

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

Country submissions

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INTRODUCTION

The Thematic Segment of the 43rd UNAIDS Programme Coordinating Board (PCB) meeting will be held on the 13th December 2018 and will focus on “*Mental Health and HIV/AIDS – promoting human rights, an integrated and person-centred approach to improving ARV adherence, well-being and quality of life*”.

In the preparation for the Thematic Segment, UNAIDS issued a call for submission of examples of effective and innovative practices integrating HIV and mental health and/or substance use focused interventions across the HIV prevention, treatment and care continuum. A total of 33 good practice submissions were received, showcasing the wide range of efforts at integrating HIV and mental health services from African States, from Asian States, from Latin American and Caribbean States, from Western European and Other States, and cases which cover multiple countries or regions.

The submissions reflect the work of governments and civil society, as well as collaborative efforts. The case studies highlight different approaches in promoting mental health and wellbeing for people living with and affected by HIV, and integrating HIV and mental health services.

I. AFRICAN STATES

1. REPUBLIC OF CONGO

TITLE OF THE PROGRAMME:

Prévalence et facteurs associés aux symptômes dépressifs chez les adolescents vivants avec le VIH en République du Congo

PERSONNE CONTACT

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- **Programme is being implemented since:** Septembre 2017
- **End date of the programme:** NA
- **Responsible parties:** Government; Private sector
- **Population reached:** People living with HIV ; People with mental health conditions; Children; Young people
- **Has the programme been evaluated/assessed?** Yes, by evaluating the prevalence of depression among adolescents living with HIV by using a screening test. The evaluation was made by psychologist and medical doctor.
- **Is the programme part of the National AIDS or Mental Health or Substance Abuse Prevention and Treatment Strategy?** No
- **Is the programme part of the National Plan other than the AIDS or Mental Health Strategy?** No

BACKGROUND

Malgré les activités de prise en charge psychologiques mises en place dans les Centre de Traitement Ambulatoire de Brazzaville et de Pointe Noire (CTA), la prévalence et les facteurs associés aux symptômes dépressifs chez les adolescents vivants avec le VIH, ne sont pas connu, quand on sait que la dépression est associée à une mauvaise observance au traitement antirétroviral.

DESCRIPTION

Les adolescents vivants avec le VIH en République du Congo, suivi dans les deux CTA, sont testés pour la dépression en utilisant un outil de dépistage, le PHQ9, à chaque fois qu'ils viennent en consultation. Les CTA sont gérés par la Croix-Rouge Française et le Ministère de la Santé.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

Nous avons pu avoir la prévalence et les facteurs associés aux symptômes dépressifs chez les adolescents vivants avec le VIH, qui est de 39%, ainsi que des facteurs associées aux symptômes dépressives. Pour parler de dépression il nous faut administrer ce test sur le long terme, cette activité continue.

LESSONS LEARNED AND RECOMMENDATIONS

Le test doit être administrer en tout temps chez les adolescents vivants avec le VIH, lorsqu'ils se présentent en consultation, mais également les autorités ministérielles doivent inclure dans la gratuité des soins lié au VIH, la prise en charge de la dépression.

ANNEXES

N/A

2. DEMOCRATIC REPUBLIC OF CONGO

TITLE OF THE PROGRAMME: Gender and Psychological Implications of HIV/AIDS for orphaned children and Adolescents case of study in the eastern part of DR.Congo

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- **Programme is being implemented since:** 2017
- **End date of the programme:** October 2017
- **Responsible parties:** Civil society
- **Population reached:** People with mental health conditions; Women and girls
- **Has the programme been evaluated/assessed?** Yes, in the evaluation of case studies for marginalized groups affected by mental health, by Members partners of Network and local administrative of public department of health.
- **Is the programme part of the National AIDS or Mental Health or Substance Abuse Prevention and Treatment Strategy?** Yes
- **Is the programme part of a national plan other than the National AIDS or Mental Health Strategy?** No

BACKGROUND

More specifically, we were working on the implementation of resolution 1325 and on the constitution of 18/02/2006 as amended and supplemented to date in articles 12 and 14, the principles of gender equality rights, in the aforementioned sectors, by ratifying several international, regional and sub regional human rights legal instruments, including: The Universal Declaration of Human Rights. This clearly includes the problem below: in our areas one of the most serious challenges for women in the eastern part of DRC in the wake of HIV/AIDS is the increasing number of orphans with the death of both parents due to AIDS. The care of children affected and infected by HIV/AIDS in developing countries and particularly in DR.Congo is falling on the poorer people within communities, especially women. Adolescent girls may be sent to a relative, family friend or no-relative's homes to work in return for money. Education is often disrupted, especially that of older female siblings who are required to take up household

tasks and caregiver chores. There has been a marked increase in poverty among women as AIDS widows and leaves children orphaned. In this study, children and adolescents showed several emotional or behavioral disturbance indicators. The girl-child or adolescent girl takes over the woman's role of domestic work, ensuring the continuity of the vicious cycle of the woman's burden in eastern part DRC, her psychological burden is greater than for the boy – child or adolescent boy. These findings suggest the importance of considering gender in understanding patterns of psychological symptom expression, in order to provide appropriate support and treatment (counseling), the need for early identification of psychological disturbance and interventions among children and adolescents orphaned by HIV/AIDS.

DESCRIPTION

Improving the mental health of women through the objectives of strengthening women victims of mental health in favor in Uvira territory by adopting a perspective of public health practices and policies and, inter alia, by improving the conditions of work and creating a social environment, especially for women. This can be done by increasing health promotion resources and reducing exposure to unhealthy factors in society, managed with the support partner of the government agency in cooperation with our partner friends and Swedish in the DRC.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

Many cases studies remain to be evaluated to reach the results because the list is not exhaustive in our districts, in terms of improving the quality of life, especially for women who are mentally ill and for adolescent girls. We took care to send the affected to a family member, a friend of the family, in exchange for money. 26 cases were identified, and their integration was almost assured. Appropriate support and treatment (counseling) and identification disruption in children and adolescents who have been orphaned by HIV / AIDS remain to be carried out for the programs.

LESSONS LEARNED AND RECCOMENDATIONS

Social mobilization and political support by adopting a comparative perspective and providing a more accurate overview of the patterns and levels of acceptance of sexual violence against women, among adolescents.

ANNEXES

The psychological consequences of war traumatization of women: has had devastating physical, psychological and social impact of the people in DR.Congo. The women and children bear the burden of war as they are the usual surviving victims. Having experienced significant physical, sexual and psychological trauma, HIV/AIDS and to be poor and lowly educated they suffered post-traumatic stress disorder, depression, anxiety and dysfunction. They have numerous physical illnesses including STIs, infertility, maiming scarification, yet without medical care. Many had pregnancies and the girl-child was increasingly marginalized. The recommendation includes the establishment of gender psych traumatization centers in all war –affected districts of Dem. Republic of Congo (DRC) for prevention, stopping and preventing war through representative and transparent democratic governance and universal respect of human rights is advocated.

Report on: Armed Conflicts and their Incidences on Children's Life in the Democratic Republic of Congo by Crispin Swedi Bilombe

3. MADAGASCAR

TITRE DU PROGRAMME : ATTENTION! LE VIH SIDA NE PARDONNE PAS.

PERSONNE DE CONTACT

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- **Date de début du programme** : 2003
- **Date de fin du programme** : NA
- **Responsable(s)** : Société civile
- **Groupe(s) de population atteint(s)** : Personnes vivant avec le VIH ; Peuples indigènes ; Enfants ; Femmes et filles ; Jeunes ; Travailleurs des sexes/TDS ou Prostituées
- **Le programme a-t-il été évalué/analysé ?** Oui, Nous Association Des Femmes Ny Mamoha Ambositra Amoron'i Mania Madagascar Entre L'ONG RESEAU MAD'AIDS Immeuble BMH Isotry Antananarivo, financé par le Global Fund pour la lutte contre le VIH – SIDA, la Tuberculose et le Paludisme s'engage à travailler ensemble ; subvention MDG-H-SECNLS numéro 1509. Par le DRSP de la Région Amoron'i Mania, l'ONG MAD-AIDS et par le Laboratoire Nationale Référence (LNR) IST/VIH-SIDA. CV VIH (Charge Virale).
- **Le programme fait-il partie de la Stratégie Nationale de Santé ?** Oui, des organisations en bonne collaboration de travail avec nos Médecin référent. Chez nous, c'est lui qui est le Médecin traitant de cette maladie mentale dans la Région Amoron'i Mania. Alors, c'est une bonne stratégie bien planifiée entre l'Association NY MAMOHA et le Médecin traitant à orienter facilement les victimes
- **Le programme fait-il partie d'un Plan National autre que la Stratégie Nationale de Santé Mentale ?** Oui,
 - La Violence Basée sur le Genre en situation de crise humanitaire (VBG). La nature et la portée de types précis de VBG varient selon les cultures, les pays et les régions.
 - Les conséquences des VBG peuvent provenir directement d'actes violents ou être les résultats d'effets à long terme.
 - Les conséquences physiques vont de blessures relativement mineures à des blessures graves entraînant le décès ou handicap permanent, des grossesses non désirées, des avortements pratiqués dans de mauvaises conditions de sécurité et des complications d'avortements.

- Une issue négative de la grossesse dont un avortement spontané, des infections sexuellement transmissibles dont le VIH, une maladie inflammatoire plus grave, une stérilité, des syndromes de douleur chronique et des infections urinaires.
- Les conséquences psychologiques sont : l'anxiété dont un état de stress post – traumatique (PTSD), la dépression un sentiment d'infériorité, la méfiance, la peur, les troubles du sommeil, les troubles de l'alimentation, les troubles sexuels et le suicide.
- La VGB touche également dans une large mesure la santé sociale de l'individu et de la communauté par le biais d'une stigmatisation, d'un isolement et d'un rejet (y compris par les maris et les familles), par la perte de revenus potentiels pour les femmes, l'interruption de l'éducation des adolescents et l'homicide (par exemple, les crimes d'honneur ou l'infanticide des filles).

INFORMATION DE BASE

Depuis les années 80, le Virus de l'Immunodéficience Humaine (VIH) est à l'origine de l'une des pandémies les plus alarmantes et les plus dévastatrices de l'histoire.

Outre le fait qu'il représente un problème de santé incommensurable, ce virus menace le tissu socio-économique de nombreuses communautés.

La pauvreté reste encore un grand handicap pour le développement dans la région Amoron'i Mania. Le chômage, la malnutrition, la faiblesse de distraction alors, les trois causes différentes qui les poussent à la prostitution (facile à trouver de l'argent).

Ce qui est spécifique dans notre région Amoron'i Mania, c'est la saison de l'exhumation « Famadihana ». Pendant cette événement, les hommes ne sélectionnent plus les jeunes filles ou avec qui ils rencontrent ; à savoir que les rapports sexuels avec des inconnues impliquent facilement l'entrée de la maladie de VIH-SIDA.

Selon l'UNICEF, chaque année près de 3 Millions d'enfants sont victimes d'exploitation sexuelle dans cadre commercial.

L'évacuation efficace des groupes cibles à son point d'utilisation dans le cadre de la vie de la population.

Confiant de ses expériences acquises, l'Association des Femmes NY

MAMOHA Ambositra Amoron'i Mania Madagascar décident clairement, par la présente offre de service de mettre en œuvre d'appui à la Lutte contre les maladies Transmissibles VIH –SIDA.

DESCRIPTION

Une brève description du travail de l'Association NY MAMOHA c'est la conscientisation des adolescents mineurs en marginal, les formations données aux personnes convaincues. La meilleure solution c'est la prévention et la prudence des groupes cibles pour limiter la propagation de cette grave maladie.

Du point de vue quantitatif, notre souhait est de voir diminuer le nombre des adolescents prostituées mineurs.

L'objectif c'est de faire sortir ces personnes de leur pauvreté, des crimes, de la violence et toute forme de pression faites aux enfants.

La stratégie adéquate que nous avons trouvée c'est la prise en charge, accompagnement des victimes.

Les actions de la lutte contre la VIH à mettre en place en priorité dans le cadre d'une réponse humanitaire concernant la prévention de la transmission du VIH :

- S'assurer que les transfusions sanguines se font en toute sécurité
- Mettre à disposition des préservatifs

- Il convient également de s'assurer que des antirétroviraux (ARV) sont disponibles pour suivre le traitement des PVVIH
- Évaluation des besoins
- Sensibilisation et prévention du VIH
- Conseil et dépistage du VIH
- Prévention de la transmission mère – enfant (PTME)
- Soins des personnes vivant avec le VIH
- Soins aux enfants vivant avec le VIH
- Soutien aux PVVIH, s'assurer que le PVVIH disposent d'un accès non discriminatoire aux aliments et compléments alimentaires nécessaires par le biais des programmes d'aides alimentaire (par exemple le PAM, FAO, ...)

RESULTATS, REPERCUSSIONS ET IMPACT DU PROGRAMME

- Adapter les campagnes de communication pour permettre une sensibilisation générale au VIH et au syndrome d'immunodéficience acquise (SIDA)
- Cibler les personnes qui peuvent être vulnérables aux pratiques augmentant les risques de transmission du VIH.
- Réduire les comportements discriminatoires
- Garantir les soins et l'aide aux personnes vivant avec le VIH
- Garantir le respect et la protection des droits de l'homme et atténuer ses effets contraires sur les personnes et les communautés.
- Le droit de la vie privée et à la confidentialité en matière de soins liés au VIH.
- Qualité de dépistage
- Taux d'utilisation des préservatifs
- Conseils et résultats post-dépistage des patients.
- Couverture de la PTME.
- Couverture des programmes

ENSEIGNEMENT TIRES ET RECOMMANDATIONS

Point-fort :

- La présence des autorités régionaux qui ont honoré et accepté le programme du projet.
- La fréquence en nombre des personnes sensibilisés, convaincues a été très remarqué.
- Nous reconnaitrons et apprécions le soutien et collaboration de travail avec le chef Fokontany / FKT ou le chef de quartier
- Travail en équipe entre les membres de l'association.

Facteurs de risques :

- L'insécurité, les bagarres et les tapages nocturnes provoquent chaque nuit l'angoisse de la population.
- Problème d'insécurité pendant la descente chez les groupes cibles.

Recommandations :

- Établir le programme de travail qui va être basé sur la marche vers la conscientisation des personnes ciblés.
- Pour la réalisation des activités, nous demandons la continuité de l'accompagnement fait par l'organisation promoteur du projet pour d'autre manière selon la conception du projet.

Conclusions :

- Ce progrès est prouvé par le changement de comportement, de mentalité des groupes ciblés.

- Pour terminer, nous Association des Femmes Ny Mamoha Ambositra Amoron'i Mania Madagascar espérons que le UNAIDS in Geneva sera toujours là pour nous épauler à notre action.

ANNEXES

- Déclaration de Constitution d'une Association reçu au Bureau de la Direction Interrégionale de l'Administration Territoriale de Fianarantsoa
- Certificat de Participation à l'atelier de renforcement des capacités des femmes candidates membres du VMLF par l'ONG EISA MADAGASCAR
- Certificat de Participation à la formation sur la « Vie associative » par le Bureau International du Travail
- Certificat de Participation à la formation sur la Gestion et l'Entrepreneuriat par le Bureau International du Travail
- Attestation de formation par le Groupement des Femmes Entrepreneurs de Madagascar
- Diplôme dans le cadre du Project d'Appui à la lutte contre le Maladie Transmissibles
- Attestation pour la formation en « Prise en charge psychosociale des survivantes de violence basée sur le genre »
- Reference letter from Corps de la Paix
- Attestation de participation sur la thématique « Promotion de la culture entrepreneuriale chez la gente féminine » par la Jeune Chambre Internationale Ambositra

4. MALAWI

4.1 TITLE OF THE PROGRAMME:

INTEGRATING NATIONAL MENTAL HEALTH STRATEGY WITH NATIONAL HIV/AIDS STRATEGY AT ALL LEVELS

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- **Programme is being implemented since:** January 2018
- **End date of the programme:** On going
- **Responsible parties:** Faith-based organizations; Government; Civil society; Private sector; UN and other inter-governmental organizations; Academic institution
- **Population reached:** People living with HIV; People with mental health conditions;
- **Has the programme been evaluated/assessed?** Yes, by the psychiatric specialists at Zomba Central Hospital and College of Medicine in Malawi in consultation with department of HIV/AIDS in the Ministry of Health and Population as a research through routine in-patient admissions at the Psychiatric Centre of Excellence Hospital in Malawi.
- **Is the programme part of the National AIDS or Mental Health or Substance Abuse Prevention and Treatment Strategy?** Yes
- **Is the programme part of a National Plan other than the National AIDS or Mental Health Strategy?** No

BACKGROUND

Currently, the Malawi Health System is not well integrated between National HIV/AIDS Strategy and National Mental Health Strategy. However, some studies in Sub-Saharan Africa and other high-income countries demonstrate that patients with psychosis have a higher prevalence of HIV compared to those without psychosis. In Malawi, due to lack of rigorous data, people with mental illness may be at risk for under diagnosis of HIV, poor access to HIV care, and worse HIV outcomes. Accordingly, in this program, we aimed at determining the prevalence of HIV in inpatients aged 15-49 years with psychotic disorders and the associated demographic and or clinical factors associated with the infection at Zomba Mental Hospital in Malawi.

DESCRIPTION

The main objective of the study as a program was to ascertain the prevalence of HIV among the 15-49 years in-patients with psychosis at Zomba Mental Hospital in comparison to the National UNAIDS Spectrum Estimates Prevalence of the same age group in 2018 which was at 9.3%. The program was systematic in nature using the same current Malawi Health System arrangement of HIV/AIDS Department resources and its partners on one hand; and Zomba Mental Hospital and its partners on the other hand. It was a descriptive cross-sectional study. Participants were recruited from all existing inpatients with psychosis as well as all subsequent admissions during the study period. They were recruited from acute, rehabilitation and infirmary wards of the national tertiary psychiatric hospital in Malawi. Presence of a psychotic disorder was verified using SCID- 4. Demographic and HIV treatment data was also collected. Data was analysed using SPSS with p-value set at 0.01.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

Of 452 inpatients, 257 were recruited while 195 were excluded because they did not have a psychotic disorder by definition criteria analysis. The majority of patients had a diagnosis of Schizophrenia (181), while 33 had psychosis secondary to a general medical condition or medications. Forty-four patients (17.1%) tested HIV positive. Female sex ($p=0.021$), being on single psychotropic medication ($p=0.024$) and psychotic illness secondary to a general medical condition ($p<0.005$) was associated with being HIV positive. 185 participants (71.9%) had a previous HIV test. Reasons for lack of previous testing included "not having thought of going for an HIV test in 85 (33.1%). Of those with HIV, 35/44 (79.5%) were on cotrimoxazole prophylaxis and 31/44 (70.5%) were on ARVs.

LESSONS LEARNED AND RECCOMENDATIONS

The Prevalence of HIV in Malawi among the 15-49 years in-patients with psychosis at Zomba Mental Hospital is higher at 17.1% compared to the National UNAIDS Spectrum Estimates Prevalence of the same age group in 2018 at 9.3%. Therefore, the Health Sector Stakeholders in Malawi Health System are encouraged to consider screening for HIV in psychiatric patients, as a confirmed high-risk population; and eventually develop Standard Operation Procedures (SOPs) for initiating treatment immediately in a trusted manner for continuity.

