefore have to meet the complex medical, psychological and social needs of individuals. This is best achieved through integrated interventions and programmes. Ideally, such integration would be multisectoral, focusing on equity, involving social, legal, health-care and educational services, and engaging community-based organizations that serve key populations and other marginalized groups. Such efforts align with the WHO Global Strategy to Reduce the Harmful Use of Alcohol, and they support achievement of the 2030 Sustainable Development Agenda (99).
55. Mental health conditions as well as the stigma and discrimination that accompany them, affect health-seeking behaviour and uptake of diagnostic and treatment services for HIV. Mental health conditions have also been associated with lower likelihood of receiving ARV medications.
56. Access to health care for people who use drugs is hindered by the stigma and discrimination that is associated with drug use, scarcity of services in many settings and fragmented care. In some contexts, access is further complicated by criminalization of drug use and/or of harm reduction services such as opioid substitution therapy and needle-syringe programmes being illegal (100).

Box 1. Project INCLUSIPH (Inclusion of persons with disabilities in the HIV response)

Although Guinea Bissau and Senegal have ratified the Convention on the Rights of Persons with Disabilities, access to health services generally and HIV and sexual and reproductive health services especially remain limited. This is especially the case for girls and women with disabilities who are often considered to be sexually inactive. As a result, people with disabilities are vulnerable to HIV because of limited access to HIV prevention services; limited access to available treatment, care and support services; stigma and discrimination that impedes their access to and use of prevention, care, treatment and support measures; and high vulnerability to sexual violence.

Handicap International is implementing Project INCLUSIPH, which uses an inclusive and human rights-based approach to prevention, treatment, care and support services to meet the needs of people with any type of disability. Handicap International's activities are based on a commitment respect the fundamental rights of women and men, whether they are disabled or not. Its gender policy promotes non-discrimination and protection with a particular focus on discrimination against women with disabilities.

INCLUSIPH activities includes prevention and other services related to TB/HIV coinfection, sexually transmitted infections and sexual and reproductive health, including providing care, strengthening access to prevention, testing and treatment services for people with disabilities. The goal is to improving access to inclusive and integrated HIV health services in six border regions of Guinea Bissau and Senegal for people with disabilities.

LEAVING NO ONE BEHIND

57. Key populations—gay men and other men who have sex with men, sex workers, transgender people, people who use drugs, and people in prisons and other closed settings—are likely to be particularly affected by stigmatization, particularly where they are criminalized. Their elevated HIV prevalence reflects their social vulnerabilities. Female sex workers have a 13-fold greater risk of HIV infection compared to the general population; gay men and men who have sex with men have a 28-fold greater risk; transgender women have 13 times the risk; and people in prisons and other closed settings have 5 times the risk. Given their social marginalization, vulnerability to health threats and experiences of rights violation, elevated rates of emotional distress and mental health problems are also not uncommon.
58. A recent review of the scientific literature on mental health among sexual minorities reported elevated rates of mental health conditions across sexual orientation and gender, including elevated rates of depression, bipolar disorders, suicide attempts and drug dependence (101). The prevalence of mental health conditions is higher among prisoners than in the general population and they have low rates of diagnosis and treatment. Prisoners are also at increased risk of all-cause mortality, suicide, self-harm, violence and victimization. Research has outlined key modifiable risk factors (102).
59. Adolescence can increase vulnerability to HIV infection and to mental health conditions. For adolescent girls and young women, depression is compounded in settings of poverty, discrimination and gender-based violence. Structural or societal factors that put adolescents at risk of suboptimal mental health include poverty, migration, discrepancies between their lived realities and their aspirations (often shaped by media imageries), as well as harmful gender norms, early and forced marriage, and sexual and intimate partner violence. Globally, 1 in 3 women have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence. Women who have experienced sexual violence are 2.3 times more likely to have alcohol dependence and 2.6 times more likely to experience depression or anxiety.
60. Other vulnerable populations include people in humanitarian emergencies, such as those displaced by persecution, war, disasters, and violence; refugees and asylum seekers; and internally displaced persons. According to the Office of the United Nations High Commissioner for Refugees, there were 68.5 million forcibly displaced people in 2017, 16 million of whom had been recently displaced. Low- and middle-income countries hosted 85% of the world's refugees in 2017 (103). Resources for HIV prevention as well as for mental health care are often limited in the host countries. Guidelines for comprehensive approaches to the mental health of people in emergencies are available, as are guidelines for HIV care (104). Migrants also face the risk of poor access to HIV prevention, treatment and care services. Immigration status, language and cultural barriers, unaffordable fees for services, and perceived or actual hostility in the new context can limit service utilization (76).
61. People in prisons and other closed settings around the world include a disproportionate number of people who use drugs and people with mental health conditions. That proportion is as high as 90% in some high-income countries; not enough data exist to estimate the proportion in most low- and middle-income countries (105). Mental health challenges among people in prisons and other closed settings may be greater in low- and middle-income countries than in high-income countries, given that low- and middle-income countries have fewer resources for psychiatric care.
62. Human rights abuses in these settings include physical abuse and assault, psychological abuse as well as unfair detention practices (105). Access to quality health care, whether for

HIV, harm reduction, alcohol and drug dependence or mental health conditions, is typically scarce in these contexts. Neither prisons nor other confined spaces should be considered as alternatives to community-based mental health services. However, models of care provision can be developed and implemented for people in these contexts so that people in prisons and other closed settings can receive better care while they are confined.