ANNEXES

NA

4.2 TITLE OF THE PROGRAMME: SOAR-Malawi Mental Health Program

CONTACT PERSON

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- **Programme is being implemented since:** 2017
- **End date of the programme:** NA
- **Responsible parties:** Government, Academic institution
- **Population reached:** People living with HIV, People with mental health conditions
- **Has the programme been evaluated/assessed?** No
- **Is the programme part of the National AIDS or Mental Health or Substance Abuse Prevention and Treatment Strategy?** Yes
- **Is the programme part of a National Plan other than the National AIDS or Mental Health Strategy?** No

BACKGROUND

In Malawi and other parts of SSA, early retention in HIV care is a major obstacle to achieving the UNAIDS 90-90-90 goals. While adherence and viral suppression among those remaining in care is high in many parts of Africa, [1] initiation of and retention in ART treatment (the “second 90”) is a major challenge. The first year of ART treatment is a particularly vulnerable period: nearly a quarter of people initiating ART are lost to care within the first 12 months. [2-4] Among people initiating ART, those with comorbid depression are a large and especially vulnerable population. Depression affects 18-30% of patients receiving HIV care in Africa[5] and is an important barrier to early ART retention.[6, 7] Depression is also strongly associated with reduced ART adherence and viral suppression5, [8-10] as well as greater perceived stigma and faster HIV clinical progression.[9, 11-14] Thus, appropriate depression care for people initiating ART is likely to be important to achieve the 90-90-90 goals. However, evidence of the impact of depression treatment on HIV care retention and treatment outcomes in Africa is currently lacking. 1. Mills EJ, Nachega JB, et al. Adherence to antiretroviral therapy in sub-Saharan Africa and North America: a meta-analysis. *Jama*. 2006;296(6):679-90. 2. Fox MP, Rosen S. Retention of Adult Patients on Antiretroviral Therapy in Low- and Middle-Income Countries:

Systematic Review and Meta-analysis 2008-2013. *J Acquir Immune Defic Syndr.* 2015;69(1):98-108. PMID: PMC4422218. 3. Rasschaert F, Koole O, et al. . Short and long term retention in antiretroviral care in health facilities in rural Malawi and Zimbabwe. *BMC Health Serv Res.* 2012;12:444. PMID: PMC3558332. 4. Massaquoi M, Zachariah R, et al. Patient retention and attrition on antiretroviral treatment at district level in rural Malawi. *Trans R Soc Trop Med Hyg.* 2009;103(6):594-600. 5. Nakimuli-Mpungu E, Bass JK, et al.. Depression, Alcohol Use and Adherence to Antiretroviral Therapy in Sub-Saharan Africa: A Systematic Review. *AIDS and behavior.* 2011. Epub 2011/11/26. 6. Smillie K, et al. Mobile health for early retention in HIV care: a qualitative study in Kenya (WeTel Retain). *Afr J AIDS Res.* 2014;13(4):331-8. 7. Franke MF, Kaigamba F, et al. Improved retention associated with community-based accompaniment for antiretroviral therapy delivery in rural Rwanda. *Clin Infect Dis.* 2013;56(9):1319-26. 8. Gonzalez JS, Batchelder AW, Psaros C, Safren SA. Depression and HIV/AIDS treatment nonadherence: a review and meta-analysis. *J Acquir Immune Defic Syndr.* 2011;58(2):181-7. PMID: 3858003. 9. Pence BW, Miller WC, Gaynes BN, Eron JJ, Jr. Psychiatric illness and virologic response in patients initiating highly active antiretroviral therapy. *J Acquir Immune Defic Syndr.* 2007;44(2):159-66. Epub 2006/12/06. 10. Kidia K, Machando D, et al. 'I was thinking too much': experiences of HIV-positive adults with common mental disorders and poor adherence to antiretroviral therapy in Zimbabwe. *Trop Med Int Health.* 2015;20(7):903-13. PMID: PMC4500937. 11. Gonzalez JS, Batchelder AW, et al. Depression and HIV/AIDS Treatment Nonadherence: A Review and Meta-analysis. *J Acquir Immune Defic Syndr.* 2011. Epub 2011/08/23. 12. Leserman J, Pence BW, et al. Relation of lifetime trauma and depressive symptoms to mortality in HIV. *The American journal of psychiatry.* 2007;164(11):1707-13. Epub 2007/11/03. 13. Leserman J. Role of depression, stress, and trauma in HIV disease progression. *Psychosom Med.* 2008;70(5):539-45. 14. Ickovics JR, Hamburger ME, et al. Mortality, CD4 cell count decline, and depressive symptoms among HIV-seropositive women: longitudinal analysis from the HIV Epidemiology Research Study. *JAMA.* 2001;285(11):1466-74.

DESCRIPTION

Depression treatment has been integrated into two public sector HIV primary care clinics in Lilongwe, Malawi. The treatment program combines two resource-efficient, context-appropriate depression treatment models — algorithm-based medication management and problem-solving therapy — into a single, stepped-care program that is offered to patients newly initiating antiretroviral treatment (ART) and who have depressive symptoms. The program was designed through a joint partnership between the University of North Carolina at Chapel Hill and the Malawi Ministry of Health with funding from USAID via the Population Council's Project SOAR. The program is implemented by regular Malawi MOH staff with training and support from the MOH. Sustainability has been a primary focus since the outset, leading to the focus on training existing personnel rather than hiring new project-specific staff people. The program involves a unified approach to the following elements: universal depression screening, clinical confirmation of depression, safety assessment for patients indicating suicidal thoughts or ideas, specification of a treatment plan involving antidepressant management and/or psychosocial counseling, and regular monitoring at follow-up visits for assessment of needed changes to the treatment plan. Universal depression screening needed to be reliable, brief, and integrated into an existing universal assessment, but did not need to be administered by a highly specialized staff person. We added the two-question Patient Health Questionnaire-2 (PHQ-2) into the standard HIV post-test counseling protocol. All patients receiving a positive HIV test now complete the PHQ-2. Clinical confirmation needed to be conducted by a staff person with clinical training using a

standardized format. All patients scoring >0 on the PHQ-2 are now given a form with the nine-item Patient Health Questionnaire-9 (PHQ-9) to take to their initial ART appointment. (Note that at these clinics in Malawi, patients are taken directly from HIV post-test counseling to the ART intake desk and then are seen by a clinician the same day.) The HIV clinician (a nurse or clinical officer) completes the PHQ-9 assessment and confirms or rules out the diagnosis of depression. Safety assessment needed to be completed by a clinical staff person with any patient who indicates any suicidal thoughts or ideas. We created a Suicide Risk Assessment Protocol (SRAP) which the HIV clinician completes with any patient scoring >0 on the suicidality question of the PHQ-9 (question 9). The SRAP result was documented on a new Mental Health Mastercard, and the team audits completeness and provides feedback to providers as needed to ensure the SRAP is always completed when needed and the result is documented. Treatment plans are determined by the HIV clinician, guided by a treatment algorithm. We trained the HIV clinicians to prescribe antidepressants when indicated, and we trained Health Surveillance Assistants (the clinic-based lay health worker cadre in the Malawi health system) as counselors in the Friendship Bench problem-solving therapy protocol. The depression treatment plan is reviewed and adjusted if needed based on the algorithm by the HIV clinicians at routine ART follow-up appointments.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

The program evaluation compares depression response, retention in HIV care, and viral suppression among patients offered the program compared to patients entering care prior to the program's launch. It is expected that this study will yield evidence on the effectiveness and cost-effectiveness of depression treatment integrated with HIV care for achieving the 90-90-90 goals as well as a stepped-care depression treatment model that will be applicable in Malawi as well as in other SSA countries. Evaluation data regarding impact on HIV outcomes and cost-effectiveness will be available in mid-2019. However, available process data include the following indicators. - To date, of over 2,000 patients newly starting ART at the participating clinics, 92% completed stage-1 screening with the PHQ-2 and of those scoring >0 on the PHQ-2, 90% completed clinical confirmation with the PHQ-9. Overall, approximately 25% of patients screened are identified with mild, moderate, or severe depressive symptoms and about 7% with moderate or severe symptoms. Approximately 5% of patients indicated any suicidal thoughts or ideas, and 94% of those indicating such thoughts completed a safety assessment. Among those patients starting antidepressant treatment, the median PHQ-9 score has decreased from a median of 11 (moderate depression) at treatment initiation to a median of 0 after 3 months; the proportion reporting any suicidal thoughts or ideas has decreased from 39% to 10%. Among those patients starting psychosocial counseling, the median PHQ-9 score has decreased from a median of 6 (mild depression) at treatment initiation to a median of 0 after 3 months; the proportion reporting any suicidal thoughts or ideas has decreased from 39% to 7%. The results of the study to date have already been presented to the Malawi MOH Technical Working Group on Non-Communicable Diseases and Mental Health, the primary body charged with advising the MOH on mental health service delivery. References: Integrating depression management into HIV primary care in central Malawi: the implementation of a pilot capacity building program. Udedi M, Stockton MA, Kulisewa K, Hosseinipour MC, Gaynes BN, Mphonda SM, Mwangomba BM, Mazenga AC, Pence BW. BMC Health Serv Res. 2018 Jul 31;18(1):593. doi: 10.1186/s12913-018-3388-z. PMID: 30064418

https://www.popcouncil.org/uploads/pdfs/2017HIV_ProjectSOAR_MentalHealthMalawi.pdf
https://www.projsoar.org/wp-content/uploads/2018/04/20180417_Malawi_MH_Bsln_Brief.pdf

LESSONS LEARNED AND RECOMMENDATIONS

Key facilitators and lessons learned: A detailed understanding of clinic infrastructure, patient flow, and staff responsibilities prior to program design. Building collaboration among the multiple stakeholders who contribute to HIV care provision at the sites, including NGOs whose workers provide clinical services Weekly clinic staff meetings to discuss progress and concerns and to seek feedback from the clinic staff. Emphasizing that the treatment program is an initiative of the government, not a research project; ensuring MOH representation at clinic meetings, engaging with the local District Health Office, and identifying clinic staff to take a leadership role in program implementation onsite. Providing repeat trainings and supervisions to ensure ongoing quality improvement as well as onboarding of new staff. Coordinating with the clinic pharmacists and their colleagues at the district and central levels to maintain antidepressant stocks at both clinics. Source: http://www.projsoar.org/wp-content/uploads/2018/04/20180417_Malawi_MH_Bsln_Brief.pdf

ANNEXES

NA

5. RWANDA

TITLE OF THE PROGRAMME: Family Strengthening Intervention (FSI-HIV)

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- **Programme is being implemented since:** 2014
- **End date of the programme:** NA
- **Responsible parties:** Academic institution
- **Population reached:** People living with HIV; People with mental health conditions; Children; Women and girls; Young people
- **Has the programme been evaluated/assessed?** Yes, this randomized controlled trial of 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 conducted in 2014 and results are published: Betancourt, TS, Ng, LC, Kirk, CM, Brennan, RT, Beardslee, WR, Stulac, S, Mushashi, C, Nduwimana, E, Mukunzi, S, Nyirandagijimana, B, Kalisa, G, Rwabukwisi, CF, & Sezibera, V. (2017). Family-based promotion of mental health in children affected by HIV: a pilot randomized controlled trial. *Journal of Child Psychology and Psychiatry*, 58(8) 922-930.
- **Is the programme part of the National AIDS or Mental Health or Substance Abuse Prevention and Treatment Strategy?** No
- **Is the programme part of a national plan other than the National AIDS or Mental Health Strategy?** No

BACKGROUND

Children affected by HIV are at risk for poor mental health. We conducted a pilot randomized controlled trial (RCT) of 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, hypothesizing that child and family outcomes would be superior to usual care social work services.

DESCRIPTION

Eighty-two families (N = 170 children, 48.24% female; N = 123 caregivers, 68.29% female) with at least one HIV-positive caregiver (n = 103, 83.74%) and school-aged child (ages 7–17) (HIV+ n = 21, 12.35%) were randomized to receive FSI-HIV or treatment as-usual (TAU). Local research assistants blind to treatment conducted assessments of child mental health, parenting practices, and family functioning at baseline, post-intervention, and 3-month follow-up. Multilevel modeling assessed effects of FSI-HIV on outcomes across three time points. Trial Registration: NCT01509573, 'Pilot Feasibility Trial of the Family Strengthening Intervention in Rwanda (FSI-HIV-R).

. <https://clinicaltrials.gov/ct2/show/NCT01509573?term=Pilot+Feasibility+Trial+of+the+Family+S+trengthening+Intervention+in+Rwanda+%28FSIHIV-R%29&rank=1>.

RESULTS, OUTCOMES AND IMPACT OF THE POGRAMME

At 3-month follow-up, children in FSI-HIV showed fewer symptoms of depression compared to TAU by both self-report (b = .246; p = .009) and parent report (b = .174; p = .035) but there were no significant differences by group on conduct problems, functional impairment, family connectedness, or parenting. Conclusions: Family-based prevention has promise for reducing depression symptoms in children affected by HIV. Future trials should examine the effects of FSI-HIV over time in trials powered to examine treatment mediators.

LESSONS LEARNED AND RECOMMENDATIONS

Participation in FSI-HIV was associated with significant reductions in children's depression symptoms at three-month follow-up. Children and caregivers reported high satisfaction with FSI-HIV, including FSI-HIV meeting their own needs, willingness to recommend FSI-HIV to others, excellent attendance and willingness to participate again. FSI-HIV seeks to activate improved family communication in order to foster healthy parent-child relationships and prevent mental health problems in children. As a core component of this model, FSI-HIV helped many families to discuss the realities of HIV status among different family members. For many families, the FSI-HIV intervention promoted some of their first in-depth discussions about HIV with their children (Chaudhury, Kirk et al., 2016). Innovations of this FSI-HIV trial must be noted. First, reductions in child depression symptoms were achieved with FSI-HIV delivered by bachelor-level counselors with FSI-HIV training, demonstrating potential to help address the limited resources for mental health services in Rwanda. Second, the home visiting model was effective in engaging mothers and fathers in dual-caregiver households. Third, this study adds to the literature by extending the intervention focus beyond children directly infected by HIV or children orphaned by HIV to also provide a model for promoting the mental health of children living in households where at least one caregiver has HIV. This allows for a focus on children directly and indirectly affected by HIV, which is extremely pertinent in today's environment with longer life expectancies among people living with HIV (Nsanzimana et al., 2015). In particular, coaching parents to use positive parenting practices and improved communication and listening may have contributed to reductions in children's depression and improvements in prosocial behavior both in HIV-infected children and in children who are HIV-negative but indirectly affected by family HIV. Study limitations must also be noted. As a feasibility study, our trial was not powered to detect smaller effects, and some effects in family process variables may have been hidden by larger differences attributable to family type. In addition, given the need to balance our standard package of intervention modules for families affected by HIV along with risk of harm issues such as violence affecting some families, not all families

experienced exactly the same number of sessions or thus 'dose' of intervention. Further, as a feasibility study, the trial does not contain a sufficient period of follow-up to assess the long-term benefits of the FSI-HIV as a preventive intervention. Nonetheless, we did see an encouraging decline in family conflict among families receiving the FSI-HIV intervention that warrants further exploration (Chaudhury, Kirk et al., 2016). Lastly, due to the use of individual level randomization there were FSI-HIV families living in the same communities as TAU families that could potentially lead to contamination. Future trials should be powered to investigate both differential effects by family configuration and to examine outcomes over a longer time horizon to understand potential preventative effects of FSI-HIV. Although retention and attendance were strong, participation was affected by time constraints of families as well as caregiver alcohol abuse (Chaudhury, Brown et al., 2016) and addressing traumatic stress responses related to the Rwandan genocide.

ANNEXES

Theresa S. Beancourt, Laurenc C. Ng, Catherine M. Kirk, Robert T. Brennan, William R. Bearslee, Christine Mushashi, Estella Ndwimana, Sylvere Mukunzi, Beatha Nyirandagijimana, Godfrey Kalisa, Cyamatore F. Rwabukwisi and Vincent Sezibera. (2017) "Family-based promotion of mental health in children affected by HIV: a pilot randomized controlled trial." *The Journal of Child Psychology and Psychiatry*.

6. SOUTH AFRICA

TITLE OF THE PROGRAMME: Mzantsi Wakho

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- **Programme is being implemented since:** 2013
- **End date of the programme:** NA
- **Responsible parties:** Academic institution
- **Population reached:** People living with HIV; Children; Women and girls; Young people
- **Has the programme been evaluated/assessed?** Yes, by University of Oxford and University of Cape Town
- **Is the programme part of the National AIDS or Mental Health or Substance Abuse Prevention and Treatment Strategy?** No
- **Is the programme part of a national plan other than the national aids or mental health strategy?** No

BACKGROUND

South Africa is home to the world's largest population of adolescents living with HIV (ALHIV) [1]. Adolescents are the age group with the highest rates of ART nonadherence, bringing higher risks of AIDS-related morbidity and mortality [2,3]. Globally, AIDS-related mortality is on the rise among ALHIV: between 2005 and 2015, AIDS-related mortality more than doubled in this high-risk population whilst all other age groups experienced reductions [4]. In the context of HIV, mental health problems are associated with negative health outcomes, including non-adherence to life-saving ART, morbidity and mortality, as well as risky sexual behaviour, which can transmit drug resistant HIV [5]. Addressing mental health among ALHIV is therefore a priority [6]. For effective programming it is essential to identify risk and protective factors associated with psychological outcomes. 1. World Health Organisation (WHO). Health for the world's adolescents. Geneva: WHO; 2014. 2. Nachega JB, Hislop M, Nguyen H, Dowdy DW, Chaisson RE, Regensberg L, et al. ART therapy adherence, virologic and immunologic outcomes in adolescents compared with adults in southern Africa. *J Acquir Immune Defic Syndr* 2009; 51:65–71. 3. UNICEF. Children and AIDS 2015 Statistical Update. New York: UNICEF; 2015. 4. The United Nations Children's Fund (UNICEF). For every child, end AIDS: seventh stocktaking report. New York: UNICEF; 2016. 5. Mutumba,

M., Resnicow, K., Bauermeister, J., Harper, G., Musiime, V., Snow, R., & Lepkowski, J. (2015). Development of a psychosocial distress measure for Ugandan adolescents living with HIV. *AIDS and Behavior*, 19, 380–392. 6. Lowenthal, E., Bakeera-Kitaka, S., Marukaira, T., Chapman, J., Goldrath, K., & Ferrand, R. (2014). Perinatally acquired HIV infection in adolescents from sub-Saharan Africa: A review of emerging challenges. *The Lancet Infectious Diseases*, 14, 627–639.

DESCRIPTION

Mzantsi Wakho is the world's largest longitudinal cohort of adolescents living with HIV (ALHIV). In 2015-2018, the study combined qualitative and quantitative research methods to fill a pressing research gap – understanding what factors contribute to 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. We completed three waves of quantitative surveys with a total of N=1,624 adolescents in South Africa's Eastern Cape. Despite the crucial role of adolescents in their own care and preventing further transmission, little research has been done expressly focusing on their experiences relating to ART and Sexual and Reproductive Health services. This experience-centred approach brings their insights into the policy arena and involves adolescents in the design of their own health services. This evidence informs social policy and programming on the best ways to care for and support young people and families living in AIDS-affected communities in South Africa. Mzantsi Wakho was designed and conceptualised in collaboration with the South African Departments of Health, Basic Education, and Social Development, UNICEF and UNAIDS, RIATT, REPSSI, Paediatric AIDS Treatment for Africa, and community-based organisations. Ongoing consultations with partners ensure that findings are directly relevant for HIV programming in South Africa. The team also collaborated with adolescents, frontline healthcare workers and social service providers to design support tools to improve adherence to medicines and access to health services. The study is supported by the Nuffield Foundation under [CPF/41513], Janssen Pharmaceutica N.V., part of the Janssen Pharmaceutical Companies of Johnson & Johnson, the Evidence for HIV Prevention in Southern Africa (EHPSA), a UKAID programme managed by Mott MacDonald [MM/EHPSA/UCT/05150014], the International AIDS Society through a CIPHER [155-Hod], Claude Leon Foundation [F08 559/C], the Regional Inter-Agency Task Team for Children Affected by AIDS - Eastern and Southern Africa (RIATT-ESA), UNFPA South Africa, UNICEF-ESARO and the University of Oxford's Clarendon-Green Templeton College Scholarship. Additional support is provided by the European Research Council (ERC) under the European Union's Seventh Framework Programme [FP7/2007-2013/ERC grant agreement no 313421], the John Fell Fund [161/033 & 103/757], the Philip Leverhulme Trust [PLP-2014- 095] and the University of Oxford's ESRC Impact Acceleration Account (IAA) [IAA-MT13-003, 1602-KEA-189, 1311-KEA-004 & 1069-GCRF-227]. We also particularly thank the Mzantsi Wakho Teen Advisory Group for their invaluable input into our research and policy.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

Despite enormous progress in ART roll-out, nonadherence remains a major challenge to the health and survival of ALHIV. Recent analyses from the Mzantsi Wakho cohort, tells us that poor mental health and exposure to violence are important risk factors preventing long-term ART adherence in ALHIV. This stresses the importance of addressing mental health and violence prevention to improve ART adherence in ALHIV. Key findings from Mzantsi Wakho: (1)

Internalised stigma in ALHIV (Pantelic et al., 2017): Reducing stigma is likely to have positive effects on the mental health of ALHIV. Internalised stigma was associated with worse mental health. Enacted stigma was associated with more posttraumatic stress and anticipated stigma was associated with higher anxiety scores. Tackling discrimination against ALHIV and violence victimization in homes, schools and communities may be essential to interrupt pathways of risk to internalized HIV stigma. (2) Mental health & internalising and externalising symptoms (Boyes et al. 2018): Better physical health was negatively associated with all measures of internalising symptoms. Negative clinic interactions were associated with higher depression scores. Access to clinic support groups appeared to be protective against symptoms of both anxiety and depression. Emotional abuse and bullying victimisation were associated with worse outcomes on all mental health measures. Parenting-related factors, positive parenting was associated with better mental health across all measures and poor parental monitoring was associated with more anxiety and conduct problems. Bullying victimisation, self-efficacy, and positive parenting may be crucial intervention targets as they were associated with better outcomes on most or all mental health measures. (3) Violence exposure in ALHIV (Cluver et al. 2018): Amongst adolescents exposed to four types of violence, only 25% were adherent in the past week, compared with 75% of non-victimized adolescents. Exposure to four types of violence was associated with lower ART adherence, independent of each other, and of socioeconomic, family, and HIV-related factors. They included physical abuse from caregivers, witnessing domestic violence between adults at home, physical violence from teachers, and clinic verbal victimization by healthcare providers. Prevention, and protection services may be essential for the health and survival of ALHIV. (4) Suicidality and depression in ALHIV (working analyses): Almost half of the ALHIV in our study has experienced some level of HIV-related stigma. HIV-related stigma is a risk factor for depression and suicide, especially in ALHIV. Higher perceived social support was directly associated with less depression, while being part of a clinic-based support group was not. However, the combination of having more available social support and participating in a clinic-based support group appeared to protect ALHIV who were experiencing HIV-related stigma from depression and suicidal thought and behaviours. Findings reinforce the potential of social support as an important protective general mental health and stress-buffering resource for ALHIV. Suicidality in ALHIV can be mitigated by strengthening multiple sources of social support, such as early clinic and community-based interventions. In order to maximise the reach of project findings, the research team strategically disseminated at the local (Eastern Cape province), national (South Africa), regional (Eastern and Southern Africa), and global (headquarters of organizations or networks). Key global documents citing Mzantsi Wakho findings: 1. UNAIDS 2016 World AIDS Day report 2. UNAIDS HIV care and support Reference document 3. UNAIDS Gap Analysis on Paediatric HIV Treatment and Support 4. UNICEF Children and AIDS Stocktaking report 2016 5. UNICEF 2017 World AIDS Day report.

LESSONS LEARNED AND RECOMMENDATIONS

Lessons learned: 1) Referrals – As researchers, we have a legal obligation to help participants in imminent danger. We also feel a moral obligation to assist participants in the direst circumstances. As researchers who are only there temporarily, it is important to establish a network with relevant government agencies or local service organisation who can help. This has allowed us to ensure that vulnerable youth are linked up with sustainable sources of support and are getting help they need. 2) Vicarious trauma & team wellbeing – Working with vulnerable youth is hard and can lead to vicarious trauma in the team. Actively checking in with your individuals and the team helps to identify issues and create opportunities to help each other. Team building, mindfulness, counselling and time off are all helpful ways to maintain the well-

being of the team. Recommendations: Policy makers – Strengthening multiple social support resources for ALHIV, through early clinic and community-based interventions, may protect them from experiencing poor mental health and suicidal tendencies. Taking into consideration the home and school environments of adolescent patients might help better support ALHIV. Healthcare providers – Making clinics more youth friendly may help retain adolescents in care and improve mental health outcomes. In resource-limited contexts where psychosocial support is not available for all patients, it may be helpful to prioritize adolescents with physical or cognitive disabilities as they are at heightened risk of abuse and bullying victimization. Community organisations – Reducing stigma, increasing positive parenting and preventing violence is likely to have positive effects on the mental health of ALHIV. Schools - Mechanisms to inform teachers of bullying and discrimination in schools are needed. Violence prevention in schools that does not single out ALHIV but targets more broadly peer and teacher violence may be beneficial for ALHIV.

ANNEXES

Reference for findings: Boyes, M. et al., Mental health in South African adolescents living with HIV: correlates of internalising and externalising symptoms, *AIDS Care*, 2018, DOI: 10.1080/09540121.2018.1524121 Cluver, L. et al., Multi-Type Violence Exposures and Adolescent Antiretroviral Non-Adherence in South Africa, *AIDS*, 2018, doi:10.1097/qad.0000000000001795. Pantelic, M. et al., HIV, violence, blame and shame: pathways of risk to internalized HIV stigma among South African adolescents living with HIV. *Journal of the International AIDS Society*, 2017, 20:21771

7. TANZANIA

TITLE OF THE PROGRAMME: Stepping Stones with Children: a psychosocial approach to building resilience among children aged 5 to 14 affected by HIV

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- **Programme is being implemented since:** 2013
- **End date of the programme:** 2016 (for the funded project), but the work is on-going,
- **Responsible parties:** Civil society
- **Population reached:** Caregivers of children living with HIV; People living with HIV, Children, Women and girls, Young people
- **Has the programme been evaluated/assessed?** Yes, we conducted our own monitoring and evaluation (qualitative and quantitative at baseline, midline, endline and follow-up), and also hired an external consultant to evaluate the work.
- **Is the programme part of a national plan other than the National AIDS or Mental Health Strategy?** No

BACKGROUND

In a nutshell (see our article, sent as an annex, for more detail and the references): 1) Younger children are often excluded from sexuality education; 2) Children in HIV-affected households and children living with HIV typically experience a range of adversities that their non-affected peers do not encounter (Goldberg and Short, 2016; Islam et al., 2014; Bryant and Beard, 2016)) HIV typically links to an accumulation of adverse childhood events such as ill-health, bereavement, violence, neglect, psychological distress, abuse, stigma and related consequences such as reduced school attendance (Dow et al., 2016). 3) For children living with HIV who are taking antiretroviral treatment adherence to treatment is key to maintaining health (Cluver et al., 2015), with reciprocal positive links to mental well-being and social acceptance (Chilemb and Phiri, 2017). One of many factors that influences adherence to treatment among children is knowledge of their HIV sero-status (Hudelson and Cluver, 2015); in general, when they know, children are more likely to cooperate and manage their health (Bikaako-Kajura et al., 2006; Jemmott et al., 2014). However, in sub-Saharan Africa, it is common for children not to know their HIV sero-status. Caregivers describe many reasons why they fear to 'disclose' to children in their care, including the possibility that that they are too young to understand, doubting they can keep the secret, fear of stigmatisation if they do tell others and feeling

unprepared and lacking in courage to tell them (Hejoaka, 2009; Kouyoumdjian et al., 2005). Our project aimed to develop a comprehensive and transformative approach for supporting children affected by HIV (mostly living with HIV) and their caregivers.

DESCRIPTION

The objective of the project was to develop, produce, publish and pilot the use of the Stepping Stones with Children materials. It was implemented by Salamander Trust and PASADA, working with PASADA's child clients and their caregivers to develop and then test the materials in workshops. The materials aim to enable the children and caregivers to live healthier, happier and safer lives. The manual contains 29 training sessions in two parts covering a wide range of topics with a gendered and child-rights focused framework. Part 1 focuses on core topics including psychosocial well-being and resilience, skills and virtues, assertiveness, relationships, mindfulness, bereavement, HIV testing and living well with HIV. The manual recognises the importance of these topics as part of sexuality education. Sexual topics begin in Part 2 and include school, friendships, sexuality, safer sex, preventing sexual abuse, supporting survivors of abuse and livelihoods. The sessions use an assets-based, solution-focused appreciative enquiry approach (McAdam and Mirza, 2009), focusing on abilities rather than problems and noticing and affirming the use 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 split by gender. The peer groups sometimes work together, or share what they have learned. The activities enable participants to explore their own issues and experiences and to develop their own responses, including developing and practising skills. They are encouraged to share their learning with friends and family outside of the workshops. The sessions contain original content along with adapted exercises from existing proven approaches, and follow key aspects of effective behaviour change programming for sexuality education with young people (UNESCO, 2018). These include context-specific activities that promote critical thinking, addressing consent and life skills, having clear goals and key learnings, being explicit about gender and power (Haberland, 2015) and addressing cultural and peer norms, risk and protective factors and how to manage specific situations. The approach also follows strategies that enhance girls' well-being through addressing social norms by providing information, safe space for dialogue and reimagining, and including boys and adults (Vaitla et al., 2017). A Stepping Stones with Children counselling guide (Riziki and Holden, 2015) accompanies the workshop manual. This aims to improve the practice of HIV counsellors when working with children and their caregivers. It informed a 5-day training for PASADA's professional counsellors and one-day orientations for its volunteer counsellors. The project, which ended in 2016, was mainly funded by Comic Relief, with a contribution from UNAIDS. Current use of the materials is funded from NGOs' own resources and monies that they raise from donors. For example, PASADA received a grant from UNAIDS to run more workshops during 2017, and has funding from Unicef for further workshops in 2018, while Unicef in West Africa is planning to adapt them for use in Mali, Niger and Burkina Faso. Salamander Trust provides technical support to users and guidance for prospective users regarding training facilitators, budgeting and adaptation. Salamander also sends free copies of the materials to organisations that cannot afford to buy them.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

185 people participated in the four workshops, comprising 23.8% children aged 5–8, 28.6% aged 9–14 and 47.6% caregivers. 56.7% of the children and 78.4% of the caregivers were female. In all, 88.7% of the children were clients of PASADA living with HIV, the remainder were

their siblings. A similar number of children and caregivers took part in our pilot workshops, before we finalised the materials. The four workshops took place in Tanzania, in two urban communities in the Kinondoni and Ilala districts of Dar es Salaam region, and in two mixed (rural/urban) communities in the Mkuranga district of Pwani Region. Our monitoring and evaluation showed a large increase in 'disclosure' of HIV sero-status to children - from 27% to 93%. Assessment of clinical data before and after the workshops showed a statistically significant increase (p-value of <.01) in the CD4 count among the child participants living with HIV (n = 85, mean CD4 change + 317; from 530 to 847) compared with the control group (n = 91, mean CD4 change + 133; from 557 to 690). The mean weight gain was 3.51 kg for child participants and 1.33 kg for controls. Feedback from participants and PASADA's counsellors indicates better adherence to treatment and attendance at clinic and counselling appointments, and more productive counselling sessions. Our questionnaire data (asked of all participants at baseline, midline and endline) showed positive impacts on various aspects of their lives and wellbeing: Improved household relationships and reduced violence against children: Children and caregivers felt strongly that the workshop had helped their relationship, with more respect and more love shown between them, and children more likely to tell their caregivers if something is worrying them. The children also reported reductions in the frequency with which they are physically punished. Greater confidence among caregivers: The caregivers appreciated practising new skills in the workshops to help them raise their children; they reported greater confidence in supporting them to deal with issues, and more willingness to engage with them when upset and to share difficult information such as the death of a loved one. Better wellbeing and greater self-determination: Children and caregivers gave higher scores to questions about how happy they feel, their sense of self-worth, their optimism for the future and their sense of being able to influence their lives. Better service provision and willingness to use those services: Following their training to use the Stepping Stones with Children Counselling Guide, PASADA's counsellors reported better skills to do their work and changed attitudes. Caregivers and children also reported improved ratings for the staff and clinics. Improved networks of community-level support: Caregivers and children reported a greater sense of belonging to their community, and more strongly agreed that they have people they can rely on to help them. In some communities the participants continue to meet regularly, and many of the children have started attending PASADA's support clubs.

LESSONS LEARNED AND RECOMMENDATIONS

Success factors included: 1) Working with PASADA, an established HIV-service provision NGO. PASADA was able to: - recruit and train local people as workshop facilitators; - involve its clients (people living with HIV) in the initial materials development workshops, the pilot workshops and the workshops using the finalised materials; - help revise and finalise the materials; - involve its professional and volunteer counsellors, thereby improving the quality of service (supply) to complement the increased demand from workshop participants; - provide clinical data for the final workshop participants and a control group; - undertake monitoring and evaluation functions, and financial oversight of the field work. 2) A flexible approach from Comic Relief, allowing us to adapt the budget and have a no-cost extension to the time the project took to be completed. 3) Using a holistic, child-centred, gendered and rights-based approach, and incorporating insights from interpersonal neurobiology, to create broad opportunities for participants to reflect and explore, practise skills and develop resilience. Challenges include: 1) Although PASADA is able to use the materials, it wants to get the Government of Tanzania's official approval for them. This regrettably requires altering the content, to fit with the current political climate. We have the same issue in Uganda. In both cases a local version is being made which passes current sensibilities. For example, the Uganda version will include

information about masturbation for facilitators, but the topic will not be included in the activities with children as the government considers it to be unacceptable in local culture and not compatible with abstinence, the only behaviour appropriate for children. 2) Because the approach is comprehensive it cannot achieve the 'reach' in terms of numbers of participants that shorter and shallower methods can. We think the investment is justified in terms of the range and depth of the impacts, but need comparative studies to confirm this.

ANNEXES

Our article:

Sue Holden, Vanessa LZ Gordon-Dseagu, Gill Gordon, Nelson Chiziza, Pfiiraeli Kiwia, Daniel Magesa, Willbrord Manyama and Alice Welbourn. "Building resilience to adverse childhood experiences: An assessment of the effects of the *Stepping Stones with Children* training programme on Tanzanian children affected by HIV and their caregivers." (2018) Health and Education Journal

Poster: "Can HIV counsellors be supported to attain better outcomes for their child clients and their caregivers? The case of *Stepping Stones with Children*"

8. UGANDA

8.1 TITLE OF THE PROGRAMME:

The Social, Emotional, and Economic empowerment through Knowledge of Group Support Psychotherapy (SEEK-GSP) project

CONTACT PERSON

Name: Etheldreda Nakimuli-Mpungu

Title: Dr

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Email: ethelmpungu@yahoo.com

- **Programme is being implemented since:** 2013
- **End date of the programme:** December 2019
- **Responsible parties:** Grand Challenges; Canada and MQ Transforming Mental Health; Government; Academic institution
- **Population reached:** Soldiers; People living with HIV; People with mental health conditions; People who use substances, including alcohol; Prisoners; Indigenous and/or local communities; Migrants, refugees or internally displaced people; Women and girls
- **Has the programme been evaluated/assessed?** Yes, The Social, Emotional, and Economic empowerment through Knowledge of Group Support Psychotherapy (SEEK-GSP) project is a collaboration between Makerere University, the Ministry of Health and The AIDS Support Organization (TASO). The project has implemented culturally sensitive group support psychotherapy (GSP) for depression treatment in 30 HIV clinics situated in 30 primary care health centres in three districts (Gulu, Kitgum and Pader) in northern Uganda. The effectiveness of GSP was evaluated in a pilot randomized controlled trial whose results are published in the Lancet HIV journal. [http://dx.doi.org/10.1016/S2352-3018\(15\)00041-7](http://dx.doi.org/10.1016/S2352-3018(15)00041-7) The SEEK GSP Project (www.seek-gsp.org/) Led by Etheldreda Nakimuli-Mpungu, PhD has further evaluated GSP using a cluster randomized trial to provide robust evidence for the change processes and outcomes we observed in the pilot studies. Further, this trial demonstrates the potential for dissemination and integration into existing HIV service delivery platforms of a culturally sensitive first line treatment for mild to moderate depression. Publications for the protocol and recruitment processes of this trial can be assessed via these links: doi:10.2196/resprot.8925 DOI: 10.2196/preprints.11560 Results of the cluster randomized trial were presented at the Global Ministerial Mental Health Summit that took place in London October 9-10,2018

- **Is the programme part of the National AIDS or Mental Health or Substance Abuse Prevention and Treatment strategy? Yes**
- **Is the programme part of a national plan other than the National AIDS or Mental Health Strategy? No**

BACKGROUND

The Social, Emotional, and Economic empowerment through Knowledge of Group Support Psychotherapy (SEEK-GSP) project is a collaboration between Makerere University, the Ministry of Health and The AIDS Support Organization (TASO). The project has implemented culturally sensitive group support psychotherapy (GSP) for depression treatment in 30 HIV clinics situated in 30 primary care health centres in three districts (Gulu, Kitgum and Pader) in northern Uganda. The effectiveness of GSP was evaluated in a pilot randomized controlled trial whose results are published in the Lancet HIV journal. [http://dx.doi.org/10.1016/S2352-3018\(15\)00041-7](http://dx.doi.org/10.1016/S2352-3018(15)00041-7) The SEEK GSP Project (www.seek-gsp.org/) Led by Etheldreda Nakimuli-Mpungu, PhD has further evaluated GSP using a cluster randomized trial to provide robust evidence for the change processes and outcomes we observed in the pilot studies. Further, this trial demonstrates the potential for dissemination and integration into existing HIV service delivery platforms of a culturally sensitive first line treatment for mild to moderate depression. Publications for the protocol and recruitment processes of this trial can be assessed via these links: doi:10.2196/resprot.8925 DOI: 10.2196/preprints.11560 Results of the cluster randomized trial were presented at the Global Ministerial Mental Health Summit that took place in London October 9-10,2018. Soft copies of the presentation can be obtained from conference organizers.

DESCRIPTION

For the above program information please visit project website: www.seek-gsp.org/ Read the following publications 1. Nakimuli-Mpungu, E., Musisi, S., Wamala, K., Okello, J., Ndyababangi, S., Mojtabai, R., ... & Mills, E. (2018) The Social, Emotional and Economic empowerment through Knowledge of Group Support Psychotherapy (SEEK-GSP) Cluster Randomized Trial: Recruitment and Baseline characteristics (Preprint) 2. Nakimuli-Mpungu, E., Wamala, K., Okello, J., Ndyababangi, S., Kanters, S., Mojtabai, R., ... & Musisi, S. (2017). Process evaluation of a randomized controlled trial of group support psychotherapy for depression treatment among people with HIV/AIDS in Northern Uganda. Community mental health journal, 1-14. 3. Nakimuli-Mpungu, E., Musisi, S., Wamala, K., Okello, J., Ndyababangi, S., Mojtabai, R., ... & Mills, E. (2017). The Effect of Group Support Psychotherapy Delivered by Trained Lay Health Workers for Depression Treatment Among People with HIV in Uganda: Protocol of a Pragmatic, Cluster Randomized Trial. JMIR research protocols, 6(12), e250. 4. Nakimuli-Mpungu, E, Wamala, K, Okello, J et al. Group support psychotherapy for depression treatment in people with HIV/AIDS in northern Uganda: a single-centre randomised controlled trial. Lancet HIV. 2015; (published online April 1) [http://dx.doi.org/10.1016/S2352-3018\(15\)00041-7](http://dx.doi.org/10.1016/S2352-3018(15)00041-7) 5. Nakimuli-Mpungu, E., Wamala, K., Okello, J., Alderman, S., Odokonyero, R., Musisi, S., Ramin Mojtabai, & Mills, E. J. (2014). Outcomes, feasibility and acceptability of a group support psychotherapeutic intervention for depressed HIV affected Ugandan adults: A pilot study. Journal of Affective Disorders. 6. Nakimuli-Mpungu, E., Wamala, K., Okello, J., Alderman, S., Odokonyero, R., Musisi, S., & Mojtabai, R. (2014). Developing a culturally sensitive group support intervention for depression among HIV infected and non-infected Ugandan adults: A

qualitative study. Journal of affective disorders, 163, 10-17

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

Results of the cluster randomized trial were presented at the Global Ministerial Mental Health Summit that took place in London October 9-10,2018. Soft copies of the presentation can be obtained from conference organizers Briefly, Group support psychotherapy delivered by trained lay health workers effectively treats mild to moderate depression in persons living with HIV and this effect is sustained and greater in the long term (12 months after treatment. Group support psychotherapy delivered by trained lay health workers also effectively reduces post-traumatic stress symptoms and alcohol use among persons living with HIV. Most important of all is that Group support psychotherapy delivered by trained lay health workers improves viral load suppression among persons living with HIV.

LESSONS LEARNED AND RECOMMENDATIONS

Lessons learned and recommendations are outlined in this publication 2. Nakimuli-Mpungu, E., Wamala, K., Okello, J., Ndyabangi, S., Kanters, S., Mojtabai, R., ... & Musisi, S. (2017). Process evaluation of a randomized controlled trial of group support psychotherapy for depression treatment among people with HIV/AIDS in Northern Uganda. Community mental health journal, 1-14.

ANNEXES

Power point presentation made at the Global Ministerial Mental Health Summit that took place in London October 9-10,2018. The Clinical benefit and Cost-Effectiveness of Group Support Psychotherapy Delivered by Trained Lay Health Workers for Depression Treatment among People with HIV in Uganda: A Cluster Randomized Trial.

8.2 TITLE OF THE PROGRAMME: Young and free campaign

CONTACT PERSON

Name: Kateregga Joseph Denis

Title: Counsellor

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- **Programme is being implemented since:** Fashion and concert show
- **End date of the programme:** 2017
- **Responsible parties:** Private sector; UN or other inter-governmental organization; Academic institution
- **Population reached:** People living with HIV; People with mental health conditions; People who use substances, including alcohol; Indigenous and/or local communities; Migrants, refugees or internally displaced people; Children; Women and girls; Young people
- **Has the programme been evaluated/assessed?** No
- **Is the programme part of the National AIDS or Mental Health or Substance Abuse Prevention and Treatment Strategy?** No
- **Is the programme part of a national plan other than the National AIDS or Mental Health Strategy?** No

BACKGROUND

To find out those affected with HIV and those who're not but with goals and stigma. The programme seeks to protect those that have not been affected by HIV, the affected ones to be alive and happy, provide another lease of life to those with stigma and engage young people in productive things to avoid bad behaviours. Data is at Bulamu archives and Ministry of Health in conjunction with UNHCR.

DESCRIPTION

The objective is to end HIV by 2030 and implanted by an NGO as cooperate response to communities, it's coordinated by health service volunteers from hospitals and run by me. Financial sustainability is from concerts and charity shows.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

The program has enabled people to bring out their talents, end stigma and bring self-esteem to those affected. It has caused a new lease of life to the people affected with HIV, who dream bigger and have better drug adherence.

LESSONS LEARNED AND RECOMMENDATIONS

It is run by youths and since Uganda is made up of 78% youths below 30 years as released by monetary statistics on Uganda population. It involves talent shows, makes people dream bigger and education. It's direct teaching to end HIV through talents eg. music, dance and drama. It's competition that keep people focused and reward.

ANNEXES

Number captured

9. UNION DES COMORES

TITRE DU PROGRAMME : Si on arrive à avoir ce programme, il aura comme titre " vivre avec le VIH"

PERSONNE DE CONTACT

Nom : Said Hassane Charifa

Titre : Responsable de l'association TAS et Représentant de la communauté affectée et infectée par le VIH au sein du CCM Comores

Organisation : TAS (Tous pour Agir contre le Sida)

Adresse : Moroni - Union des Comores

Tél : 002693338046

Courriel : saidhassanecharifa@gmail.com

- **Date de début du programme** : N'ayant pas de programme aux Comores, l'un des combats de l'association est de mettre en place le plus rapidement possible le programme afin d'améliorer la santé des PVVIH.
- **Date de fin du programme** : NA
- **Responsable (s)**: Société civile
- **Groupe(s) de population atteint(s)**: Personnes vivant avec le VIH
- **Le programme a-t-il été évalué/analysé ?** Non
- **Le programme fait-il partie de la Stratégie Nationale de la Santé ?** Non
- **Le programme fait-il partie d'un plan national autre que la Stratégie Nationale de Santé Mentale ?** Non

INFORMATION DE BASE

Ce programme n'existe pas encore en Union des Comores mais nous voudrions de ce fait le mettre en place grâce aux connaissances que vous nous apporterez.