63. Indigenous and/or local communities may experience many of the social and economic vulnerabilities that can increase HIV vulnerability and risk, such as social exclusion, adverse early life experiences, unstable housing and employment, alcohol and drug dependence and food insecurity. The distribution of these social determinants of health contributes to higher mortality and morbidity and poorer health outcomes among Indigenous and/or local communities (106). For example, Indigenous Canadians, who constitute 4.3% of the population, accounted for 18.8% of AIDS cases in 2011 (107).
64. A recent review of determinants of HIV infection among Indigenous peoples in Australia, Canada, New Zealand and the United States of America identified social disadvantage, high rates of injection drug use, limited access to cultural sensitive and competent health care and exposure to stigma and discrimination as factors that increased HIV risk (106). Disparities in mental health among some Indigenous groups are evident in high rates of suicide which exceed national averages. Suicide rates among the Nenets of northwest Russia were 1.6 time greater among of non-natives in the past decade; Alaska Native suicide rates were double those of non-native Alaskans during the same period, with young men disproportionately affected (108). Maintaining connection to elders, traditional cultural practices, and holistic approaches to wellbeing can support mental health (109).
65. Roma people have experienced persecution and discrimination for much of their history in Europe (110). Though largely under-researched, disparities in child health outcomes, noncommunicable disease prevalence and suicide have been reported. Elevated HIV risk among men in some Roma communities is associated with multiple concurrent sexual partners, low rates of condom use and drug use (111).

RESPONSES

Supporting wellness and quality of life across the course of life

66. Opportunities to prevent or treat HIV and promote mental health and psychosocial wellness exist across the entire course of life.
67. Supporting the health of women by ensuring access to reproductive health and family planning, good nutrition, gender equality and prevention and protections from domestic violence lays a foundation for a healthy life (112). Primary prevention of HIV and prevention of unintended pregnancies promote women's health and can prevent vertical transmission of HIV. Programmes to monitor and prevent malnutrition during pregnancy and early infancy improve neurodevelopment and prevent noncommunicable diseases, including depression in later life (113, 114). Treating common mental health conditions in pregnancy and after the birth of a child, ensuring good nutrition in pregnancy, access to ARV medicines for women living with HIV (115) and preventing a range of infectious diseases can avert conditions that affect the social, emotional and cognitive development of infants and children (116).
68. The first 1,000 days of life—up to age 2—constitute a sensitive period for brain development. Exposure to impoverishment, malnutrition and trauma during this period can affect the potential for healthy child growth, cognition and mental development during

childhood (116). Good nutrition is critical during this time as part of a broader approach of nurturing care, which is the basis for good early child development. Access to quality primary school education, a nurturing home environment and supportive parenting facilitate mental and psychosocial wellness and cognitive development in childhood (112). For infants and young children with HIV, access to ART and equipping parents with skills and support (both practical and financial) to provide sensitive and responsive parenting and create stimulating environments are particularly important (see Box 2) (115).

Box 2. Psychosocial wellbeing and mental health interventions for children and families in Rwanda and the United Republic of Tanzania

Case 1: Family Strengthening Intervention in Rwanda.

The Family Strengthening Intervention (FSI-HIV), a family home-visiting intervention to promote mental health and improve parent–child relationships in families with caregivers living with HIV, was delivered to families in Rwanda.

Eight-two families (170 children and 123 caregivers) with at least one caregiver living with HIV and school-aged child were randomized to the intervention or treatment as-usual. Local research assistants conducted assessments of child mental health, parenting practices and family functioning at baseline, after the intervention, and at three-month follow-up.

At the three-month follow-up, children in the intervention group showed fewer symptoms of depression compared to those in the standard treatment group, which suggests family-based prevention holds promise for reducing depression symptoms in children affected by HIV.

Participation in the intervention was associated with significant reductions in children's depression symptoms at the three-month follow-up. Both children and caregivers reported high satisfaction with the intervention, which is aimed at activating improved family communication to foster healthy parent-child relationships and prevent mental health problems in children. For many families, the intervention facilitated some of their first in-depth discussions about HIV with their children.

UNAIDS/PCB (43)/ CRP2 Rwanda

Case 2: Stepping Stones with Children: a psychosocial approach to building resilience among children affected by HIV in Tanzania

For children living with HIV and who are receiving ART, treatment adherence is key (117). This project, which focuses on children aged 5–14 years, involves a transformative approach for supporting children affected by HIV (mostly living with HIV) and their caregivers.