DESCRIPTION

Comme nous l'avons souligné plus haut, nous n'avons pas de programme mais nous intervenons auprès des PVVIH pour le suivi psychosocial tel que le soutien psychologique, l'adhésion au traitement, l'appui nutritionnel, partage d'expériences tout en ayant comme objectif d'avoir une confiance en soi et vivre avec la maladie. Les activités menées jusqu'aujourd'hui sont financées par le fonds mondial. La pérennité financière de nos activités est assurée par les activités de levée de fonds systématiques, une cotisation des membres de l'association. Notre principale partenaire est le fonds mondial à travers la Direction de Lutte contre le Sida.

Le nombre actuel de PVVIH suivis est d'à peu près une soixantaine de personnes qui ont un suivi régulier. Nous avons lutté pour avoir une psychologue, que chaque patient ait un kit nutritionnel

mensuel mais aussi qu'il ait à partir de janvier 2019 sa carte mutuelle de santé. Nous nous sommes également battus pour que la loi soit promulguée, ce qui permet actuellement de la vulgariser. Nous avons également un suivi préventif régulier de la coinfection TB/VIH.

RESULTATS, REPERCUSSIONS ET IMPACT DU PROGRAMMES

NA

ENSEIGNEMENT TIRES ET RECOMMANDATIONS

NA

ANNEXES

Autres messages :

Une prise en charge mentale des PVVIH en tant que telle avec un spécialiste en santé mentale n'existe pas encore aux Comores. Néanmoins, une association surnommée TAS (Tous pour Agir contre le Sida) intervient dans ce domaine en essayant d'aider psychologiquement les PVVHIH et les soutenir dans tous les domaines afin de mieux vivre la maladie. C'est dans cet optique que nous voulons mettre en place ce programme avec l'appui du psychologue nouvellement recrutée par la Direction de lutte contre le Sida afin d'améliorer la qualité de vie et le bien-être des PVVIH aux Comores. Cette réunion serait un moyen de connaître les différentes approches et thématiques déjà utilisées dans ce domaine pour continuer à la mise en place de ce programme en Union des Comores.

10.ZAMBIA

TITLE OF THE PROGRAMME: Litigation and advocacy to advance legislative reform on mental health

CONTACT PERSON

Name: Annabel Raw (SALC)

Title: Health Rights Lawyer

Organisation: Southern Africa Litigation Centre (SALC). Submission obo SALC, the Mental Health Users Network of Zambia (MHUNZA), the Treatment Advocacy and Literacy Campaign (TALC), and Validity

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- **Programme is being implemented since:** 2016
- **End date of the programme:** NA
- **Responsible parties:** Civil society
- **Population reached:** Persons with psychosocial disabilities; People living with HIV; People with mental health conditions
- **Has the programme been evaluated/assessed?** No
- **Is the programme part of the National AIDS or Mental Health or Substance Abuse Prevention and Treatment Strategy?** No
- **Is the programme part of a national plan other than the National AIDS or Mental Health Strategy?** No

BACKGROUND

Zambia applies an outdated legislative regime under the 1949 Mental Disorders Act which provides for the coercive and indefinite detention of persons in prisons and psychiatric facilities on suspicion of their psychosocial disabilities. The Act gives extensive powers to the Police and members of the community to arrest and detain persons with presumed mental health conditions without due regard to their rights to liberty, legal capacity, and procedural rights. As a result of the application of the Act, persons with psychosocial disabilities continue to suffer chaining, being restrained physically and chemically, isolation, deprivation of liberty, and abuse. Research by MHUNZA and Validity has shown that the provisions of the Act themselves are frequently misapplied, meaning that many people detained under its provisions have no legal basis for such detention, rendering it arbitrary under both national and international law. Moreover, many people have been documented to languish for decades at so-call "Mental Health Settlements." The Mental Disorders Act does not support community-based, human-rights affirming mental health services being provided to persons with mental health needs.

People who fall under the Act are physically and socially isolated and forced to access mental health services through centralised, detention-centric facilities. This perpetuates psychosocial disability and violates human rights. Mental health and disability activists in Zambia have for many years sought to document the barriers to HIV services for persons with disabilities (see for example: <https://www.hrw.org/report/2014/07/15/we-are-also-dying-aids/barriers-hiv-services-and-treatment-persons-disabilities>). In addition, the oppressive legal regime operates in pervasive ways to perpetuate the disempowerment of women and girls in particular, a social phenomenon that is known to drive inequality and vulnerability to HIV. For example, under the oppressive legal regime that denies people with psychosocial disabilities legal capacity while simultaneously excluding the possibility of any person deemed to be mentally disabled the ability to consent to sex through defilement laws, women and girls with presumed mental disabilities are caught between the criminal justice system's resistance to receive their testimony when subjected to sexual violence, and their exclusion from the possibility of exercising consent to marriage and sexual relationships. The drive to repeal the outdated Mental Disorders Act and enact rights-affirming laws is illustrating that the harms of discrimination and exclusion go both ways – not only are persons with psychosocial disabilities facing barriers to accessing HIV services, but the constrained and stigmatised access to mental health services in Zambia is a lived reality for all Zambians, which directly affects people living with HIV.

DESCRIPTION

Following years of activism and frustrations with delays in legal reform, in 2016, three persons with psychosocial disabilities and the Mental Health Users Network of Zambia (MHUNZA) brought a court case directly 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 Act by government. In addition, it ordered that mental health services must be provided at primary health care level and people treated with dignity and full respect for their rights. Since the judgment, MHUNZA and disability activists have used the judgment to push for new mental health legislation to be tabled. In recognition of the fact that mental health affects all Zambians and that the patterns of discrimination under the law and in society find intersectional applications, MHUNZA and others have been reaching out to HIV activists to support their efforts for reform.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

A successful judgment from the High Court has established a legal precedent and urgency for reform, creating further opportunities for building solidarity amongst activists in both HIV and disability rights. A new Bill is pending to be tabled soon in Parliament.

In November 2018, the Minister of Health, Dr. Chitalu Chilufya issued a statement detailing that Cabinet had approved the presentation to Parliament the repealing of the Mental Health Act which was last reviewed in 1951. The Minister said the repeal will remove any derogatory descriptions used to refer to mental patients and will provide for decent infrastructure and care for patients. It has taken approximately 15 years of ongoing work to reach this milestone. The Acting National Mental Health Coordinator at the Ministry of Health, Dr. Chioni Siwo has confirmed that the draft Bill will be tabled in parliament early December 2018. The content of the

Bill has not yet been made public and it is not known whether it is compliant with the Convention on the Rights of Persons with Disabilities (CRPD) or the Court order. While repeal of the Mental Disorders Act has been a key goal of the advocacy, activists continue to demand that the enactment of any subsequent legislation, if any is indeed necessary (something of debate amongst mental disability activists), that such legislation must be fully compliant with the CRPD, to which Zambia is a party.

LESSONS LEARNED AND RECOMMENDATION

The work of persons with psychosocial disabilities to liberate mental health from stigma and legislated abuse is an interest of immense potential value to advance the HIV response in Zambia. The integration of services and availability of mental healthcare at primary healthcare level as ordered through the High Court will expand access to both HIV services for mental health users and to mental health services for people living with HIV. Disability and HIV activists also have shared interests in addressing challenges to informed consent in healthcare, to the use of stigmatizing and degrading language, and in reducing the false distinctions between mental health users and other areas of health and rights. Moreover, important parallels must be recognized between the social determinants and structural barriers in realising mental health and responding to HIV. The excessive focus on biomedical approaches in both these areas undermines the significant driving factor of denials of human rights that perpetuate marginalisation and vulnerability to poor health.

ANNEXES

- 1) Bill brief: “Why is Enacting the Mental Health Bill Important for the HIV Response?” (2018)
- 2) Case booklet: “Reforming Zambia’s Mental Health Law: The Case of Mwewa and Others v. The Attorney General and Another”

11.ZIMBABWE

11.1 TITLE OF THE PROGRAMME:

Treatment of depression and non-adherence to people living with HIV in Harare, Zimbabwe

CONTACT PERSON

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Title:

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- **Programme is being implemented since:** March 2013
- **End date of the programme:** In progress
- **Responsible parties:** Government, Civil society, Academic institution
- **Population reached:** People living with HIV; People with mental health conditions; Indigenous and/or local communities
- **Has the programme been evaluated/assessed?** Yes, by University of Zimbabwe and Kings College London
- **Is the programme part of the National AIDS or Mental Health or Substance Abuse Prevention and Treatment Strategy?** Yes
- **Is the programme part of a national plan other than the National AIDS or Mental Health Strategy?** No

BACKGROUND

Zimbabwe is a Low income country (LIC) located in Sub-Saharan Africa with a population estimated at 16 million. At least 15% of the adult population are infected with HIV (UNAIDS 2015). Although 77% of people living with HIV in Zimbabwe are receiving antiretroviral therapy data on early indicators taken from a national sample shows evidence of problems in adherence to ART. Studies done in Zimbabwe have shown individual level barriers to adherence to include depression (Kufungisisa) (Kadia 2015). More than 30% of adults treated in Primary Health care facilities are said to have depression (Chibanda 2016). Other factors include poverty, beliefs about medicines, marital and disclosure issues (Kadia 2015). To address such barriers combined cognitive behavioural and educational interventions have been used and shown to work in encouraging the use of antiretroviral therapy and in some cases improving viral suppression Koenig et al., 2008; Simoni et al., 2009; Williams et al., 2006). There had been no studies done in Zimbabwe in this area until recently. Formative work done included culturally adapting the Lifesteps, a Psychological therapy developed for Art adherence (AD) in the United States (Bere 2016). We followed the ADAPT ITT model and locally named the

intervention Nzira Itsva (Bere 2016). Another study focused on an in depth understanding of beliefs about medicines (publication under peer review). Lifesteps was combined with the classical Problem Solving therapy (PST) to give the combined Tendai intervention (PST AD). A pilot randomised controlled trial was carried out at Parirenyatwa Hospital in Harare to see the feasibility and acceptability of the Tendai intervention. Parirenyatwa centre of excellence, is a government clinic . This clinic provides comprehensive HIV care for around 3000 adults and 1000 children on ART (Abas 2017). Registered patients receive clinical reviews, ART, HIV related prophylaxis, CD4T cell profile and Vlral load checks (Abas 2017). We recruited patients who had a detectable viral load (1000+ copies) and scored above cut off on the Shona Symptoms Questionnaire 14 (SSQ14)- (A screening tool for common mental disorders in Zimbabwe). Cut off score was 8/14. Results showed acceptability and feasibility of the intervention. The results also showed an improvement in adherence, viral suppression and depression outcomes as shown below (Abas 2017). Inclusion Criteria Age 18 years + On antiretroviral therapy for at least 4 months Score above cut-point for depression on locally validated scale (SSQ14) Indicator of poor adherence via any one of 1) missed clinic appointments 2) failing CD4 count 3) self-reported adherence problems 4) detectable viral load

Annexe 1 Results for the Pilot RCT

DESCRIPTION

Pilot RCT for Problem-Solving Therapy for Depression and HIV Medication Adherence (PST-AD) locally named Tendai. The intervention was a 6 sessions Task shifting intervention delivered over a period of 6 weeks. The intervention was delivered by primary care adherence counselors. In severe cases they referred patients to the Psychologist

Session 1: 50 min of the adapted Lifesteps locally named Nzira Itsva is the introduction of the adherence therapy , the culturally and linguistically adapted intervention Nzira Itsva has a series of motivational, informational, problem solving and behavioural steps. In the problem solving section of the intervention clients are encouraged to look at individual barriers to adherence and come up with a list of possible solution to try in the coming week. Barriers identified in the local context included 1. Getting to appointments (because of very constrained finances) 2. Asking questions from medical team, 3. Having a regular pill-taking schedule (which was especially hard where the person had not disclosed their status in the household) and, for women, dealing with ways in which their husband might be interfering with pill-taking. This first session included a detailed daily adherence data over the past 2 weeks generated by the Wisepill electronic device (for research) and self reports. Session 2: Problem solving Therapy for depression Included psycho-education about depression, eliciting, listing and reflecting back to the participant their problems; helping them to select one problem from the list to focus on- locally called Kuvhura Pfungwa Brainstorming solutions; rating them according to importance and feasibility and choosing a solution -Kusimudzira. Making a plan to implement it over the next week- Kusimbisa. This session included 5 minutes of follow up on Nzira Itsva first session. Session 3-6: Follow up for Nzira Itsva and Follow up for PST for depression happens which includes evaluating progress on generated solutions- Kusimbisisa. The main objectives of the study were to see how feasible the intervention would be in busy clinics, whether or not the intervention could be successfully conducted by non specialists and if it would improve depression, and viral load outcomes. Patients who were in the control arm received enhanced care counseling which included information about depression and treatment as usual. Stepped Care At session 4, the counselor repeated the SSQ-14 screening scale for depression. If the SSQ-14 score remained above 8/14 and/other adherence counselor would refer to the psychologist to see the client in session 5 as a joint session. The psychologist could advise the counselor and/or deliver Session 6 also as a joint session. The counselor repeated the

SSQ-14 assessment at Session 6.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

This was a pilot study done with 32 patients. The results were positive and promising. Results showed feasibility and acceptability of the intervention and have been discussed in a paper in the journal AIDS and behaviour (Abas 2017). The Tendai intervention has received funding from National Institute for Mental Health (NIHM) to carry out an RCT at a larger scale in rural Mashonaland East in Zimbabwe. This is a randomized controlled trial (N=290) will aim to test the effectiveness and cost-effectiveness of an intervention (TENDAI) vs. Enhanced Standard Care, targeting poor ART adherence and depression in participants attending ART clinics in rural Zimbabwe. Specifically, the aims of this study are: 1a) To evaluate the effectiveness of the task-shifted TENDAI intervention on viral suppression 12-months after randomization. 1b) To evaluate the effectiveness of task-shifted TENDAI intervention on ART adherence and on depression 4, 8, and 12-months after randomization. 2a) To test changes in adherence and depression between baseline and follow-up as theory-based mediators of the intervention effect on viral suppression. 2b) To test moderators (sex, depression severity) of the treatment effect on viral suppression, adherence, and depression. 3) To estimate the cost effectiveness of the task-shifted TENDAI intervention on viral suppression and quality of life 12-months after randomization.

LESSONS LEARNED AND RECOMMENDATIONS

For the pilot RCT we had the full support of the hospital and University staff at the clinic level. We worked with the ministry of Health- Mental health and TB and Aids departments ensuring the buy in from the policy makers. Ethics approval was granted by the University of Zimbabwe, Kings College London, Medical research council of Zimbabwe and the Parirenyatwa Joint research ethic committees. The participants were easy to recruit and willing to get help since depression is getting lots of attention in Zimbabwe. The RCT is starting in November 2018 and if results are positive we hope to scale this up to the 10 provinces in Zimbabwe. The only challenge we encountered was of the maintenance of wise pill boxes as they require electricity. In future use of other methods of adherence reporting will be useful e.g self or treatment buddies reports.

ANNEXES

Publications: Cultural adaptation of CBT to encourage ART, Feasibility and Acceptability of a Task-Shifted Intervention to Enhance Adherence to HIV Medication and Improve Depression in People Living with HIV in Zimbabwe, a Low Income Country in Sub-Saharan Africa, Table of Results., I was thinking too much Experiences of Adults living with HIV and depression in Zimbabwe.

11.2 TITLE OF THE PROGRAMME:

Mindful Arts Zimbabwe- Encouraging ART adherence and psychological well-being of Young People Living with HIV at risk of HIV treatment failure through engaging in a group support therapy.

CONTACT PERSON

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Title: Mr

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- **Programme is being implemented since:** June 2017
- **End date of the programme:** NA
- **Responsible parties:** Academic institution
- **Population reached:** People living with HIV; Young people
- **Has the programme been evaluated/assessed?** Yes, by a video from the Brit School in London
- **Is the programme part of the National AIDS or Mental Health or Substance Abuse Prevention and Treatment Strategy?** No
- **Is the programme part of a national plan other than the National AIDS or Mental Health Strategy?** No

BACKGROUND

Our program seeks to help young people living with HIV in Zimbabwe, struggling with poor adherence to antiretroviral therapy (ART) and emotional stress. Our program focuses on high risk young people aged 17-24 living with HIV who are less than optimally engaged in HIV care. Inclusion criteria is a persistent high viral load as shown by viral load blood test result, or poor clinic attendance. Viral non-suppression has serious health consequences, including drug resistance, opportunistic illnesses and untimely death. A detectable viral load also has public health implications as viral suppression is necessary to reduce infectivity to sexual partners and new born infants. Young people aged 17-24 are at high risk of non-adherence to ART. Population level estimates of viral load suppression for young women in seven countries in Eastern and Southern Africa reveal only 45% are virally suppressed [1]. In Zimbabwe only 38% of young people attending Parirenyatwa Hospital were virally suppressed in the last 4 months. Stigma and discrimination, lack of social support, HIV nondisclosure, and beliefs about medication act as barriers to adherence in sub-Saharan Africa [2]. Psychosocial factors including emotional stress and depression are consistently associated with non-adherence. Emotional stress and depression in Zimbabwe are common and most patients do not receive effective treatment [3]. In Zimbabwe, access to mental health treatment is severely restricted by limited mental health workforce, with only 14 psychiatrists serving a population of 16 million [4].

Task shifting has been an effective strategy for addressing shortages in health care professionals, and is essential in this context. Young people face unique challenges such as coping with developmental change, parents' illness or death, loneliness and low self-esteem. Reviews of youth-focused interventions have found that successful interventions to improve adherence to ART include interactive reminders, problem solving, patient and caregiver education, and peer support [5, 6]. Adherence counselling alone has been found to be inadequate. Developing interventions within the broader psychosocial issues present in the lives of youth in Zimbabwe is essential. There is a desperate need to find innovative ways to engage young people and encourage peer support and motivation. Effective support could improve engagement in HIV care and allow participants to attain all the benefits of effective antiretroviral therapy. Utilizing the Arts may be an innovative way to engage young people, build self-esteem and facilitate peer support. Participatory arts groups have benefits for mental wellbeing in people experiencing mental health problems [7]. Creative activity can help participants focus on positive life experiences and enhance self-esteem. It is widely documented that the arts can facilitate the development of social relationships and networks, which is particularly valuable for socially marginalised groups [8]. A programme using the Arts to build self-esteem and engage young people with poor adherence and emotional stress, before introducing adherence counselling has been piloted with a small group of 21 young people aged 17-25 in Harare. 16 participants referred by a hospital clinic were sub-optimally engaged in HIV care, with most having persistent high HIV viral loads and emotional stress. A further five HIV positive young people from the Zvandiri HIV charity joined the group. This four-month programme led by a Zimbabwean musician in partnership with King's College London, comprised of 14 sessions each lasting 2 hours and included music, meditation, movement, drama, art and poetry alongside optional counselling. After the first six sessions the clinical psychologist introduced "Positive Steps" adherence counselling to encourage problem solving around barriers to adherence. There was greater than 80% attendance to all the 14 sessions of the group.

DESCRIPTION

The programme goal is to improve engagement in health care in young people living with HIV aged 17-24 with poor adherence to ART. This will include improving ART adherence and achieve viral suppression, building motivation and peer support, reducing stress and isolation and improving mood. We will engage 40 high risk young people using a creative arts activities group. The group will include music, drama, dance and meditation alongside adherence counselling. We believe that through the group, young people will find self-expression and relaxation improves their understanding of mental and physical health. We anticipate that through adherence counselling the young people will develop the problem-solving skills and knowledge of ART to adhere to their medication and attend scheduled clinic appointments. As the group sessions progress, we will encourage the young people to develop safe income generating projects. We predict the income-generating project will reduce financial dependence and improve economic conditions resulting in improved retention in HIV care. This will be conducted through a total of 12 sessions. The first 10 sessions will focus on creative arts and relaxation techniques, where there will be optional counselling for emotional stress available to the participants during the first 5 sessions. Group adherence counselling will be held in sessions 6 to 10. Session 9 to 12 will include livelihoods training for economic empowerment. Booster sessions will take place 5 weeks after session 12. Follow up will be at 3 and 6 months, with data also collected at baseline before the creative arts activities begin. The programme is curated by Tariro NeGitare and supported by the Brit School, London. Kings College London is one of the partners and is supported by AHF- Parirenyatwa Centre of Excellence.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

The program aims to support a total of 40 young people aged 17-24 registered with any HIV clinic in Harare, with emotional stress who are recognized at high risk of HIV treatment failure. Our program will impact 40 young people (in two groups of 20) in the first instance. Participants will participate in all activities detailed in the program structure, including creative arts, group adherence counselling and economic empowerment. 6-8 participants from each group will be selected and trained to deliver parts of the program to develop a sustainable model. Improved ART adherence will have an impact on participant's overall health and vulnerability to opportunistic infections. The program also aims to reduce emotional stress to improve physical and mental health.

LESSONS LEARNED AND RECOMMENDATIONS

We anticipate that the program will be integrated in to care though organizations such as Zvandiri charity in the future. 6 – 8 participants from each group of 20 will be trained to deliver the program to ensure task shifting is utilized to develop a sustainable model.

ANNEXES

NA

11.3 TITLE OF THE PROGRAMME:

An adapted intervention for problematic alcohol use in people living with AIDS and its impact on alcohol use, general functional ability, quality of life and adherence to HAART: A cluster randomized control trial at Opportunistic Infections Clinics in Zimbabwe.