The project developed, published and piloted the use of "Stepping Stones with Children" materials, including a manual describing 29 training sessions that cover a wide range of topics, with a gendered and child-rights focused framework. The sessions are based on an assets-based, solution-focused appreciative enquiry approach, focusing on abilities rather than problems and affirming the value of virtues, such as kindness and courage. Most activities are carried out with the participants

working in peer groups of younger children (5–8 years), older children (9–14 years) and caregivers, sometimes divided by gender.

Four workshops involving 185 participants were held in the United Republic of Tanzania. Monitoring and evaluation showed a large increase in "disclosure" of HIV serostatus to children, from 27% to 93%. Assessment of clinical data before and after the workshops showed a statistically significant increase in CD4 cell counts among child participants living with HIV, compared with the control group. The mean weight gain was 3.5 kg for child participants and 1.33 kg for those in control group. Children and caregivers indicated higher levels of happiness, self-worth and optimism for the future. In some communities, participants continue to meet regularly.

UNAIDS/PCB (43)/ CRP2 Tanzania

69. Stimulating social connectedness in families, at school and with peers can mitigate some of the threats to mental health and wellbeing that accumulate during adolescence. Good mental health provides the foundation for strengthening agency, especially among adolescent girls and young women, and reducing risky sexual behaviours. Provision of school-based prevention and comprehensive sexuality education, behaviour change programmes and pre-exposure prophylaxis can further support risk reduction.
70. Psychosocial interventions that focus on developing adolescents' problem solving, social and emotional skills have been effective in improving their mental health and in reducing the occurrence of emotional and behavioural problems. The effect is especially strong when interventions are accompanied by other activities that address contextual factors in the family, school and community (11, 118). The interventions also provide the foundational skills for promoting healthy behaviours and preventing or reducing health-risk behaviours, such as violence (including bullying), tobacco use, and excessive alcohol use and substance abuse. Engaging young people in community activism also appears to be beneficial (118).
71. Adolescents living with HIV, including those who were born with HIV, have specific care and support needs. These include support in how to disclose their HIV status, how to deal with stigma, including internalised stigma as well as treatment adherence support (see Box 3). Specific interventions are also needed to support the wellbeing of young members of key populations who may be doubly stigmatized, criminalized and/or may need the consent of their parents to access health care, including mental health services.

Box 3. Empowering and supporting adolescents in African countries

Case 1: READY+ (Resilient, Empowered Adolescents and Young People)

READY+ promotes an environment that supports healthy choices around sexuality. It seeks to improve the physical and psychological wellbeing of adolescents and young people living with HIV, reduce their risk of unintended pregnancies, sexually transmitted infections, mother-to-child transmission of HIV and maternal complications, and improve adherence to ART.

From October 2016 to June 2018, READY+ reached over 14 000 adolescents and young people living with HIV with sexual and reproductive health and rights and HIV information in safe spaces at health facilities and in community settings. A total of 287 community adolescent treatment supporters (CATS) were trained, and they reached 10 703 adolescent and young people living with HIV through one-to-one visits. Psychosocial support services received included disclosure and/or stigma support and emotional/psychological counselling. Other services provided included adherence counselling, ART defaulter counselling, ART pill count and viral load monitoring.

READY+ is being implemented by a consortium led by the International HIV/AIDS Alliance. It operates in Eswatini, Mozambique, the United Republic of Tanzania and Zimbabwe, where it was launched by the respective Ministries of Health and Education.

(UNAIDS/PCB (43)/ CRP2)

Case 2: Ask, Boost, Connect, Discuss for improved mental health adolescent mothers living with HIV in Africa

The Ask, Boost, Connect, Discuss (ABCD) intervention is aimed at reducing maternal depression among young mothers living with HIV. Currently under development, ABCD involves young mothers and peers living with HIV in focus group discussions and participatory visual design. It uses an app to facilitate the delivery of the mental health interventions.

The intervention has four main elements:

- ASK: Peer supporter screens for maternal depression using the Edinburgh Postnatal Depression Scale;
- BOOST: Delivery of an adapted version of the WHO-endorsed Thinking Healthy Programme by peer supporters, assisted by a mobile phone app-based platform that contains programme contents and allows access to a support network of peer supporters;
- CONNECT: Helping young mothers access other mental health services. Any urgent cases, such as severe depression or suicidality, are referred directly to specialist mental health services; and
- DISCUSS: Mobile supervision of peer supporters by specialists in chat forums.

A pilot study of ABCD will be implemented in five sub-Saharan African countries (Kenya, Malawi, Uganda, United Republic of Tanzania and Zambia) by the nongovernmental organization, Paediatric Adolescent Treatment Africa.

(UNAIDS/PCB (43)/ CRP2)

Case 3: Mzantsi Wakho

South Africa is home to the world's largest population of adolescents living with HIV (119). Mzantsi Wakho is the world's largest longitudinal cohort of adolescents living with HIV. In 2015–2018, the study combined qualitative and quantitative research methods to identify the factors that support long-term adolescent ART adherence. Mzantsi Wakho seeks to answer questions about youth health, with a focus on long-term medication, contraception, and sexual and reproductive health.