CONTACT PERSON

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- **Programme is being implemented since:**
- **End date of the programme:** 20th May 2018
- **Responsible parties:** Academic institution
- **Population reached:** People living with HIV; People who use substances, including alcohol
- **Has the programme been evaluated/assessed?** Yes, by principal investigators and researchers
- **Is the programme part of the National AIDS or Mental Health or Substance Abuse Prevention and Treatment Strategy?** No
- **Is the programme part of a national plan other than the National AIDS or Mental Health Strategy?** No

BACKGROUND

Alcohol use is common in people living with HIV. Alcohol use interacts with HIV throughout the HIV treatment cascade. Alcohol has the potential to delay the achievement of the 90-90-90 goals therefore. Psychosocial treatments are the mainstay of treatment for alcohol use. There have been calls to institute the alcohol use interventions in PLWH. The aim of this study was to assess the efficacy of an alcohol use intervention in PLWH in Zimbabwe through a task-sharing model.

DESCRIPTION

The study aimed to 1. Assess the effectiveness of an alcohol use intervention based on motivational intervention in PLWH and compared it to the WHO MH GAP IG. 2. To assess the utility of nurses in delivering an intervention through a task-sharing model. 3. To assess the

effects of the intervention on alcohol use, viral load, CD4, functionality and quality of life. The project was funded through an NIH traineeship program, Wellcome trust grant and National Research Foundation in South Africa. The government hospitals, church hospitals and City Health Clinics were the major partners.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

The study enrolled 236 participants, through 9 provinces of Zimbabwe at 16 HIV care clinics. The project was integrated into the day to day HIV care. The project resulted in notable improvement in quality of life. Although alcohol use is associated with HIV transmission, adherence to treatment, increased physiologic harm and worse retention in care yet, few clinical trials targeting unhealthy alcohol use in people living with HIV (PLWH) have been undertaken (Brown, DeMartini, Sales, Swartzendruber, & DiClemente, 2013; Justice et al., 2016; Marshall et al., 2017; Monroe et al., 2016). A recent systematic review found alcohol use was one of the key determining factors of adherence to HIV treatment (Azar, Springer, Meyer, & Altice, 2010; Heestermans, Browne, Aitken, Vervoort, & Klipstein-Grobusch, 2016). Research on psychological or behavioural interventions for alcohol use have not provided consistent evidence for their effectiveness in PLWH (Brown et al., 2013; Samet & Walley, 2010). While, Zimbabwe has 1.6 million PLWH and 6.0 litres per capita alcohol consumption and the deleterious effects of the combination of HIV and alcohol use are known, the Zimbabwe National AIDS Council 2015-2020 HIV Strategy, has no policy initiatives that address alcohol use (nac.org.zw/hiv-and-aids-situation/; www.who.int/substance_abuse/publications/global_alcohol_report/profiles/en/). The aim of this dissertation was to assess the effectiveness of psychological interventions for alcohol use in PLWH through a cluster randomised controlled trial (RCT) in order to inform future policy on interventions for them in Zimbabwe. Systematic review of interventions for alcohol use disorders A systematic review to synthesize the evidence of the effectiveness of psychological interventions for unhealthy alcohol use in PLWH was carried done. The primary outcome for the review was a reduction in the frequency of alcohol use. The secondary outcomes were the effects of the interventions on CD4 count, viral load, other substances use, risky sexual behaviour and quality of life. The participants were PLWH receiving care at hospitals, clinics and communities. Experimental studies have shown that the daily allowable alcohol intake for PLWH, especially if they have not achieved viral suppression, needs to be lower than 21 units per week for males and 14 units per week for females as PLWH, they need less alcohol to get intoxicated and suffer physiologic harm from a lower quantities of alcohol (Braithwaite et al., 2008; Cook et al., 2017; Justice et al., 2016; McGinnis et al., 2016). Damage to the liver due to alcohol use and hepatitis C, which are both associated with HIV, have been associated with a reduction in the effectiveness of antiretroviral therapy and poorer treatment response (Fuster et al., 2016; Kresina et al., 2002; Sonderup & Wainwright, 2017). Both the quantity and the frequency of alcohol intake have been found to adversely affect viral suppression (Braithwaite et al., 2005; Canan et al., 2017). Our review identified 14 studies that met the eligibility criteria, three from Africa and the rest from US. Heterogeneity in the measurement of alcohol use outcomes did not allow for a meta-analysis to be carried out. The overall quality of studies was moderate to low on account of selection and attrition biases. The main findings of the review were that (i) motivational interviewing alone and with adjunctive mobile technology and (ii) cognitive behavioural therapy alone reduced alcohol consumption frequency. The findings of our review are similar to two previous systematic reviews (Brown et al, 2013 and Samet et al, 2010) but differed from a recent systematic review by Scott-Sheldon et al (2017), who found evidence for behavioural/psychological interventions on alcohol consumption, condom use and adherence to treatment in PLWH (Brown et al., 2013; Samet & Walley, 2010; Scott-Sheldon, Carey, Johnson, Carey, & Team, 2017). More randomised controlled trials are needed

LESSONS LEARNED AND RECOMMENDATIONS

With the advent of antiretroviral therapy, the HIV pandemic has become a chronic illness requiring lifelong treatment. The 90-90-90 strategy, adopted by UNAIDS, aims for (i) 90% of HIV infected persons knowing their status, (ii) 90% on antiretroviral therapy; and (iii) 90% achieving viral suppression. The goal is to reach these aims by 2020. Alcohol use affects the attainment of the 90-90-90 goals. Research shows that people living with HIV (PLWH) drink twice as much as their HIV negative counterparts. Alcohol use disorders (AUD) in PLWH are associated with poor adherence to ART. Recommendations have been made to include interventions for AUDs in HIV prevention and treatment strategies. Brief interventions are recommended for hazardous alcohol use; however, for alcohol dependence a stepped care model incorporating behavioural/psychological treatments and pharmacological interventions may be required. Pharmacological treatments may lead to a higher pill burden and psychological interventions are, therefore, the treatment of choice. Psychological interventions have traditionally been delivered by a highly skilled workforce. However, in low and medium income countries (LMIC) where the HIV prevalence is high, there is a shortage of a skilled workforce. Task sharing has been recommended as a way of scaling up the delivery of services. The aim of this study was to adapt an evidence-based intervention for HIV and AUDs in Zimbabwe and to assess its effectiveness in a cluster randomized controlled trial (RCT). To achieve this, we first conducted a systematic review of the evidence for the effectiveness of psychological interventions. Second, a qualitative study was done to understand knowledge and perceptions of AUDs among PLWH and potential barriers and facilitators of interventions for AUDs. Third, we conducted a pilot and feasibility study in preparation for the RCT. The systematic review found limited evidence for the effectiveness of psychological interventions for AUDs, particularly on the frequency of drinking. Motivational interviewing (MI) alone and in combination with mobile technology, and cognitive behavioural therapy (CBT) were found to be effective. Additionally, MI was effective in reducing risky sexual behaviour, adherence to ART, other substance use disorders, viral load reduction, and increase in CD4 count. The qualitative study found that PLWH had adequate knowledge of the direct and indirect effects of alcohol use on HIV transmission and adherence to treatment, and were concerned about the stigma faced by PLWH who have and AUDs. Furthermore, participants were concerned about the stigma faced by PLWH who have AUDs. They called for stigma reduction strategies to be implemented and were receptive of the idea of interventions for AUDs. Following a pilot study which indicated that an intervention for AUDs was feasible, a cluster RCT was carried out at 16 HIV care clinics. The adapted intervention included motivational interviewing blended with cognitive behavioural therapy (MI/CBT). The comparator intervention was the alcohol use section of the World Health Organisation (WHO) mental health Gap Action Program Intervention Guide (mh GAP IG). The MI/CBT and mh GAP IG interventions were delivered by registered general nurses (RGN) embedded in HIV care clinics. The primary outcome was a reduction in alcohol use as measured by the Alcohol Use Disorders Identification Test (AUDIT) score. Secondary outcome measures included: (i) HIV disease parameters, as measured by the viral load and CD4 count; (ii) functionality, as assessed by the WHO Disability Assessment Schedule (WHODAS 2.0); and (iii) quality of life, as measured by the WHO Quality of Life HIV (WHOQOL HIV). The cluster RCT demonstrated that RGNs can be trained to deliver an MI/CBT intervention for AUDs in PLWH. Additionally, the MI/CBT intervention significantly reduced alcohol consumption in PLWH.

ANNEXES

1. Protocol for the intervention; 2. Study findings

11.4 TITLE OF THE PROGRAMME: Primary counsellor programme

CONTACT PERSON

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- **Programme is being implemented since:** 2005
- **End date of the programme:** NA
- **Responsible parties:** Government
- **Population reached:** People living with HIV
- **Has the programme been evaluated/assessed?** Yes, Beatrice Dupwa PhD study (Mixed methods)
- **Is the programme part of the National AIDS or Mental Health or Substance Abuse Prevention and Treatment Strategy?** Yes
- **Is the programme part of a national plan other than the National AIDS or Mental Health Strategy?** No

BACKGROUND

In order to achieve the 90-90-90 goals while maintaining a quality service for people living with HIV, innovative programmatic strategies for differentiated service provision along with quality service provision, data management active engagement of expert clients and the community at large are needed. The Ministry of Health and Child Care developed an Operational and Service Delivery Manual (OSDM) which outlines the “what to do” and job aide which give guidance on the “how to do it” with the aim of increasing retention at all steps of the cascade accompany the 2016 clinical guidelines. The 2016 guidelines incorporated screening of mental health signs and symptoms for clients coming after defaulting treatment and with high viral loads. Then referral and linkages are done depending on the scale. The new global 90–90–90 targets call for 90% of all people living with HIV to be diagnosed, 90% of people with HIV diagnosed to receive ART and 90% of those on ART to have a suppressed viral load by 2020 (Treves-Kagan et al., 2016). The first 90 (diagnosis of HIV) is essential to the second 90 (initiation of ART among people with HIV) and the ultimate outcome of the third 90 (viral load suppression among people on ART), improves client outcomes and prevents HIV transmission (Treves-Kagan et al., 2016). The introduction of “Treat All” and the intention to meet the 90-90-90 targets and end AIDS by 2030 in Zimbabwe, requires innovative strategies to identify those who currently do not know their HIV status, link them to care and retain them on ART within a health system that is already

over-burdened. Provision of quality, accessible and acceptable HIV counselling services to all clients regardless of their differing needs in the health system is a critical component of the 90, 90, 90 HIV treatment cascade. The first 90 innovations for testing and counselling All service delivery points - including medical inpatient and outpatient facilities provide HIV testing and counselling services to attending patients at central, provincial, district, health centre and clinic levels as part of the standard of care in Zimbabwe. Clients testing HIV positive are linked to ART services for continuing care. The second 90: Psychosocial readiness for clients who are to start ART The primary counsellor has a key role to prepare and ensure readiness of newly diagnosed HIV positive clients to be started on ART. All clients on ART should be screened for depression and anxiety annually Clients with red-flag characteristics (VL >1000 copies/ml, signs of clinical failure, missed appointments) should be screened for symptoms of depression and anxiety. The third 90: Viral load suppression and enhanced adherence counselling, the client should be seen by the counsellor to start enhanced adherence counselling on the day the result is given. The high viral load form should be filled at each counselling session as this will facilitate the multi-disciplinary discussion of the client when being considered for second-line treatment. The first session of enhanced adherence given on the day the viral load result is given is to discuss possible behavioural, cognitive, emotional and socio-economical barriers to adherence. After presenting the result, the best way to start the session is to ask the patient: What do you think is the reason for your high viral load? In addition, exploring the client's motivation for taking medication often highlights reasons for non-adherence. Clients with high viral load should also have a formal mental health assessment, including the use of alcohol and other substances of misuse. The second session is done four weeks later, and is aimed at following up the strategies put in place during the first session. If the client requires a third or more intensive adherence support, this is provided on a case-by-case basis. With the client's permission, they are linked with expert clients for additional support.

DESCRIPTION

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ART services for continuing care. The second 90: Psychosocial readiness for clients who are to start ART The primary counsellor has a key role to prepare and ensure readiness of newly diagnosed HIV positive clients to be started on ART. All clients on ART should be screened for depression and anxiety annually Clients with red-flag characteristics (VL >1000 copies/ml, signs of clinical failure, missed appointments) should be screened for symptoms of depression and anxiety. The third 90: Viral load suppression and enhanced adherence counselling The client should be seen by the counsellor to start enhanced adherence counselling on the day the result is given. The high viral load form should be filled at each counselling session as this will facilitate the multi-disciplinary discussion of the client when being considered for second-line treatment. The first session of enhanced adherence given on the day the viral load result is given is to discuss possible behavioural, cognitive, emotional and socio-economical barriers to adherence. After presenting the result, the best way to start the session is to ask the patient: What do you think is the reason for your high viral load? In addition, exploring the client's motivation for taking medication often highlights reasons for non-adherence. Clients with high viral load should also have a formal mental health assessment, including the use of alcohol and other substances of misuse. The second session is done four weeks later, and is aimed at following up the strategies put in place during the first session. If the client requires a third or more intensive adherence support, this is provided on a case-by-case basis. With the client's permission, they are linked with expert clients for additional support.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

Primary counsellors were effective in providing counselling services that ensured the majority of the clients on first line treatment with a few on second line and none on third line treatment regimen. While clients had adherence strategies, the predisposing factors for non-adherence were emotional, social and physical challenges, non disclosure, stigma, discrimination and treatment fatigue. Primary counsellors were effective and equipped in the use of counselling tools, skills and techniques, client centred and family centred approaches to provide enhanced adherence counselling as well as psychosocial support coordination working with expert clients in defaulter tracing and remotivation of clients to achieve reduced viral loads. Thus, without follow up counselling and support, clients may default treatment. There is need for targeted HIV and mental health programmes to ensure provision of quality counselling and psychological services for both gender with special attention to women and young people of the 15- 24 age group who are mostly affected. The HIV and mental health services to cover clients newly HIV diagnosed, just initiated on ART, diagnosed with viral load failure and others (co infected with TB and HIV, drug induced - Efavirenz induced defaulters, on second line treatment, with marital problems and discordant couples and stage 4 HIV and cancer. Psychosocial support coordinated by primary counsellors was effective in ensuring adaptation to lifestyle among for some clients and were able to meet the mental health needs of clients as reflected by the absence of mental health signs and symptoms after counselling service provision. It was however noted that, psychologists were only available at central hospitals and beyond referrals and linkages was mainly with nurses. While nurses were supposed to supervise and mentor primary counsellors on HIV counselling, the nurses were not well equipped to provide support in counselling services.

LESSONS LEARNED AND RECOMMENDATIONS

Changes in HIV and mental health as primary counselling occurs • There is need for targeted HIV and mental health programmes to ensure provision of quality counselling and psychological services for both gender with special attention to women and young people of the 15- 24 age group who are mostly affected. The HIV and mental health services to cover clients newly HIV

diagnosed, just initiated on ART, diagnosed with viral load failure and others (co infected with TB and HIV, drug induced - Efavirenz induced defaulters, on second line treatment, with marital problems and discordant couples and stage 4 HIV and cancer. • The study revealed that, psychosocial support coordinated by primary counsellors was effective in ensuring adaptation to lifestyle among for some clients and were able to meet the mental health needs of clients as reflected by the absence of mental health signs and symptoms after counselling service provision. It was however noted that, psychologists were only available at central hospitals and beyond referrals and linkages was mainly with nurses. While nurses were supposed to supervise and mentor primary counsellors on HIV counselling, the nurses were not well equipped to provide support in counselling services. Service coverage and experiences of primary counsellors in Zimbabwe • There is great potential for improvement of this cadre to offer services beyond HIV counselling. • The primary counsellors have been instrumental in the coordination of linkages and referral of clients to critical services at different levels of care. There is need for continued support and coordination for the clients in need of HIV and mental health services. • Looking at clients' diverse needs it is recommended that the cadre continue to provide counselling services. The psychological services model recommends upgrading of the primary counsellor to therapist level with referral to specialists in psychological services in the MOHCC to manage the psychological component of clients with primary counsellors working under the psychological services rather than the over stretched nursing department for effective management, mentorship, support and coordination. • Capacity build primary counsellors and other psychosocial service providers (nurses, adult expert clients and adolescent expert clients) on skills to fighting stigma, mentorship and support opportunities which include case conferencing and debriefing to discuss difficult and complicated cases.

ANNEXES

PowerPoint Presentation: "Efficacy of primary counsellor programme in HIV counselling in Zimbabwe" Chinhoyi University of Technology Thesis (2013-2018), Beatrice Dupwa

11.5 TITLE OF THE PROGRAMME:

TENDAI - Task-shifting to treat Depression and non-Adherence to HIV medication

CONTACT PERSON

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- **Programme is being implemented since:** 2014
- **End date of the programme:** NA
- **Responsible parties:** Government; Academic institution
- **Population reached:** People living with HIV; People with mental health conditions; People who use substances, including alcohol; Indigenous and/or local communities; Women and girls; Young people
- **Has the programme been evaluated/assessed?** Yes, through an NIH R21 grant to Dr M. Abas et al.
- **Is the programme part of the National AIDS or Mental Health or Substance Abuse Prevention and Treatment Strategy?** No
- **Is the programme part of a national plan other than the National AIDS or Mental Health Strategy?** No

BACKGROUND

This program targets adults who have had a detectable viral load in the past 1-2 months, either following routine testing or from viral load screening of high-risk groups (e.g. PLWH with missed appointments, or those who self-report adherence problems). In terms of routine testing, the National Strategy allows for routine viral load (VL) testing six months after ART initiation. Those who are suppressed (currently defined as VL<1000 copies/mL) have an annual blood test thereafter. Those with a detectable viral load six months after initiation, or from routine annual tests, or because of being tested for clinical indication, receive standard of care enhanced adherence counselling, and a repeat VL after three months. Our intervention is an alternative to the standard of care enhanced adherence counselling, and is especially suitable for those with depression, as it includes Problem-Solving Therapy, a simple talk therapy for depression. Since our initial grant was completed in 2016, a local clinical psychologist has continued to implement the program in a clinic serving over 3000 PLWH in Harare, Zimbabwe. We have adapted the format to be suitable for delivery for young people aged 17-26 with persistently poor adherence

- in this case we provide the intervention in groups. The MoH in Zimbabwe is extremely interested and would be willing to look at implementing this intervention on a wide scale. However, we are embarking with them on a large effectiveness trial in rural Zimbabwe over the next five years, 2018 - 2023.

DESCRIPTION

Depression affects one in four people living with HIV (PLWH) in Sub-Saharan Africa, being associated world-wide with economic and educational disadvantage [1]. Depression is consistently associated with worse adherence to antiretroviral therapy and viral non-suppression (ART) [2, 3]. Finding ways to help PLWH maintain adequate adherence on first and second-line ART regimens is critical, given the unaffordability of third-line regimens across most of the public care system in the south and eastern Africa. Treatment for depression can therefore be a matter of life or death for those living with HIV. But there is a vast treatment gap for depression and other mental disorders in low resource settings. Zimbabwe has the 5th highest prevalence of HIV globally, with high rates of viral non-suppression at population level and of drop-out from HIV care. Zimbabwe also has an extremely low ratio of psychiatrists and psychologists to the general population: somewhere close to 2 specialists per million people. In 2010, government funded mental healthcare was less than 1% of the overall budget. Evidence from the US. In the U.S., trials have shown that adherence interventions which include motivational and visual educational techniques, with problem-solving around barriers to adherence, are more effective for improving adherence than basic education and advice giving [4, 5]. One such intervention is Life-Steps, developed by Steven Safren. And yet, across most low-income countries, including Zimbabwe, adherence counsellors rely on the less effective styles like didactic advice giving delivered verbally, and scare tactics. In the US, Cognitive Behavioural Therapy for Adherence and Depression (CBT-AD) has been developed which blends Talking Therapy for Depression with Life-Steps for non-adherence. A pilot efficacy trial [6] of CBT-AD showed that patients with HIV and clinical depression randomized to CBT-AD had better improvements in electronically measured adherence, viral suppression and depression than those who received enhanced treatment as usual. These gains were maintained at 12 months. An efficacy trial in substance users (N=89), compared CBT-AD to enhanced treatment as usual (ETAU) [7]. HIV-positive patients with substance use histories who had a clinical diagnosis of depression were enrolled. Those receiving the treatment had better adherence and improved depression (independently assessed) than those in ETAU. The results were maintained for depression at 12 months, and the adherence gains were maintained at follow-up for those who did not experience substance use relapse [8]. Treatment-related changes in adherence were mediated by treatment-related changes in depression [9]. A full-scale efficacy trial with three arms (CBT-AD, ETAU, and informational/supportive psychotherapy integrated with adherence counselling), was conducted to test CBT-AD in HIV care. Findings demonstrated that CBT-AD was superior to ETAU in MEMS-based adherence and depression after treatment discontinuation, and that these differences were maintained over follow-up. In short, CBT-AD has generally been a successful approach to treating depression and improving adherence. CBT is the most studied and efficacious psychosocial treatment for depression, and the track record is strong of integrating CBT for depression with adherence counselling (CBT-AD) in PLWH. Given evidence of efficacious interventions from the US, & given the high rates of depression, nonadherence, and treatment failure in resource limited settings, our group has been adapting and testing empirically supported adherence and depression interventions in Zimbabwean people with viral non-suppression. Our intervention TENDAI, blends Problem Solving Therapy, a simple cognitive behavioural intervention for depression, with an adapted form of Life-Steps for adherence. This

means we have a simple culturally-adapted version of CBT-AD for use in low-resource settings

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

We validated translated the Patient Health Questionnaire (PHQ-9) for Depression into the Zimbabwean Shona and Ndebele languages in a primary care sample of 264 adults of whom 63% were PLWH. The optimal cut-off for PHQ-9 was >11, providing sensitivity of 85% (95%CI:78-90%), specificity of 69%(95%CI:59-77%), 78% of cases correctly classified, and high reliability (Cronbach α =0.86) against a SCID diagnosis of depression. We adapted and evaluated The Life-Steps adherence intervention [4] for Zimbabwean context through formative work, including analysis of 47 in-depth interviews with PLWH and health staff to gather data on local barriers to adherence [11]. Modifications to Life-Steps included language, session length, tailoring of context for delivery by lay counsellors, and inclusion of culturally-competent probes [12]. The culturally adapted adherence intervention was called Nzira Itsva, which translates as New Direction. We tested in over 90 PLWH. It was found to be acceptable, feasible, and associated with improved adherence [12]. Through an open trial (n=9), we integrated treatment for depression with the adherence intervention. TENDAI is the name of this intervention, which stands for Task-shifting to treat Depression and non-Adherence to HIV medication. TENDAI comprises six sessions of individual Problem-Solving Therapy for depression and adherence to ART delivered by an HIV counsellor. For those whose depression does not respond, the intervention includes the option of 2 levels of stepped care for depression: additional psychological therapy (Step 2) and an antidepressant (Step 3), each provided by a more qualified cadre with supervision from a mental health clinician. We have conducted a feasibility study using a pilot trial design. 32 participants (65% female) were randomized to either the TENDAI PST-AD intervention or enhanced usual care (EUC). Acceptability of TENDAI was high for participants and adherence counsellors, as demonstrated through qualitative interviews and 85% attendance to at least 5 of the 6 sessions. Participants receiving TENDAI saw significant improvements in depression on the PHQ-9 for depression, compared to EUC (PHQ-9; -4.7,95%CI: -8.2,-1.3, adjusted p=0.01) [13] [12]. The study was not intended to be powered to detect statistically significant differences between the treatment arms, but more participants receiving TENDAI had a greater absolute increase in 90% adherence (25%) than in EUC (14%). Promising changes were seen in viral suppression (TENDAI arm 9/12 suppressed vs EUC arm 4/8 suppressed). We have previously provided evidence of an effect of PST on depression in PLWH in Zimbabwe from our recently completed trial of the Friendship Bench [14]. Of the 563 participants, 283 (42%) were PLWH; the prevalence of depression after 6 months in PLWH was 21% in the intervention arm compared to 46% in the control group (prevalence ratio=0.43; 95%CI 0.26, 0.70). " TENDAI...is designed to uncover our participants' natural problem-solving abilities to enable them to re-engage with the activities of their lives in a way that will protect their mood going forward and empower them to be more effective managing HIV, their health, and their own self-care ". We are currently conducting an effectiveness trial of TENDAI to learn more about its implementation in a provincial hospital and a district hospital in rural Zimbabwe. This will include an economic evaluation.