Recent analyses from the Mzantsi Wakho cohort show that poor mental health and exposure to violence are major factors undermining long-term ART adherence in adolescents living with HIV. This highlights the importance of addressing mental health and violence prevention to improve ART adherence in adolescents. Additional selected findings include:

- Stigma reduction is likely to have positive effects on the mental health of adolescents living with HIV. Internalized stigma was associated with poor mental health. Enacted stigma was associated with more post-traumatic stress and anticipated stigma was associated with higher anxiety scores. Tackling discrimination against adolescents living with HIV and violence victimization in homes, schools and communities may be essential to interrupt pathways of risk to internalized HIV stigma (120); and
- Almost half of the adolescents living with HIV in the study had experienced some HIV-related stigma, which is a risk factor for depression and suicide, especially among adolescents living with HIV. Strengthened social support was directly associated with less depression, while being part of a clinic-based support group was not. The findings underscore the potential of social support as an important protective factor for general mental health and stress-buffering resource for adolescents living with HIV.

(UNAIDS/PCB (43)/ CRP2)

72. In adulthood, healthy diet and exercise help maintain good health and contribute to emotional and cognitive health. Access to mental health care in the workplace and community can help prevent disability, prolonged time out of work and poor functioning in the family (121). Initiation and maintenance of ART in the context of quality preventive primary care services can help sustain health. Beyond the health-care sector, anti-poverty initiatives and protective laws and policies can facilitate access to care, food, income and other resources that help sustain wellbeing. Social and community engagement can also support health: in some ethnic minority communities, activism and community mobilization are linked to wellbeing (122).
73. In older adults, preserving mental activity through continued learning, working, exercise and maintenance of health supports mental health and psychosocial wellness, too. People living with HIV are at higher risk of developing noncommunicable diseases, particularly cardiovascular disease, depression and diabetes, which are also linked to nutrition. Consequently, it is important to ensure that screening, prevention and treatment of cardiovascular diseases through smoking cessation, blood pressure monitoring and cholesterol management occurs routinely (72). Screening for depression and providing appropriate treatment further support mental health and HIV care. Ideally, noncommunicable disease services, including screening and care for depression, should be integrated into the HIV care management platforms (69).
74. The provision of information, skills building, reduction of negative attitudes, and counselling and/or support groups for people with living with HIV and contact with people affected by HIV can reduce stigma associated with HIV status, substance use and/or mental health conditions (123).

75. An enabling legal environment that is free of discriminatory and punitive laws (e.g. criminalization of drug use, HIV non-disclosure, exposure and transmission, sex work and sex between consenting adults of the same sex) and that provides legal protection against discrimination related to HIV status and/or mental health conditions can also reduce stigma.
76. Increasing HIV treatment literacy among communities and health-care providers, including disseminating information about treatment as prevention, could reduce stigma and increase willingness to initiate treatment (124). Social contact has also been shown to be an effective intervention to reduce stigma associated with mental health conditions (125). Given the complexities of stigma, especially for vulnerable groups, interventions should operate at multiple levels: individual attitudes and knowledge; interpersonal relationships; organizational structures; community values, norms and attitudes; and public policies (123).

Increasing access to mental health services for people living with and affected by HIV

77. Access to quality mental health care has both preventive and curative functions. Depression care for pregnant and postpartum women can preserve the women's health and help prevent mental health problems in their children. In many settings, however, a scarcity of specialists and insufficient investment in mental health and substance use programmes limits access to such services.
78. Globally, there are a median 9 mental health providers per 100 000 population and there is, on average, 1 psychiatrist for every 100 000 people. Even smaller numbers of social workers and psychologists are available to meet global mental health needs (126). Barriers related to stigma and poor quality or inconsiderate care also limit access. Increasingly, digital solutions may help bridge the mental health-care resource gap (see Box 4) (17).

Box 4. "Living Positive with HIV": An online self-help programme for people living with HIV and suffering from depressive symptoms in the Netherlands

The online programme "Living Positive with HIV" consists of a website with lessons focused on reducing depressive symptoms. It includes psycho-education and exercises that use evidence-based techniques such as cognitive behavioural therapy and motivational interviewing. The programme is available in Dutch and English and can be translated easily into other languages. It comprises 8 lessons (1 lesson per week) that focus on 4 main topics: activation, relaxation, changing negative cognitions and goal attainment. People can do the use the programme with or without (minimal) coaching.

The objective is to reduce depressive symptoms in people living with HIV and to promote their improved mental health, higher medication adherence and zero HIV transmission rates. The programme is being implemented across the Netherlands by Leiden University.

A randomized controlled trial has shown that the programme is effective in reducing depressive symptoms and increasing quality of life and that it is cost-effective. The programme is being tested in Botswana as well.

(UNAIDS/PCB (43)/ CRP2 Netherlands)

79. To address the scarcity of mental health specialists, service-providers have turned to task-shifting or task-sharing to deliver evidence-based mental health interventions. Task-shifted workers include primary care staff, community health workers and peers. Adequate sustained supervision is an important for maintaining quality care.

80. Numerous studies from low- and middle-income countries demonstrate that a variety of providers (including lay health workers) can deliver effective, evidence-based psychological interventions such as cognitive behavioural therapy, interpersonal psychotherapy or problem-solving therapy for common mental health conditions such as depression (127-132). This suggests that similar skills could be transferred to HIV care providers as part of an integrated programme of care (133, 134).
81. Medications can successfully treat the symptoms of common mental health conditions in HIV care. The class of antidepressants known as selective serotonin re-uptake inhibitors reduces depressive and anxiety symptoms in people with moderate to severe depression and/or anxiety. It has relatively few side effects compared with other categories of antidepressants. It is increasingly available in many low- and middle-income countries and can be administered to people receiving ART (91).
82. Some selective serotonin re-uptake inhibitors (e.g. citalopram) may have anti-inflammatory effects and decrease cellular susceptibility to HIV-infection (135). The effectiveness of evidence-based psychological therapies for common mental health conditions and medications provides clinicians with options to tailor the treatment of common mental health conditions according to local resources and according to the preferences and symptom profiles of people seeking care.
83. The WHO Mental Health Gap Action Programme (mhGAP) provides guidance to nonspecialist health-care providers on the management of several mental health conditions. The intervention guide provides evidence-based protocols for the care of people with depression, psychosis, bipolar disorders, epilepsy, dementia, harmful use of alcohol and drug dependence, as well as developmental and behavioural disorders in children and adolescents and those at risk of self-harm/suicide (136). A mobile phone version of the intervention guide is also available. Structured training methods and materials have been developed and are used to train primary health-care staff. An operations manual provides guidance to programme planners and managers.
84. QualityRights is WHO's global response to improving the quality of care in mental health and social services and promoting the human rights of people with mental health conditions and psychosocial disabilities. Key standards and tools have been published including the WHO QualityRights assessment toolkit as well as a set of 15 guidance and training materials on mental health, human rights and recovery. The guidance promotes strategies to end involuntary admission, involuntary treatment, seclusion restraint and other coercive practices, as well as measures and practices, in line with the CRPD, to promote people centred, recovery oriented care, support legal capacity, informed consent, community inclusion and the right to liberty and security of person. (137).
85. Simple and cost-effective interventions exist for drug dependence and for harm reduction for people who inject drugs (including opioids). People who inject opiates can benefit from methadone maintenance therapy, which has been associated with a 54% reduction in the risk of HIV infection among people who inject drugs. Yet many countries remain reluctant to implement proven approaches. Only about 50% of countries reporting injecting drug use implement effective harm reduction programmes. Ideally, programmes would include a multidisciplinary team, drawn from local human resources, to support comprehensive care which emphasises wellbeing and quality of life (see Box 5).

Box 5. "Integra Saúde SP" programme: linking outreach and services for key populations and users of psychoactive substances in São Paulo, Brazil

"Integra Saúde SP" Programme is an integrated effort of the Reference Center for Alcohol, Tobacco and Other Drugs and the Center for Reference and Training in AIDS at the São Paulo State Secretariat. The initiative establishes consistent contact with users of psychoactive substances living in the central region of the city of São Paulo in Brazil (541 000 inhabitants) or from the entire city (10 million inhabitants), including emergency cases.

Around 70% of users seeking help from the programme are homeless. They include pregnant women, transgender persons, immigrants from African countries and people with mental health conditions.

The programme offers a broad range of services, including access to showers, a gym, an experimental kitchen and music, art and computing labs. For women of childbearing age, it offers—through a partnership with the Women's Reference Center—sexual counselling, routine exams and voluntary progesterin-release hormone implants.

The programme also links people to treatment services, including detoxification. People with non-urgent needs are evaluated by a social worker and a psychologist. If necessary, they are then referred for community treatment at a psychosocial care centre. The Reference Center also offers a specific lesbian, gay, bisexual and transgender programme that features health groups, leisure activities, psychological support and more.

Integration of services for HIV and mental health

86. Integration is seen as one of seven key actions for improving mental health across populations (17). Integration of HIV and mental health services implies acknowledgment of the bidirectional links between mental health and HIV. It also reflects the shared values of increasing individual agency and reducing disparities in access to quality services and care.
87. The Lancet Commission on Global Mental Health and Sustainable Development recommends scaling up mental health services as a component of UHC and integrating them with services for other conditions, such as HIV and noncommunicable diseases services, and with maternal and child health programmes. Importantly, evidence-informed interventions for the treatment of depression and other mental health conditions can be administered in a variety of sociocultural and health system contexts (138). Integration of services should be accompanied by a commitment to create and sustain structures that reduce stigma, discrimination and other social, legal, human rights-related or gender-related barriers.
88. A recent review identified several models of the integration of mental health and HIV as well as, substance use, mental health and HIV services. Integration can occur at the level of the health system or delivery system, although studies show that it tends to occur within single facilities. Examples include the integration mental health and HIV services with other services such as primary care, obstetrics and gynaecology, TB services or noncommunicable disease care (139).
89. Other studies describe multifacility integration models where referral mechanisms are established between agencies or across a network of collaborating providers. This might mean referring people in need of mental health services to a specific group of specialists or

to a particular network of mental health services. Another model uses care-coordination by a nonspecialist provider (e.g. a nurse or social worker as case manager) who develops a treatment plan and coordinates referrals and care. Overall, integrated services may be associated with improved health and care-related outcomes (139).