LESSONS LEARNED AND RECOMMENDATIONS

we developed this slowly, with a lot of consultation with local HIV clinicians, local mental health specialists, and peer counselors and adherence counselors. this helped guide us to focus on people with poor ART adherence, rather than just depression. We ensured the program dovetails with the national HIV strategy. The MoH AIDS and TB Unit, medical staff including provincial medical superintendent have been engaged and facilitated the plans for the ongoing

effectiveness trial. the initial grant from NIMH, which allowed us to do proper formative work and pilot testing, was a game-changer. we received excellent support from our program officer at NIMH and latterly Dr Dianne Rausch herself, Head of the Division of AIDS. Collaboration with experts such as Steven Safren and Conall O'Cleirigh from Harvard was very helpful.

Dr Tsitsi Apollo, Deputy Director AIDS and TB Unit, Ministry of Health Zimbabwe, said, 'TENDA is an excellent opportunity for collaboration between the Zimbabwe Ministry of Health and Child Care and researchers from different backgrounds, to explore and find interventions that are context-relevant to address depression and poor adherence for those who are virally non-suppressed'

ANNEXES

NA

11.6 TITLE OF THE PROGRAMME: The Friendship Bench

CONTACT PERSON

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- **Programme is being implemented since:** 2007
- **End date of the programme:** NA
- **Responsible parties:** Government, Academic institution
Population reached: People living with HIV; People with mental conditions
- **Has the programme been evaluated/assessed?** Yes, the efficacy and feasibility of the Friendship Bench intervention has been evaluated through a pilot intervention study (Chibanda et al., 2011). A mixed methods study to evaluate the acceptability and implementation of the intervention was funded by Grand Challenges Canada (Abas et al., 2016).
- **Is the programme part of the National AIDS or Mental Health or Substance Abuse Prevention and Treatment Strategy?** No
- **Is the programme part of a national plan other than the National AIDS or Mental Health Strategy?** Yes, the municipal councils in three Zimbabwean cities are funding the scale up of the Friendship Bench intervention.

BACKGROUND

The population of Zimbabwe is estimated at 13.1 million. The estimated HIV prevalence in 2015 is 14.7% among those between 15-49 years. The HIV annual incidence estimate in that age group for 2015 is 0.88%. Treatment coverage in 2014 was at 65% of the total estimated antiretroviral treatment (ART) program need of 1,152,077 persons. Currently, ART initiation continues at 12,300 persons per month, however, insufficient funds for ARVs is key to the major gap in achieving high ART coverage and epidemic control. Epidemiological data indicate that 80% of people living with HIV (PLHIV) and 80% of the treatment gap is concentrated in 36 districts, which include the major urban areas Harare, Bulawayo, Chitungwiza and Mutare. Prevalence of chronic mental disorders is extremely high among those on ART (61% versus 39%; $p < 0.001$).

DESCRIPTION

Currently, problem solving therapy is being implemented in several HIV treatment settings in Harare. A stepped care, lay health worker-delivered, brief psychological intervention focused on problem-solving—The Friendship Bench—has been tested in a randomized trial. The project was named the Friendship Bench because the lay therapists deliver the 6-session talk therapy intervention on a bench on the clinic grounds in a quiet, private outdoor space. The program is coordinated by Dr. Dixon Chibanda, one of the few psychiatrists in Zimbabwe. Over the years, the Friendship Bench has received funding and/or logistical support from Grand Challenges Canada, the National Institute of Mental Health (NIMH), the Centers for Disease Control and Prevention (CDC), and other institutions.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

The Friendship Bench has demonstrated effectiveness and feasibility in reducing depressive symptoms among people living with HIV. In the pilot intervention, the mean score of the Shona Symptom Questionnaire (SSQ) decreased from 11.3 to 6.5 after participants attended three to six Friendship Bench sessions. Findings also suggest that HIV-related problems, such as adherence, organically come out during the problem-solving sessions which have implications for HIV-specific outcomes that can be incorporated into the intervention. The success of the Friendship Bench intervention in Zimbabwe has garnered global attention. Recently, the Friendship Bench has been adapted by the New York City Department of Health and Mental Hygiene to address the heavy burden of mental illness in this major city and bridge the gap to effective screening and treatment. Chibanda, D., Mesu, P., Kajawu, L., Cowan, F., Araya, R., & Abas, M. A. (2011). Problem-solving therapy for depression and common mental disorders in Zimbabwe: piloting a task-shifting primary mental health care intervention in a population with a high prevalence of people living with HIV. *BMC public health*, 11(1), 828. Abas, M., Bowers, T., Manda, E., Cooper, S., Machando, D., Verhey, R., ... & Chibanda, D. (2016). 'Opening up the mind': problem-solving therapy delivered by female lay health workers to improve access to evidence-based care for depression and other common mental disorders through the Friendship Bench Project in Zimbabwe. *International journal of mental health systems*, 10(1), 39.

LESSONS LEARNED AND RECOMMENDATIONS

With funds from NIMH/DAR, the team is working to incorporate viral load testing into the Friendship Bench intervention. This will provide us with a biological measure to understand how treating depression impacts a patient's adherence to ART and subsequent viral load. The team has encountered challenges with follow-up viral load testing due to false home addresses from participants. This is largely due to the high HIV-related stigma and the fear among people living with HIV in the area. In addition to the ongoing recruitment of adult participants for the Friendship Bench, the team has received funding from NIMH/DAR to conduct formative research among adolescents living with HIV in Harare. Findings will be used to inform a version of the Friendship Bench intervention that aligns with the developmental state of adolescents.

ANNEXES

II. ASIAN STATES

12. BAHRAIN

TITLE OF THE PROGRAMME: HIV management program

CONTACT PERSON

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- **Programme is being implemented since:** 2011
- **End date of the programme:** NA
- **Responsible parties:** Government
- **Population reached:** People living with HIV; People with mental health conditions; People who use substances, including alcohol; Prisoners; Women and girls
- **Has the programme been evaluated/assessed?** A follow quality assessment by WHO
- **Is the programme part of the National AIDS or Mental Health or Substance Abuse Prevention and Treatment Strategy?** Yes, the National HIV Committee
- **Is the programme part of a National Plan other than the National AIDS or Mental Health Strategy?** No

BACKGROUND

Globally, an estimated 35.3 (32.2–38.8) million people were living with HIV in 2012. An increase from previous years as more people are receiving the life-saving Antiretroviral therapy. There were 2.3 (1.9–2.7) million new HIV infections globally, showing a 33% decline in the number of new infections from 3.4 (3.1–3.7) million in 2001. At the same time the number of AIDS deaths is also declining with 1.6 (1.4–1.9) million AIDS deaths in 2012, down from 2.3 (2.1–2.6) million in 2005.

The kingdom of Bahrain is a country in the Arabian Gulf; it has a population of 1,234,571. Since the beginning of the HIV epidemic, there has been strict screening program for HIV. In Bahrain there are currently 246 HIV patients living. The services that were given to the HIV patients were fragmented between primary care, secondary care, laboratory, pharmacy and the public health laboratory. There was no structured program to care of these patients. Proper follow up was difficult with missing appointments and hard to get labs to monitor their progress as the lab results were run between different labs.

Most of these patients were followed in the primary care health centers and were followed by a family physician. There is a good registry of all the patients who were positive and the data was closely monitored by the public health department. There have been several initiatives to improve the service without good results.

As per the reconditions internationally of the UNAIDS is to have 90% diagnosed, 90% on treatment and 90% controlled. So we are in this committee achieved this goal; within these seven years of work. We started in 2012 with only 39 patients on treatment currently we have 158 patients on treatment (64.2%), 97 of them are started on new treatment. 123 of them are active patients following their appointments which is 77.8% of the total patients receiving treatment, and 23 patients are missing their appointment equal to 14.5% of the total patients receiving treatment, and the rest of 65 patients we found that they are refusing treatment. So the new plan is to find out the reason why this patients are refusing the treatment and solve it, wither it is social problem, or psychological problem, or any other reason, with assist of public health, We are calling through the public health for the rest of this 88 patients which are not taking their medications.

The HIV management committee in Secondary care:

This committee worked to provide helps to the HIV patients, reduce the mortality, and follow up with the patients their treatment and investigations.

The importance of the committee is to solve patients' problems, ease their treatment, and reduce the cost of their treatment.

Purpose of the committee:

- Encourage other members from another department to cooperate and work together for easy and faster treatment;
- Reduce stigma for HIV patient.

DESCRIPTION

In 2011, a multidisciplinary team was established for HIV management involving major stakeholders: public health, infectious diseases, pharmacists, nursing and virologists. The team established a system which capture each step of patients care to improve its quality. It was established by under a higher authority in the secondary care. This team meets regularly, where we started with putting an action plans to form an integrated system to provide the best care for these patients.

The main objectives of this team were the followings:

- 1.To structure a program which optimize the patient journey.
- 2.To capture all the positive Bahraini patients and to improve their compliance
- 3.To introduce up to date new HIV medications
- 4.To implement the international guidelines for HIV management
- 5.To create and follow quality indicators that can measure the progress of the team work.
6. To eliminate the discrimination against HIV patients
7. To provide the prevention and treatment for all patients irrespective of their gender, sex, underlying diseases
8. To create a multisectoral approach to treat all patients

The HIV committee in Secondary care:

HIV care committee started on Jan-2011, under care of Dr. Jameela Al-Salman

The committee consists of eight members:

- (Chief of HIV Care Committee),
- (Consultant of the pathology / Microbiology SMC medical lab),
- (Public health consultant-Head of communicable diseases group),
- (ID Doctor),
- (ID Doctor),
- (head of Pharmacist),
- (Pharmacist Technician),
- (HIV Coordinator).

This committee worked to provide helps to the HIV patients, reduce the mortality, and follow up with the patients their treatment and investigations.

The importance of the committee is to solve patients' problems, ease their treatment, and reduce the cost of their treatment.

We started collecting the basic data which involved the followings:

1.First form: The demographic information about the patients, their risk factors, their progress and response to treatment and their follow up, their prevention protocol.

2.The second form include the serial of their blood tests specifically, HIV viral load, CD4 count and the genotyping.

3.Third form: Lists form the pharmacy where we assigned one pharmacist to look after these patients, where we get an updated list of the patients with their medications and if they missed taking them to call them urgently to ensure compliance.

We assigned a Nurse coordinator for the HIV service and who overlooks the whole process of data collection, entering and providing patient support services

These data were entered in a soft copy excel sheets to analysis the data. The data were followed up closely and discussed in regular meetings.

Over the same period we introduced new and updated HIV medications to increase the response rate to HIV medications. At the same time they were a lot of educational services provided to the staff. We are in the process of publishing patient educational materials.

A software database was established to include all patients: to record their visits, labs results, clinical progress, medications regimen and their appointments to flag missed ones.

Objective of the committee:

- a) Improve the quality of patients care.
- b) Provide social base and social support.
- c) Provide the best care to the HIV patients.
- d) Provide the medication as patient needs.
- e) Provide the needed lab test.
- f) Provide routine visit to the patients in the clinic.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

The program structure was reviewed regularly to optimize our services.

We have a great success over the last three years where we started with uncontrolled 39 patients on medications. Now, most of patients 158 on treatments have good results. The reminder is being tracked to start their treatment. Up to this date: we are following, 246 patients 158 of them are on regular medications.

200 patients are males and the rest 46 are females. Age range from 4 years to 73 years old. 97 patients have CD4 count < 200 (56%), (30%) of them have undetectable viral load. (The time of abstract submission), 7 patients have CD4 between 200 - 350 (4%), and 69 patients above 350. (39.8),

Educational sessions were given to health care workers to decrease HIV stigma and improve their care. We were able to conduct educational sessions in to primary care, secondary care, public health personnel and psychiatry health care workers. We educated around 1500 health care workers.

The new system improved the quality of care of HIV patients. Where we are able to increase the patients' compliance, increase the clinical response to treatment.

Achievements of the HIV care committee:

- Stigma training trainer Workshop.
- Yearly HIV symposium 1st, 2nd and 3rd.
- Trained around 300 staffs.
- Provide the medicine, and replace some medication which is not effective.
- To follow the blood tests and provide the best medical management for the patients and adjust the medication.
- Involve the public health to follow patients' lab test and prepare the result as soon as possible.
- Train a number of doctors to follow the patient medication and lab test and best practical guidelines.
- Collect all the information about the patients' medicine, CD4%, CD4 count and genotype it is make easy to follow patients' care.
- Provide a team work system for the best care of the patients
- Address the patients with mental health issues and working in collaboration with the psychiatry hospital to facilitate their treatment
- Address the patients with drug abuse and working in collaboration with the drug abuse unit in the psychiatry hospital I to facilitate their treatment
- All the team from each department working together, to make easy treating the patient.
- Side effect of the medicine is less.
- No repetition to the expensive blood test, as was happening in the past as it is monitored and regulated by the coordinator.
- Improvement in the patients' lab result. As at least half of the patients are controlled with undetectable viral load with the new system. This in oppose to the past where they were rarely controlled.
- Reduce the rate of mortality among the HIV patients.
- Decrease the number of inpatient admissions to the HIV patients over the last three years.
- Increase the average of HIV patients' age.
- A complete and regular Meeting and minutes.
- Brochures with information about the medications (under print).
- Increase the quality of the HIV care in Bahrain to be a unique model for the countries.
- A special program for the prisoners in collaboration with Ministry of interior

1. Prisoners are screened on entrance to the prison and on regular basis for HIV and other infections

2. Any case which is found to be positive for HIV referred to the center for treatment
3. All HIV patients in prison are entitled for free treatment like the other patients
4. All HIV positive patients in prison in Bahrain are in regular follow up in the clinic and receiving treatment
5. Close follow up with the medical team in prison to ensure the compliance of the patients
6. All HIV patients in prison are screened for TB and treated accordingly
7. All HIV patients in prison are screened for hepatitis C and B and treated accordingly

A unique approach for HIV patients with drug abuse problems and mental health issues:
Through three main venues we could provide the best care for HIV patients

8. The multidisciplinary approach for these patients:

- a. All positive HIV cases whether they are with mental health issues or drug users will be included in the program for treatment
- b. We follow these patients closely to ensure compliance through the medication's records in the pharmacy for refill and pick up of medications
- c. A patient support group has been created where the patients help each other and support each other and is led by one of the patients who was IV drug user
- d. Screening for high risk group in drug unit for HIV and other blood borne diseases
- e. We also provide to all these patients the prevention and treatment of hepatitis B and C.

9. The direct and open channel contact with the drug abuse unit: where we refer all the cases under treatment for HIV for their evaluation as needed and they referred all the cases screened for HIV for further management

- a. Once the patients are admitted under our care in the hospital, they are followed by both the infectious disease and the psychiatry physician

10. Special cases:

- a. Based on the needs of the patients and if they need continuous support and observation if they are mentally challenged we admit to the hospital for their own protection and to ensure that they are taking the medications as prescribed.

LESSONS LEARNED AND RECOMMENDATIONS

Remarkable plans lead to remarkable performances, which lead to remarkable rewards.

Therefore, spending enough time in making remarkable plans and preparing for a remarkable performance will pay off with extraordinary rewards. Our project started after several meetings in order to put the best plan that has to be successful. Plan ahead: A good plan is first step in success; by planning ahead we could identify the problems, categorize, prioritize and create a response plan. Unfortunately, many organizations do not succeed, especially when facing obstacles, because they don't anticipate it or, if they do, they do not plan how to respond to them.

- Becoming proactive: Without proper planning we would not be ready to respond to challenges. Hence we become reactive. Planning ahead helps you become proactive.
 - By becoming proactive, you will be able to take the right action in the face of challenge and adversity. As a result, you welcome change because you are ready for any type of challenge. When you are proactive, you respond to situations rather than reacting to them.
- Improving performance: By improving your performance through good planning and preparation, you will be clearer about what to do next. You will also experience less stress, be more productive, provide better service, deliver higher quality products, create a more joyful environment to work in, and become a more effective and influential leader.

- Give enough time to develop a team: Team development is vital to success, projects, and the organization as a whole. Teams suffer without plans. Unfortunately, many organizations do not plan for team development. After a while, teams experience internal and external conflict, which results in confusion, low productivity, less creativity, dissociation and failure. Through the project we started with a small number and once we were able to ensure that we have the backbone to expand the services we trained and recruited more residents.
- Revise and update your plan: Effective plans are revised and updated regularly. In fact, our original plans can and should evolve over time so we can stay on the right track and get to the destination. By planning ahead we give ourselves time to revise our plans based on updated information on risk, quality, resources, stakeholders, assumptions, and constraints.
- To be innovative and try to create your own way of solving your problems instead of adopting a ready-made plan which will not fit your settings and will not give you the looked for outcomes

ANNEXES

Jameela Al Salman, Rawan Al Agha, Eman Fareed, Leena Ali, Kubra Nasser, Zainab AlSikri, Rehab Al Noaimi "Human immunodeficiency virus infection and chemotherapy treatment in the Kingdom of Bahrain" (2016). *The International Arabic Journal of Antimicrobial Agents*

13. INDIA

TITLE OF THE PROGRAMME: Pehchan

CONTACT PERSON

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- **Programme is being implemented since:** October 2010
- **End date of the programme:**
- **Responsible parties:** Government; Civil society
- **Population reached:** Men who have Sex with Men (MSM) and Transgender (TG): People living with HIV; People who use substances, including alcohol
- **Has the programme been evaluated/assessed?** Yes, by both neutral research agency like Kadence and by National AIDS Control Organization (NACO)
- **Is the programme part of the National AIDS or Mental Health or Substance Abuse Prevention and Treatment Strategy?** No
- **Is the programme part of a National Plan other than the National AIDS or Mental Health Strategy?** No

BACKGROUND

In 2016, National AIDS Control Programme III in India, estimated that approximately 2.35 million people have high risk same sex behaviour therefore at risk to HIV, that too among already identified population. This group were not homogenous, they consist of numerous sub-groups, significantly men who have sex with men (MSM), Transgender populations, and the Hijras (MTH). MTH was an important key population (KP) who were and continue to remain highly vulnerable to HIV and was also a strategically important group for focusing HIV prevention programs during NACP III implementation. Vulnerability to HIV was rooted within the context of identity, acute stigma and discrimination, it was also particularly true for Hijra and transgender populations. Within Nation programme they were lacking with the recognition as separate transgender population in India since they were included under the larger umbrella of MSM. Punitive laws such as section 377 hindered health care services immensely and community remained closeted. It was in this context that Pehchan ('identity,' 'recognition' or 'acknowledgement' in Indian language) programme funded by The Global Fund (from 2010-2015) was focused on 'community system strengthening' of 200 community based organisations (CBOs) to provide effective, inclusive and sustainable 'community specific' HIV prevention

programming in 18 high risk priority states in India for more than 0.4 million MSM, transgender and hijras (collectively known MTH). The core objectives of programme was to increase the unreached coverage of MTH; strengthen the capacities of the CBOs and community leaders; create policy reforms through the community led advocacy approach and expand 'community specific' services for sustainable health seeking behavior. It was perfect example of the 'person centric approach' since it was addressing specific community needs for MTH and worked on improving quality of life.