90. The HIV care infrastructure and the mental health-care or substance use infrastructure can serve as the basis for integrating services in high- and in low- and middle-income countries. Promising practices and effective interventions have been reported in low- and middle-income countries where mental health resources are scarce. In one example, adherence counsellors were trained to use problem-solving therapy to support adherence to HIV care and manage depression in an HIV care setting in Zimbabwe (133). Another example used a support group format that integrated elements of evidence-informed psychological therapies to manage symptoms of common mental health conditions in Uganda (see Box 6) (140). The Friendship Bench intervention (see Box 6) uses an evidence-informed psychological therapy in primary care settings where HIV services are also delivered (130, 141). Examples of integrated HIV care and mental health services are less common in low- and middle-income countries. In Rwanda, HIV counselling, testing and care was integrated into a tertiary care psychiatric hospital (142), along with efforts to integrate care at district hospitals.

Box 6. Managing depression and achieving improved HIV outcomes for people living with HIV in Malawi, Uganda and Zimbabwe

Case 1: SOAR-Malawi Mental Health Programme

Depression treatment has been integrated into two public sector HIV primary care clinics in Lilongwe, Malawi, in a partnership between the country's Minister of Health and the University of North Carolina in the United States of America.

The programme involves universal depression screening using the Patient Health Questionnaire-2 (PHQ-2); clinical confirmation of depression using the Patient Health Questionnaire-9 (PHQ-9); safety assessment for patients indicating suicidal thoughts or ideas; specification of a treatment plan involving antidepressant management and/or psychosocial counselling; and regular monitoring at follow-up visits to assess the need for changes to the treatment plan.

Approximately 25% of patients screened were identified with mild, moderate or severe depressive symptoms and about 7% displayed moderate or severe symptoms. Approximately 5% of patients indicated suicidal thoughts or ideas and 94% of those indicating such thoughts completed a safety assessment. Among patients who started antidepressant treatment, depressive symptom scores were reduced to median of 0 within 3 months and the proportion reporting any suicidal thoughts or ideas decreased from 39% to 10%. Among patients starting psychosocial counselling, the scores for depressive symptoms decreased to a median of 0 after 3 months and the proportion reporting any suicidal thoughts or ideas decreased from 39% to 7%.

The study is also expected to yield evidence on the effectiveness and cost-effectiveness of depression treatment that is integrated with HIV care for achieving the 90–90–90 targets, as well as a stepped-care depression treatment model that will be applicable in Malawi and elsewhere in sub-Saharan Africa. Data regarding the HIV outcomes and cost-effectiveness will be available in mid-2019.

(UNAIDS/PCB (43)/ CRP2 Malawi)

Case 2: Social, emotional and economic empowerment through Knowledge of Group Support Psychotherapy

Knowledge of Group Support Psychotherapy is a collaboration between Uganda's Makerere University, the Ministry of Health and The AIDS Support Organization. The project has implemented culturally sensitive group support psychotherapy for depression treatment in 30 HIV clinics located in 30 primary health facilities in three districts in northern Uganda.

The effectiveness of group support psychotherapy was evaluated in a pilot randomized controlled trial (140). It showed that when delivered by trained lay health workers, the method effectively treated mild to moderate depression in persons living with HIV. The effect was sustained and greater in the long term (12 months after treatment). It also reduced post-traumatic stress symptoms and alcohol use and improved viral load suppression among people living with HIV.

(UNAIDS/PCB (43)/ CRP2 Uganda)

Case 3: The Friendship Bench

The Friendship Bench project trains lay health workers to treat depression outside clinical settings, using a technique known as problem-solving therapy. The pilot work and a clinical trial were conducted in low-income suburbs or "townships" in south Harare, Zimbabwe.

Benches, placed out in the community, are the platform for the therapy. In a clinical trial involving 560 adults aged 18 years and over, around 40% of participants were people living with HIV. Those who received the therapy, including the people living with HIV, showed reduced symptoms of depression and less disability at 6 months follow-up, compared to those who received enhanced standard care (130).

Approximately 70 000 people in Zimbabwe have used the Bench approach. The team is currently working with the US National Institute of Mental Health and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) to conduct a study to evaluate the impact among people living.