DESCRIPTION

The project focused on establishing 90 new CBOs through 'community led CBO development process' to provide basic HIV prevention services around HIV/AIDS including prevention awareness, condoms, referrals for STIs, HIV testing and creating enabling environment for crisis mitigation. On the second level the programme worked with the existing 'targeted interventions' (TIs) implemented by support from State AIDS Control Society (SACS) to provide additional 'community specific services' such as TG identification, mental health, psychosocial support, crisis mitigation, gender transition support and advocacy for policy change. The project focused on following major services, • It was observed that by providing additional 'community specific' services such as mental health, psychosocial health, positive counselling, family counselling, sexuality and gender counselling; new unreached MTH in same geographical population started coming out and accessing the services under existing TIs. • The programme used rare combination of the technical expert along with the community leaders to create 18 thematic modules focused on organizational support, mental health, gender and sexuality, violence mitigation, human rights issues, reading to female spouse of the married MTH, family support, and gender issues related to TG community, community friendly services, life skills education, positive living and community preparedness for sustainability. More than 185 community trainers were capacitated, including 80 trainers from TG community for the first time in India. • Operational research was conducted on the areas such as trauma and violence, feminization needs and stigma among health care providers in collaboration with the community leaders. These researches provided important evidences for programmatic strategies and priorities and strengthen the advocacy initiatives. • Specific events were conducted to address the discrimination and violence due to section 377 law which criminalizes the sexual minority in the eyes of India law. Solidarity events focused around gay men and MSM community around human rights and section 377 was conducted. For transgender and hijra community 'hijra habba' specific event on transgender advocacy was conducted every year focused around building transgender activism in country and also sensitising and engaging the policy makers on the transgender rights. As a holistic HIV service approach, programme focused mostly on the counselling and mental health support. There were two major barriers in delivering the mental health services; professional mental health providers were not sensitized on the mental health issues of the MTH and we did not had trained community staff to provide first level of psychosocial support. Pehchan developed specific modules on mental health support, family support, mental health, gender and sexuality, positive living and dealing with like skill education. These areas were larger mental health basket services for MTH person to gather strength, address issues related to his/her life and also empower them to access services. The programme trained, people from MTH community providing HIV awareness for more than five years on psychosocial support, positive living, sexuality & gender counselling and also support for the positive living. More than 340 community counsellors were trained to provide first level of mental health support and connect them to the community friendly mental health professionals near intervention area who were sensitised by Pehchan team.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

The programme has reached to 295,338 MTH for the first time for HIV services; it has also provided base for the National AIDS Control Programme to arrive at the .4million sexual minority mapping universe in India. More than 60% (177,211) registered clients have been not only tested for HIV in ICTC, however also collected their reports and received the post-test counselling. 1910 MTH PLHIV clients have been linked with the ART centers and 96% of the positive detected clients have received ART adherence support. It has developed 18 thematic training modules in collaboration with the community and technical experts. The programme has trained more than 150 master trainers from the community and linked with the State Training Resource Centre. . In the history of the MSM HIV intervention for the first time Pehchan has reached to the 1,708 female partners of the married MSM and linked them successfully with the sexual reproductive clinics for testing, condom and other services. The programme managed to provide such services due to strong community mental health support available through community counsellors associated with 200 CBOs and with strong referral for mental health services. Through gender and sexuality support programme managed to encourage new unidentified clients for HIV services, with positive living support it helped to create stronger linkages with ARV support; with positive living support the opportunistic Infections were followed up effectively along with adherence support and with the other counselling supports the programme managed to create enabling environment with family members, spouse, partners. The programme has managed to provide 227,526 mental health counselling over five years of project implementation. As you can clearly see below in the table no 1; major support has been provided in the area of mental health (23%) followed by sexuality in gender (20%), then family counselling (18.5%) and psychosocial support (10.2%). When MTH community do not have aspiration for healthy life the HIV service uptake will be always affected by the mental health issues.

LESSONS LEARNED AND RECOMMENDATIONS

Pehchan focused around the 'person centric approach', this is one of the strongest examples on the success story of the community centric person centric approach in India and also demonstrate strongly that HIV prevention and care services will have higher impact through community participation in designing, implementing and assessing the programme outcomes. While working with MSM and TG community, it's important to also address the specific vulnerabilities of the sexual and gender identities (gay, double decker, transwoman, Jogti etc.) 1specifically provide the 'community specific services' such as gender change support, social welfare schemes etc. Creating legal and human rights awareness among MSM and TG empower them effectively to address structural barriers of the punitive laws, create enabling environment and also create human rights base HIV service approach which is more sustainable in HIV prevention approach. Mental health, psychosocial counselling, family support counselling, positive living counselling, partner counselling and specific counselling support around gender and sexuality was crucial to create awareness on HIV and also build the dignity among sexual minority community to access the health care. Community led counselling provided 'faith' among MSM and TG population and supported in reaching to unreached, hidden and unidentified MSM and TG population in 18 priority states of India.

ANNEXES

1. Pehchan impact assessment study, 2. Pehchan person centric approach – International HIV/AIDS Alliance

14. PAKISTAN

TITLE OF THE PROGRAMME: Global Aids Conference

CONTACT PERSON

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Title: Mr.

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- **Programme is being implemented since:** 2018
- **End date of the programme:** Depends on resources and activist volunteer activism will be alive
- **Responsible parties:** Civil society
- **Population reached:** Key population through peer education; we have personal experience that worst in Mental Hospital. With ou WHO medicines has been given. More case studies are also available; People living with HIV; People with mental health conditions; People who use substances, including alcohol; Prisoners; Indigenous and/or local communities; Migrants, refugees or internally displaced people; Children; Women and girls; Young people;
- **Has the programme been evaluated/assessed?** Yes, we are working on different researchers and we are still collecting responses with diverse backgrounds. Our Team meets monthly with team of doctors, researchers, experts, SRHR leaders and other diverse backgrounds of people to deep understand.
- **Is the programme part of the National AIDS or Mental Health or Substance Abuse Prevention and Treatment Strategy?** Yes
- **Is the programme part of a national plan other than the National AIDS or Mental Health Strategy?** Yes, we are engaging participants, speakers and mentors and experts of HIV and Mental Health experts which whole year through our different programs yearly online and non online in their field, International delegation will work in their areas and countries. Every year active participants will be invited at Global AIDS Conference.

BACKGROUND

We are working on every background without boundaries even any status we all equally work and treat each other. Data is being presented at local national and wider international programs.

DESCRIPTION

Dr. Rachel Clare Baggaley Trust team is implementing it with other organizations: Sarmad David Legacy Fund, Youth Emerge Organization and Sindh Green Development and with support of political parties. We have no funds, we contribute by our pocket money, salary and other natural resources. We are excited, motivated and expert in our fields, We just need support for our struggle.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

In past we have participated in Law changes and policy reforms. But we are also working with current government to work with us in remote areas of Sindh and Balochistan region. We are working in boarder of both regions! We have created a positive impact on lives of people but have lack of resources and lack of funds! We still motivated to work without funds until we are alive our team goal is that.

LESSONS LEARNED AND RECOMMENDATIONS

Financial support

ANNEXES

We can provide you on request as initial draft after Global Aids Conference when we have compiled results.

III. LATIN AMERICAN AND CARIBBEAN STATES

15.BRAZIL

TITLE OF THE PROGRAMME: Integra Saude SP

CONTACT PERSON

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- **Programme is being implemented since:** 2002
- **End date of the programme:** NA
- **Responsible parties:** Government
- **Population reached:** LGBTQIA groups; People living with HIV; People with mental health conditions; People who use substances, including alcohol; "Migrants, refugees or internally displaced people; Women and girls; Young people
- **Has the programme been evaluated/assessed?** No
- **Is the programme part of the national aids or mental health or substance abuse prevention and treatment strategy?** Yes
- **Is the programme part of a national plan other than the national aids or mental health strategy?** No

BACKGROUND

Brazil is a continental-sized country with nearly 210 million inhabitants – and is the world's 8th largest Gross Domestic Product (GDP), amounting to approximately US\$ 2,254 billion. Over the past three decades, the Human Development Index (HDI) in Brazil has increased from 0.522 to 0.730 (20%) (1). However, the country still struggles with great structural problems, as well as deep social and regional inequality. In this context, Brazil appears to be presently the largest cocaine market in South America (2). The country has one of the biggest populations of crack-cocaine users worldwide, the majority of them living and smoking crack-cocaine on the streets or in open air drug scenes (cracolândias) (3,4). The high level of poverty in Brazil – combined with the relatively low cost of crack-cocaine – has contributed greatly to the massive national expansion of this drug over the last three decades, mainly among marginalized and poor Brazilians (5). Moreover, the specific associations between crack-cocaine use and severe physical and mental health problems (6) have identified this specific route of administration of cocaine as an independent risk factor involving serious harm to the user and society (6). In this sense, crack-cocaine users have clearly higher rates for many infectious diseases – mainly HIV and Hepatitis C – when compared to other illicit drug users (7). The use of crack-cocaine is also associated with several psychiatric comorbidities, including depression, anxiety, and suicide

attempts (8). Several other studies have reported that the involvement of crack-cocaine users in the illicit drug trade and the criminal justice system are more frequent than among users of other illegal drugs (9). Finally, evidence indicates elevated mortality rates among crack users, well above international standards, and homicide as the main cause of death (10). Besides facing the already mentioned its profound and social and regional inequality and nationwide crack-cocaine consumption (11), Brazil also presents one of the world's worst scenarios concerning LGBT rights and needs (12,13). The country has the highest rate of transgender people homicides in the world (12,14,15). HIV and syphilis are highly prevalent among the Brazilian TGW, as recently observed by Bastos et al (2018), who recruited a sample of TGW (n=2,846) from 12 Brazilian state capitals, with HIV and Syphilis rates of 25% and 50% (16), respectively. TGW living in Brazil present less adherence to treatment, with lower viral suppression rates (35.4%), in comparison with Brazilians overall (46%) (17). Finally, the use of psychoactive substances is still poorly understood among the TGW population in Brazil, considering its importance as an independent outcome, its association with sexually-transmitted HIV, as well as its relation with adherence to HIV treatment. Facing these challenging characteristics, epidemiological studies interested in the profiles of crack users seeking treatment began to be published as of the arrival of this drug in Brazil (18). About a decade later, specific treatment strategies and public policies have addressed this issue, including federal, state and municipal levels (4). However, evidence suggests that only a small proportion of crack-cocaine users receive basic social or health services (19); moreover, they experience more difficulties in seeking and adhering to treatment compared to other illegal drugs users (20,21). As a special group, programmes capable of integrating mental health care with prevention, diagnosis and treatment for ISTs became necessary. This was the origin of the "Integra Saude SP", as described above. The 21 references can be read in Annex 1.

DESCRIPTION

The main objective of the "Integra Saúde SP" Programme (ISSP) is to establish constant and permanent contact with users of psychoactive substances who inhabit the Central Region of the City of São Paulo (n = 541,000 inhabitants), or from the entire city, considering emergency cases (n=10 million inhabitants). This region harbours an enormous open drug scene (cracolândia) (n = 2,000 users); many of the users have lived in the area for over five years. Around 70% of the users seeking help in the programme are homeless, and there are several groups of vulnerable individuals: women, pregnant women, transgender people, immigrants from African countries, mental health patients. The ISSP is the result of an integrated effort by two São Paulo State Secretariat departments: The Reference Center for Alcohol, Tobacco and Other Drugs (CRATOD) and the Center for Reference and Training in AIDS (CRT-AIDS). Resources for initiatives are independent of the two institutions' budget appropriations and under the form of following public legislation: the Pluriannual Plan and the Annual Budgetary Law. For users who live in cracolândia, consume crack and do not wish to be treated, ISSP offers an 11-floor building called "Unidade Helvetia." This unit harbours a group of outreachers and several low-threshold programmes: users find all they need to take a shower and clean their teeth; there are also a gym, an experimental kitchen and music, art and computing labs. For women of childbearing age, ISSP offers – through a partnership with the Women's Reference Center – sexual counselling, routine exams and voluntary progestin-release hormone implant. Those interested in treatment are taken by outreachers to the CRATOD – or seek the service directly from other parts of the city. Initially, the users undergo risk assessment by a nurse, who classifies them according to the severity of their cases: urgency, emergency and non-emergency. The first case is referred to the CRATOD Observation Unit, where it can remain for up to 72 hours: the unit offers 35 beds; isolation for cases of tuberculosis; psychiatrists and general practitioners 24 hours a day. Detoxification vacancies for

15 to 30 days are available for the most serious cases. The detoxification programme offers a specific nursery for pregnant women. The non-urgent cases is evaluated by a social worker and a psychologist, and then referred to community treatment at a Psychosocial Care Center (CAPS-AD). CAPS-AD CRATOD offers a specific LGBT Programme, with health groups, leisure activities, psychological support, and more. These individuals can also be referred to therapeutic communities (TC); some of them have been specifically trained to attend transgender people. A half-way house can be used for up to 30 days, while a new housing structure is provided to the user by CRATOD's social service. In general, 75% of cases are referred to community care; 10% to TC; and 15% to detox. The Helvetia Unit harbours the "Monitored Housing," a space with beds for 24 men and 12 women (LGBTQIA-friendly), in which users being treated in CAPS-AD CRATOD, committed to a regular agenda of activities, can live from 6 to 9 months. CRATOD offers a complete care for HIV/AIDS counseling and treatment – including prescription of antiretrovirals. For all individuals undergoing first nursing care, rapid tests for HIV, Hepatitis B and C and Syphilis are offered. When a test is positive, confirmatory tests are collected in the same place and the user immediately begins treatment with the service's infectologist. The prevalence of rapid positive tests for Syphilis, HIV and Hepatitis C is 12%, 3.5% and 2.5%, respectively. Among women and transgender people, this rate is over 40% for Syphilis and 15% for HIV. CRATOD respects the diversity and human rights of users, promotes their participation in the organization of the service, through monthly assemblies, thematic forums and through a monthly wall-journal publication.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

When we began this approximation between the institutions we did not imagine that we could achieve so expressive results in such a short time, since this population always has a great deal of difficulty in approaching institutions for various reasons throughout their own struggles and achievements for social rights. When the CRT team brings to mental health nursing the learning of applying the rapid tests and the diagnostic disclosure to the patients allows the host to meet with the management from another perspective of care approaches for drug users. So we have changed our internal protocols by approaching the institutions that complement our work and so more or more important or effective than changing a law and still save important resources that turn to new actions. In the case of the CRATOD itself, all this new methodology that the "Integra Saude SP" has made possible even if we created it, finally by the demand our LGBT group in the CAPS AD that has been taught is promoted many practical changes of coexistence and coping in the treatment. The team of CRATOD / UH outreachers has performed in the last 5 years (2014-2018), 8,547 | 7,939 | 6,964 | 4,976 | 4,682 (JAN-SEP) annual approaches to health and social assistance with crack users in the "cracolândia" region. The CRATOD nursing team performed an average of 13,943 risk evaluations annually for the same period. Rapid tests were instituted on CRATOD as of September 2015. Since then, 12,223 individuals have been tested for HIV, syphilis, hepatitis B and C - for preliminary results, see Annex 5 and 6. The service has an emergency unit to manage acute psychiatric and general medical condition cases, which is responsible for making more than 3,000 acute evaluations a year. Finally, the outpatient unit, CAPS-AD, has more than 2,000 regular users, several health care approaches, harm reduction procedures and activities that value respect for diversity and citizenship - such as groups, field visits, thematic workshops, etc.

LESSONS LEARNED AND RECOMMENDATIONS:

In the Brazilian context, the National Health Plan (NHP) is the central planning instrument that guides the implementation of all management initiatives within the Unified Health System (SUS). The referred planning is designed during the first year of each new government, and establishes goals for the next four years; the last goal should be accomplished during the first year of the next government, guaranteeing continuity to essential state policies such as the Brazilian IST and AIDS Programme. The current NHP is valid for the period between 2016 and 2019. Designing the 2016-2019 NHP involved Ministry of Health organs and entities, and took place in a way that complies with the same period's Pluriannual Plan (PPA), the maximum government budget instrument – designed by the National Congress – that establishes goals and considers the sources of financing as well as the guidelines recommended by the National Health Council (CNS). Thirteen goals with their respective targets were established for the present quadrennium. The second NHP goal – “Improve and implement the Health Care Networks [including mental health]” – put special emphasis on the need to expand to the emergency and emergency network, as well as the psychosocial care centers (CAPS) – outpatient units with several mental health and substance misuse care issues, including prevention, harm reduction and treatment approaches. The effective and humane articulation between these services and the adequate training of their health team were also considered priority goals. The fourth NHP goal – “Reduce and prevent risks and health effects of the population” –, the UNAIDS 90-90-90 treatment target to help end the AIDS epidemic, has been included as a specific target for this quadrennium. The new treatment option for Hepatitis C was mentioned, but did not become a specific target. Each one of the Health Departments of the 27 Brazilian States must design their own State Health Plan (SHP), taking the NHP as “major front,” and then adapting the provided resources considering local needs. The State of São Paulo, where CRATOD is located, has established eight health axes in its SHP. The second one, “Development of programs to specific groups,” presents specific guidelines for prevention, treatment and recovery of alcohol and drug misuse, while the third one – “Health surveillance” – covers IST issues discussed previously in the NHP. So we believe that Brazil's extremely relevant tradition regarding ISTs, HIV and Viral Hepatitis seems to now become more pragmatic with alcohol and drug policies: during the last two National and São Paulo State Health Plans, the drug consumption topic occupied an adequate place concerning goals, targets and financing. Regarding the latter, we believe that a great deal of ISSP's success is due to the clarity and stability of resources, provided in part by the Ministry of Health, in part by the São Paulo Health Secretariat. Finally, it has also been possible to work with more experienced managers in the field of policies aimed at the consumption of psychoactive substances; 20 years ago, Brazil did not even have a national policy. It has also been only a few years that the different sectors of Brazilian society that work in the field of psychoactive substance consumption have been able to dialogue in a more productive way, free of any kind of pejorative competition. We believe that all of this has allowed for strengthening the dialogue between sectors that once saw each other with mistrust, such as occurred with mutual aid groups, with academic sectors, with harm reduction and recovery organizations.

ANNEXES

- References or “the context in which the programme is being implemented”
- CRATOD Structure
- Alisson Trevizol, Sonia Maria Motta Palma, Ariadne Ribeiro, Elisa Brietzke, Renata Rigacci Abdalla, Claudio Jerônimo da Silva, Quirino Cordeiro, Ronaldo Laranjeira, Marcelo Ribeiro “Preliminary Results from Brazil's First Recovery Housing Program”

- Ribeiro et al. "Adulterants in Crack Cocaine in Brazil"
- Prevalence and Key Co-Variates of Syphilis Infection among Patients in a Large Public Addiction Care Centre in Sao Paulo, Brazil
- "Uma proposta de cuidado ao Dependente Quimico" Luiz Gustavo Vala Zoldan and Macelo Ribeiro

IV. WESTERN EUROPEAN AND OTHER STATES

16. NETHERLANDS

TITLE OF THE PROGRAMME: Living Positive with HIV: An evidence-based online self-help program for people living with HIV suffering from depressive symptoms

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- **Programme is being implemented since:** Program is available since 2015; first in RCT; final national implementation in Spring 2019
- **End date of the programme:** NA (continuing project after successful findings RCT)
- **Responsible parties:** Academic institution
- **Population reached:** Dutch and English-speaking people living with HIV; People living with HIV; People with mental health conditions
- **Has the programme been evaluated/assessed?** Yes, by a large scale national Randomized Controlled Trial, conducted in PhD project. Responsible PI's: Vivian Kraaij and Nadia Garnefski. PhD student: Sanne van Luenen. Grant: Aidsfonds.
- **Is the programme part of the National AIDS or Mental Health or Substance Abuse Prevention and Treatment Strategy?** Yes
- **Is the programme part of a national plan other than the National AIDS or Mental Health Strategy?** No

BACKGROUND

Background context of this programme is to fill in the gap with regard to mental health care for PLH. Programme, research and implementation has been funded by the Aidsfonds. Programme has started in 2015. Currently the programme is being implemented, nation-wide. Next step is scaling up to other countries. One project is already running in Botswana. PLH have an increased risk of mental health problems. Depressive symptoms occur in around 33% of PLH (1). This implies: lower quality of life and reduced adherence to antiretroviral therapy. Therefore, psychological intervention programs are essential (1,2,3). What is needed are psychological programs which are low on stigma, easily accessible for large groups, without geographical barriers and against low costs. On basis of these needs and prior research (4,5), the online self help programme was developed for PLH with depressive symptoms. A large, nation-wide RCT has demonstrated that the programme is effective in reducing depressive symptoms (6). In addition, cost-effectiveness has been shown (7). Now that the program is evidence-based, the

next step is full implementation and scaling up. With regard to (nation-wide) implementation: finalized Spring 2019 With regard to (globally) scaling up: For our project in Botswana we adapted the online intervention into a booklet version, fitting the needs of PLH with depressive symptoms in Botswana. Currently this programme is under evaluation in an RCT (PhD study) (8). References: 1. Van Luenen, S., Kraaij, V., Spinhoven, Ph., & Garnefski, N. (2016). An Internet-based self-help intervention for people with HIV and depressive symptoms: study protocol for a randomized controlled trial. *Trials*, 17, 172. 2. Van Luenen, S., Garnefski, N., Spinhoven, Ph., Spaan, P., Dusseldorp, & Kraaij, V. (2018). The benefits of psychosocial interventions for mental health in people living with HIV: A systematic review and meta-analysis. *AIDS & Behavior*, 22, 9-42. 3. Spaan, P., van Luenen, S., Garnefski, N., & Kraaij, V. (2018). Psychosocial interventions enhance HIV medication adherence: A systematic review and meta-analysis. *Journal of Health Psychology*, 1-15. 4. Kraaij, V., Van der Veek, S.M.C., Garnefski, N., Schroevers, M., Witlox, R., & Maes, S. (2008). Coping, goal adjustment and psychological well-being in HIV-infected men who have sex with men. *AIDS Patient Care and STDs*, 22, 395-402. 5. Kraaij, V., van Emmerik, A., Garnefski, N., Schroevers, M.J., Lo-Fo-Wong, D., van Empelen, P., Dusseldorp, E., Witlox, R., & Maes, S. (2010). Effects of a cognitive behavioral self-help program and a computerized structured writing intervention on depressed mood for HIV-infected people: A pilot randomized controlled trial. *Patient Education and Counseling*, 80, 200-204. 6. Van Luenen, S., Garnefski, N., Spinhoven, P., & Kraaij, V. (2018). Guided Internet-based intervention for people with HIV and depressive symptoms: A randomised controlled trial in the Netherlands. *The Lancet HIV*, 5, 488-497. 7. Van Luenen, S., Garnefski, N., Kraaij, V., Spinhoven, P., & van den Akker-van Marle, M. (In revision). Cost-utility of a guided Internet-based intervention in comparison with attention only for people with HIV and depressive symptoms: A randomized controlled trial. 8. Vavani-Tembo, B., Kraaij, V., Spinhoven, P., & Garnefski, N. (submitted). A booklet self-help intervention to reduce depressive symptoms among people living with HIV in Botswana: study protocol for a randomized controlled trial.