(UNAIDS/PCB (43)/ CRP2 UK and Zimbabwe)

Integration of mental health into HIV programmes

91. Opportunities for integrating mental health services into HIV programmes exist across the prevention and care continuum. In the context of HIV prevention, it is important to ensure that comprehensive HIV prevention interventions (including harm reduction, comprehensive sex education and targeted behaviour change interventions) integrate components to promote mental wellbeing.
92. HIV testing and diagnostic service settings must address HIV-related stigma as well as stigma and discrimination towards key populations. They also have to ensure access to HIV testing for people with mental health conditions and for other key populations and should support voluntary HIV testing in community mental health service settings and in-patient treatment settings.
93. Psychosocial interventions should be offered as part of an integrated package of services that includes ART and sexual and reproductive health services, and in collaboration with community organizations. Access to quality treatment with dignity for all people, including people with mental health conditions, is an essential part of the rights-based approach to HIV. Adherence support should be provided to all people on ART and they should have access to screening and treatment for mental health conditions (pre-existing or not), including depression and anxiety, as well as social support, including peer-to-peer support, to improve their quality of life.
94. HIV prevention and testing as well as referral to treatment should also be integrated into community-based and residential drug and alcohol dependence treatment settings.
95. Human rights education and training should be provided to health-care staff, prison staff and other relevant professionals, with a focus on non-discrimination, free and informed consent and respect for confidentiality and privacy. HIV care providers (including lay providers) should also be trained in screen for mental health conditions, harmful use of alcohol and drug dependence (see the WHO mhGAP Intervention Guide) as well as to deliver low-intensity psychological intervention for depression and anxiety.

96. Training on basic self-care techniques (e.g. relaxation, physical activity, education about mental health, use of mobile or web-based psychosocial support interventions) should be provided to people living with and affected by HIV. Identifying referral and consultation pathways for people in need of more specialized care is also important. Access to spiritual support and guidance should also be facilitated, where appropriate.
97. Engagement of the people affected in planning and implementing services is an important aspect of the rights-based approach to HIV and mental health, as is empowering people living with and affected by HIV and those with mental health conditions to know and exercise their rights. Peer-to-peer support is also important. There is evidence that being a “helper” can transform the “vicious cycle” of internalized stigma into a “virtuous cycle” (143, 144).

Integration of HIV into mental health services

98. HIV prevention, testing and treatment services should be integrated into community-based mental health services or primary care as well as secondary and tertiary mental health-care settings. Training should be provided to mental health-care professions on HIV prevention, treatment and care, including on the importance of informed consent, counselling, confidentiality and stigma reduction, particularly in institutional settings.

Addressing HIV and mental health needs in prisons

99. Collaboration and coordination among all stakeholders, including Ministries of Health and ministries responsible for prisons, as well as community-based service providers, should be strengthened to ensure that people in prisons and other closed settings have access to integrated mental health and HIV care.² The UN Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)³ state that prison administrations should make all reasonable accommodations and adjustments to ensure that prisoners with physical, mental or other disabilities have full and effective access to prison life on an equitable basis. Every prison should have in place a health-care service that is tasked with evaluating, promoting, protecting and improving the physical and mental health of prisoners, paying particular attention to prisoners with special health-care needs or with health issues that hamper their rehabilitation.

Community engagement

100. Communities, including community-based organizations and community workers, should be engaged in efforts to enhance the quality of life of people living with and affected HIV in relation to self-esteem, relationships, families, employment, education, health care, social services and access to justice. Community gate-keepers (parents, police, teachers, community elders and community workers) should be involved and trained in the early identification of mental health conditions and provision of scalable psychological interventions.
101. Parenting programmes to support early childhood development should also be implemented at community level. The establishment of self-help and support groups for alcohol and drug dependence at the community level should be supported.

² http://www.unodc.org/documents/hiv-aids/HIV_comprehensive_package_prison_2013_eBook.pdf

³ http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/70/175&referer=/english/&Lang=E

Integration at the sociopolitical level

102. Sociopolitical actions include addressing the common social determinants of HIV, mental health conditions and drug and alcohol dependence. Campaigns to increase mental health literacy and HIV awareness should be implemented to address stigma and discrimination. Collaboration and shared learning between HIV and mental health anti-stigma and discrimination initiatives should be fostered.
103. Countries should review and reform discriminatory laws, including those criminalizing HIV non-disclosure, as well as legislation that discriminates against key populations or people with mental health conditions. Mental health legislation, policies and strategic plans should be reviewed and updated, as necessary, to fully integrate a human rights-based approach (see Box 7). Countries should decriminalize people who use drugs and provide a comprehensive HIV services for people who use drugs, including harm reduction. Availability and demand for alcohol should be regulated, including by establishing minimum age limits for access to alcohol.

Box 7. Strategic litigation to improve access to mental health care

Zambia's 1949 Mental Disorders Act provides for the coercive and indefinite detention of persons in prisons and psychiatric facilities on suspicion of having psychosocial disabilities. The Act gives extensive powers to the police and members of the community to identify and detain persons with presumed mental health conditions, without due regard to their rights to liberty, their legal capacity or procedural rights. As a result of the application of the Act, persons with psychosocial disabilities continue to be deprived of liberty and to be isolated, abused and restrained.

Following years of activism and frustrations with delays in legal reform, three individuals with psychosocial disabilities joined with the Mental Health Users Network of Zambia (MHUNZA) in 2016 to bring a court case challenging the constitutionality of the Mental Disorders Act.

In 2017, in *Mwewa, Kasote and Katontoka v the Attorney General and Others*, the High Court of Zambia declared an operative provision of the Act unconstitutional for being discriminatory and called for the "thorough review" of the entire Act. It also ordered that mental health services should be available at the primary health-care level and that all people should be treated with dignity and full respect for their rights.

The Mental Health Users Network and disability activists have used the judgment to advocate for new mental health legislation. They are also reaching out to HIV activists to support their efforts for reform.

In November 2018, the Minister of Health stated that the Cabinet had approved the repealing of the Mental Health Act, which had been reviewed last in 1951. The Minister said the repeal would remove any derogatory descriptions used to refer to mental patients and would provide for decent infrastructure and care for patients. It has taken approximately 15 years of work to reach this milestone. The Acting National Mental Health Coordinator at the Ministry of Health has confirmed that a draft Bill will be tabled in parliament early December 2018. The content of the Bill has not been made public yet.

104. Supporting the implementation of child protection laws as well as gender equality laws and policing, including laws to prevent violence against women and girls is important for addressing social determinants of HIV and mental health risks.

WAY FORWARD

105. In order to integrate mental health into HIV prevention, treatment and care services with mental health services and to promote wellbeing and quality of life, a number of key actions need to be taken.

Develop integrated and rights-based policies

106. Mental health policies and national mental health strategies or plans are essential for coordinating and delivering effective services. In the absence of such frameworks, mental health conditions are likely to be treated in fragmented and inefficient fashion. Policies and action plans should be developed with the meaningful participation of affected populations. Policies should be backed with actionable plans to achieve policy objectives and goals.
107. Countries should integrate public policies that address intersecting epidemics or risk factors—for example, streamlining responses to the harmful use of alcohol, gender-based violence and infectious diseases. Also relevant is support for integrating HIV services and noncommunicable disease screening and care, including for mental health conditions and drug dependence.
108. Successful integration will require articulating shared goals at various levels of care. Integration should include commitment from HIV, mental health and substance use treatment services to:
- provide comprehensive and human rights-based care, prevention and early intervention;
 - integrate national and local strategies, policies and implementation plans;
 - locate mental health and HIV services together; perform joint planning, resource mobilization and information sharing;
 - engage affected communities;
 - carry out joint programmatic and monitoring and evaluation activities; and
 - ensure effective case referral, service planning and follow-up (145).
109. Countries should address the social determinants of mental health and HIV by passing and implementing social protection laws and policies, antidiscrimination and stigma reduction policies and plans, antipoverty strategies and more. They should engage community and health-care providers and people living with and affected by HIV in advocacy to eliminate harmful policies and to support the implementation of policies that provide protections from discrimination and access to health care, education, livelihoods, etc.

Implement best practices and guidelines

110. Successful and verified best practices in service delivery approaches, community-based interventions and engagement of people living with and affected by HIV need to be highlighted, promoted and shared with a view to adaptation and wider adoption.
111. It is important to design and implement evidence-informed training for health-care and social support personnel, law enforcement officials, prison staff and other relevant

professionals on human rights and the reduction of stigma and discrimination. Joint training of HIV and mental health-care providers should be provided.

112. Countries should develop a cadre of non-specialist providers for mental health care and drug dependence using the local resources available, including at community level. Community-based interventions to promote mental health, wellbeing and quality of life should be scaled up. The mhGAP Intervention Guide for evidence-informed care and treatment protocols should be utilized.
113. People receiving mental health services and/or HIV services should be involved in the design and implementation of relevant policies and services, and their concerns should guide efforts to address gaps.
114. Countries should identify which tasks should be shifted and which cadres of providers should be trained and mobilized to deliver care, as well as organize sustained supervisory systems and identify resources at regional and national levels for sustainability (134).

Conduct research to fill the knowledge gaps

115. Countries and other stakeholders should address gaps in current knowledge on the best approaches to integrating mental health care and drug dependence treatment in the context of HIV. This can be done by:
 - promoting independent, qualitative and quantitative social science research and research platforms to explore service models that promote mental health, wellbeing and quality of life for people living with and affected by HIV;
 - increasing the inclusion of people with co-occurring mental health conditions, people who use drugs, and/or people living with HIV in the design of research studies;
 - establishing a more robust evidence base for the integration of HIV, mental health care and substance use care in low- and middle-income countries;
 - studying the best approaches to integrating HIV care into specialist mental health-care facilities for people with severe mental disorders;
 - evaluating whether and how integrated care approaches can reduce stigma associated with HIV, mental health conditions or substance use;
 - designing and studying effective models for ongoing supervision of health-care personnel, as well as community-based lay health-care providers;
 - integrating elements and approaches common to psychological interventions into HIV service settings in order to address common mental health conditions and improve quality of life;
 - studying the best approaches to improve the quality of services in diverse, integrated care settings;
 - conducting mixed methods research and evaluations to better understand the predictors and causes of unsuccessful care integration efforts;
 - increasing research and research capacity-building on substance use in low- and middle-income countries; and
- studying the health-care needs and social context of risk and resilience for key populations in low- and middle-income countries.

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