DESCRIPTION

The online programme 'Living Positive with HIV' consists of a website with lessons, all focused on reducing depressive symptoms. The programme includes psycho-education and exercises, using evidence-based techniques such as Cognitive Behavioral Therapy and Motivational Interviewing. The programme is available in Dutch and English and can easily be translated into other languages. The programme consists of 8 lessons (one lesson per week). The focus of the lessons is on four main topics: Activation, Relaxation, Changing negative cognitions, and Goal attainment. People can do the program with or without (minimal) coaching. The direct objective of this programme is to reduce depressive symptoms in PLH. Overarching goal is to contribute to better mental health in PLH, higher medication adherence, and zero transmission rates, worldwide. The program is nationally implemented by Leiden University in their clinical treatment facility. This is also the place where the programme is managed and coordinated. The programme is provided on non-profit basis, with small costs involved for participants, for sustainability purposes only. Coaching (online or by telephone) is provided by trained volunteers. Major partners are: the Aidsfonds, HIV treatment centers and the Dutch national patient organisations. Because it is a programme which can be offered online or in booklet format, there are no geographical barriers.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

All PLH who are connected to one of the HIV treatment centers can be reached without geographical barriers. They are informed about the existence of the online programme by their treatment center. In addition, patient organisations bring the programme to the attention of their members. People can register themselves. There is no limit in the number of people who can participate at the same time. The RCT has shown that the programme is effective in decreasing depressive symptoms and increasing quality of life. In addition, HIV treatment centers and PLH value the program. The program has been shown to be cost-effective.

LESSONS LEARNED AND RECOMMENDATIONS

Funding by the Aidsfonds made it possible to carry out the PhD project with the large-scale RCT and to make the program evidence-based. In the RCT project we had a good cooperation with HIV treatment Centers throughout the country. This made it possible to reach all PLH with depressive symptoms who were connected to one of the centers. We also cooperated with the patient organisations. This made possible to run focus groups and a pilot study, to ensure that the programme fitted the needs of the target group. Leiden University had the coordinating role. This ensured the stability and continuity of the project. Our recommendations for future projects with regard to mental health care for PLH would be: to find evidence for the effectiveness of a programme, to cooperate on a nation-wide level, to work with focus groups to fit the needs of the target group and to make sure that there is a stable, coordinating party.

ANNEXES

We can provide you with the pdfs of the articles on request.

17. UNITED STATES OF AMERICA

17.1 TITLE OF THE PROGRAMME: Ryan White Program

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The Ryan White HIV AIDS Program (RWHAP), under Health Resources and Services Administration (HRSA) provides comprehensive clinical and support services for people with HIV to improve their health outcomes. **Mental health services** under the RWHAP are psychological and psychiatric treatment and counseling services for individuals with a diagnosed mental illness. They are conducted in a group or individual setting and provided by a mental health professional licensed or authorized within the State to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers. **Psychosocial support services** are support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. Access to these services is usually provided through referral from a clinician or health care worker such as a case manager. Services may be provided within the same setting as the HIV clinic (often under one roof) or patients may be referred to another setting for mental health services. Please contact Harold Phillips for more information on the Ryan White HIV AIDS Program (Harold J. Phillips, MRP | Director | Office of Domestic & Global HIV Training & Capacity Development Programs | HRSA/HAB/OTCD | 5600 Fishers Lane | Room 9N-114 | Rockville, MD 20857 | [\(301\) 443-8109](tel:(301)443-8109) | hphillips@hrsa.gov

The Special Projects of National Significance (SPNS) Program, a component of the RWHAP, funded a project called “**Building a Medical Home for Multiply Diagnosed HIV-positive Homeless Populations**”. This initiative was a multi-site demonstration project funded during fiscal years 2012-2017. The nine demonstration sites designed, implemented, and evaluated innovative interventions to improve the timely entry, engagement, and retention in HIV care and support services for homeless and unstably housed people living with HIV with co-occurring mental illness and/or substance use

disorders. The interventions employed models of care focused on the development of sustainable linkages to mental health, substance abuse treatment, and HIV primary care services for homeless or unstably housed people living with HIV. The transient and unstable lives of homeless people living with HIV and co-occurring mental health or substance use disorders required coordinated efforts to engage and retain them in care by addressing their complex service needs and to ensure their adherence to treatment.

Therefore the interventions adopted a set of organizational structures characterized by integrated or co-located strategies for service provision by each demonstration site. Demonstration sites also provided intensive coordination of care and service needs to ensure retention and adherence to treatment. Integrated services were defined as the management and delivery of HIV primary care, substance abuse and mental health treatment. Demonstration sites also included access to housing resources and services for their target population through the co-location of services within an HIV primary care clinic, within a public housing facility that serves the target population, or by building a network of providers through the execution of memoranda of understanding or contracts.

We provide two examples of how this SPNS project was implemented:

Example 1:

- Building a Medical Home for Multiply-Diagnosed HIV-positive Homeless Populations
- Homeless HIV Outreach and Mobile Engagement (HHOME) Program
- 2012-2017

Description of the Project:

San Francisco has one of the largest populations living with HIV in the U.S. with an estimated 15,995 people living with HIV, and second highest rate of homelessness.

How to best serve individuals who are experiencing homelessness and living with HIV through mobile integrated care: case management, navigation, HIV primary care, mental health and substance use treatment, and housing support. People experiencing homelessness in SF who are medically fragile, facing complex co- morbidities/barriers, and not engaged in housing, HIV treatment, or behavioral health care

The local iteration of this program emerged out of a unique public/private partnership model designed to support the services of the San Francisco Homeless Outreach Team (SF HOT), which engages individuals who are experiencing homelessness to provide support such as temporary housing and other basic needs. HHOME added the medical services of Tom Waddell Health Center, a public community health clinic with an established practice of caring for people experiencing homelessness, and a respected and highly trusted community-based organization, the Asian & Pacific Islander Wellness

Center. Together, this partnership strengthens one of the core missions each entity has maintained on its own: to enhance the utilization of and retention in HIV medical care by underserved populations in San Francisco.

SFDPH HHOME staff created a mobile, multidisciplinary team-based model designed to engage and retain in care the most severely impacted and hardest-to-serve persons experiencing homelessness and living with HIV in San Francisco. HHOME differs from prior mobile team models in that it explicitly focuses on individuals experiencing homelessness who are the most difficult to engage and retain in care, namely those facing complex, multiple comorbidities and barriers who have not previously or successfully engaged in housing and/or HIV treatment. The Health, Hope and Recovery model to address the multiple, complex needs of this population.

Contact information

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Website/Links for further/additional detail or materials

- <http://cahpp.org/wp-content/uploads/2018/01/med-home-multisite-overview.pdf>
- <http://cahpp.org/HRSA-meeting-2017-06-27>
- <http://cahpp.org/wp-content/uploads/2018/01/HHOME-SFDPH-one-page.pdf>

Example 2:

- Building a Medical Home for Multiply-Diagnosed HIV-positive Homeless Populations
- NC-REACH (Rurally Engaging and Assisting Clients who are HIV-positive and Homeless)
- 2012-2017

Description of the Project:

People living in the Deep South make up 34% of PLWHA, and North Carolina is one of the 15 states in the U.S. with the highest number of new HIV diagnoses (Southern AIDS Coalition, 2012). Nearly 37,000 people are living with HIV/AIDS in North Carolina with 13.4 new cases per 100,000 people reported in 2015. Nearly 22 percent of the state's general population lives in rural counties of North Carolina, which accounts for 80% of the state (AIDSVu). There are high rates of homelessness among people living with HIV in North Carolina, and about half have co-occurring mental health or substance use disorders.

Homelessness in rural areas takes on different forms than urban homelessness—one does not see people under bridges or grouped in tents. However, it remains a barrier to health care for many rural clients. The NC-REACH project opened health care providers' eyes to the difficult circumstances facing many of their rural clients.

Most clients enrolled in the NC-REACH program do not have a lease or mortgage in their name. They may be couch surfing (staying with a friend or family member but moving frequently) or living in unsafe living conditions. Many have mental health or substance use disorders and struggle with treatment compliance, negatively impacting their relationships with family and friends, and thereby eliminating safe housing options. Unstable housing greatly impedes a client's ability to take HIV medication regularly. Additionally, the triple stigma of HIV, mental illness, and substance use may cause clients to hide medications and avoid taking them in front of family members. A lack of daily routine and structure makes it difficult to arrange for client transportation and appointment reminders, ultimately resulting in missed appointments.

Introducing the network navigators into the health care team was a crucial first step in bridging this divide. The navigators are the voice of the client, advocating for them in meetings with the comprehensive care team. Navigators address clients' needs in ways that other staff members cannot. "They have the flexibility in their schedule to go out in the community, to go with our clients to apply for food stamps or a social security card—whatever the client needs and whatever will help them be successful in finding and maintaining housing," said Lisa McKeithan. "Having the network navigators enhances the ability of the clinic to provide housing options to clients. Everyone at CommWell Health believes that housing has greatly improved the health status of our client population

CommWell Health introduced NC-REACH, a new component to the Positive Life medical home model. The goal of the program was to engage and retain the most vulnerable PLWHA in their service area in care and provide them with comprehensive social services. NC-REACH was one of the first Ryan White HIV/AIDS Program (RWHAP) SPNS initiatives to be implemented in a rural setting. As the only rural site among nine sites participating in this initiative, NC-REACH offered additional services to meet the three primary goals for the National HIV/AIDS Strategy goals: reducing HIV incidence, increasing access to care/optimizing health outcomes, and reducing HIV-related health disparities.

Contact information

- PI Name: Serena Rajabiun , M.A., M.P.H, PhD
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Website/Links for further/additional detail or materials

- <http://cahpp.org/wp-content/uploads/2018/01/med-home-multisite-overview.pdf>

- <http://cahpp.org/HRSA-meeting-2017-06-27>
- <http://cahpp.org/wp-content/uploads/2017/10/CWH-NC-REACH.pdf>

The Special Projects of National Significance (SPNS) Program, a component of the RWHAP, funded another project called “**System-level Workforce Capacity Building for Integrating HIV Primary Care in Community Health Care Settings**”. This initiative was a multi-site demonstration project funded during fiscal years 2014-2018. We provide two examples of how this SPNS project was implemented:

Example 1:

- System-level Workforce Capacity Building for Integrating HIV Primary Care in Community Health Care Settings
- The MetroHealth System (MHS) HIV - Implementation of a Collaborative Care Model
- 2014 -2018

Description of the Project

This project provides integrated primary HIV care and behavioral health care to residents of Northeast Ohio who have been diagnosed with HIV. The MetroHealth (MHS) HIV Clinic is the largest provider of HIV care and Ryan White Part A supported care in Northeast Ohio with 1,385 unique patients seen in 2013.

Depression is among the most prevalent, yet unaddressed problems identified in people living with HIV (PLWH) leading to poor self-care, poor antiretroviral adherence and poor disease outcomes. Successful treatment of depression in has resulted in improvements in other chronic diseases such diabetes and heart disease. Barriers to successfully treating depression include lack of screening, absence of regular measurement of symptoms, the need for an evidence-based protocol to guide management of depression, and significant practice variability in management of depression.

Collaborative care models facilitate collaboration between primary medical care and specialty mental health care providers, incorporate self-management, a cost-effective and under-utilized intervention of depression, address all of the identified barriers mentioned above and lead to improved quality of depression care, and improved depression and chronic disease outcomes.

The collaborative care model for depression transforms MHS HIV primary care delivery by integrating depression screening and treatment into the medical infrastructure, by task shifting of responsibility for depression screening and monitoring response to therapy to non-physician providers, and by decreasing overall healthcare utilization and costs for PLWH. Implementing the model optimizes HIV outcomes by improving rates of engagement in care, optimizing HIV medication adherence and result in sustained viral suppression. Essential training is provided to the clinic staff (medical and support) on how to manage mental illness and enable a team approach to challenging patients.

Contact information

- Project Director Name: Ann Avery, MD
- Contact Phone Numbers: [216 778 7828](tel:2167787828)
- Email Address: aavery@metrohealth.org

Website/Links for further/additional detail or materials

- <https://midusforhiv.org/>
- <https://midusforhiv.org/testimony/patient-perception-of-the-collaborative-care-model-ccm/>
- <https://midusforhiv.org/testimony/patient-perception-of-the-phq-9/>

Example 2:

- Building a Medical Home for Multiply-Diagnosed HIV-positive Homeless Populations
- Health, Hope and Recovery(HHR)
- 2012-2017

Description of the Project:

While PHNTX has high quality case management services with effective linkage to care and regular referral follow-up, outcome data indicated that an alarmingly low percentage of HIV-positive individuals with co-occurring mental/substance use disorders actually become engaged in treatment, revealing a service system deficiency. This priority population is highly vulnerable, fearful of and often resistant to seeking needed mental health or substance use treatment services, and has difficulty in adhering to or continuing with life-saving HIV/AIDS medical treatment. The complexity and multiplicity of challenges faced by this population require comprehensive services provided within a highly coordinated system of care. The services must address an array of needs: primary care, HIV/AIDS specialty medical care; substance use and mental illness treatment; social support; and income, housing and vocational needs. Drawing upon a framework that utilized behavioral interventions such as strength-based counseling, trauma informed care, cognitive behavioral therapy and motivational interviewing, PHNTX created the Health, Hope and Recovery model to address the multiple, complex needs of this population.

Contact information

- PI Name: Serena Rajabiun , M.A., M.P.H, PhD
- Contact Phone Numbers: [\(617\) 638-1934](tel:6176381934)
- Email Address: rajabiun@bu.edu
- <http://cahpp.org/team-members/serena-rajabiun/>

Website/Links for further/additional detail or materials

- <http://cahpp.org/wp-content/uploads/2018/01/med-home-multisite-overview.pdf>

- <http://cahpp.org/HRSA-meeting-2017-06-27>
- <http://cahpp.org/wp-content/uploads/2017/06/HHR-Prism-Health-one-page.pdf>
- <http://cahpp.org/wp-content/uploads/2017/06/HHR-Prism-Health-poster.pdf>

17.2 TITLE OF THE PROGRAMME: Special Projects of National Significance Program: Building a Medical Home for Multiply-Diagnosed HIV-positive Homeless Populations

CONTACT PERSON

Name: Serena Rajabiun

Title: PI

Organisation: Health Resources & Services Administration

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Tel: 617-638-1934

Email: rajabiun@bu.edu

- **Programme is being implemented since:** 2012
- **End date of the programme:** 2017
- **Responsible parties:** Government
- **Population reached:** People living with HIV; People with mental health conditions; People who use substances, including alcohol; Prisoners; Indigenous and/or local communities; Migrants, refugees or internally displaced people; Children; Women and girls; Young people
- **Has the programme been evaluated/assessed?** Yes, HRSA
- **Is the programme part of the National AIDS or Mental Health or Substance Abuse Prevention and Treatment Strategy?** Yes
- **Is the programme part of a national plan other than the National AIDS or Mental Health Strategy?** Yes, Ryan White HIV AIDS Program

BACKGROUND

The Ryan White HIV AIDS Program provides comprehensive clinical and support services for people with HIV to improve their health outcomes. Mental health services under the RWHAP are psychological and psychiatric treatment and counseling services for individuals with a diagnosed mental illness. They are conducted in a group or individual setting and provided by a mental health professional licensed or authorized within the State to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers. Psychosocial support services are support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. Access to these services is usually provided through referral from a clinician or health care worker such as a case manager. Services may be provided within the same setting as the HIV clinic (often under one roof) or patients may be referred to another setting for mental health services. The Special Projects of National Significance (SPNS) Program a component of the Ryan White HIV AIDS Program (RWHAP) funded a project called "Building a Medical Home for Multiply

Diagnosed HIV-positive Homeless Populations”. This initiative was a multi-site demonstration project funded during fiscal years 2012-2017. The nine demonstration sites designed, implemented, and evaluated innovative interventions to improve the timely entry, engagement, and retention in HIV care and support services for homeless and unstably housed people living with HIV with co-occurring mental illness and/or substance use disorders. The interventions employed models of care focused on the development of sustainable linkages to mental health, substance abuse treatment, and HIV primary care services for homeless or unstably housed people living with HIV. The transient and unstable lives of homeless people living with HIV and co-occurring mental health or substance use disorders required coordinated efforts to engage and retain them in care by addressing their complex service needs and to ensure their adherence to treatment. Therefore, the interventions adopted a set of organizational structures characterized by integrated or co-located strategies for service provision by each demonstration site. Demonstration sites also provided intensive coordination of care and service needs to ensure retention and adherence to treatment. Integrated services were defined as the management and delivery of HIV primary care, substance abuse and mental health treatment. Demonstration sites also included access to housing resources and services for their target population through the co-location of services within an HIV primary care clinic, within a public housing facility that serves the target population, or by building a network of providers through the execution of memoranda of understanding or contracts.

DESCRIPTION

Name of SPNS initiative/Name of Project/Project Period (CASE 2) • Building a Medical Home for Multiply-Diagnosed HIV-positive Homeless Populations • Health, Hope and Recovery(HHR) • 2012-2017 Description of the Project: While PHNTX has high quality case management services with effective linkage to care and regular referral follow-up, outcome data indicated that an alarmingly low percentage of HIV-positive individuals with co-occurring mental/substance use disorders actually become engaged in treatment, revealing a service system deficiency. This priority population is highly vulnerable, fearful of and often resistant to seeking needed mental health or substance use treatment services, and has difficulty in adhering to or continuing with life-saving HIV/AIDS medical treatment. The complexity and multiplicity of challenges faced by this population require comprehensive services provided within a highly coordinated system of care. The services must address an array of needs: primary care, HIV/AIDS specialty medical care; substance use and mental illness treatment; social support; and income, housing and vocational needs. Drawing upon a framework that utilized behavioral interventions such as strength-based counseling, trauma informed care, cognitive behavioral therapy and motivational interviewing, PHNTX created the Health, Hope and Recovery model to address the multiple, complex needs of this population. Contact information • PI Name: Serena Rajabiun , M.A., M.P.H, PhD • Contact Phone Numbers: (617) 638-1934 • Email Address: rajabiun@bu.edu • <http://cahpp.org/team-members/serena-rajabiun/> Website/Links for further/additional detail or materials • <http://cahpp.org/wp-content/uploads/2018/01/med-home-multisite-overview.pdf> • <http://cahpp.org/HRSA-meeting-2017-06-27> • <http://cahpp.org/wp-content/uploads/2017/06/HHR-Prism-Health-one-page.pdf> • <http://cahpp.org/wp-content/uploads/2017/06/HHR-Prism-Health-poster.pdf>

RESULTS, OTCOMES AND IMPACT OF THE PROGRAMME

See above

LESSONS LEARNED AND RECOMMENDATIONS

See above

ANNEXES

NA

**17.3 TITLE OF THE PROGRAMME: Special Projects of national Significance (SPNS)
Program: System-level Workforce Capacity Building for Integrating HIV Primary Care in
Community Health Care Settings**

CONTACT PERSON

Name: Ann Avery

Title: Project Director

Organisation: Health Resources & Services Administration

Address: 5600 Fishers Lane, Rockville MD 20857

Tel: 216-778-7828

Email: aavery@metrohealth.org

- **Programme is being implemented since:** 2014
- **End date of the programme:** Ongoing
- **Responsible parties:** Government
- **Population reached:** People living with HIV; People with mental health conditions; People who use substances, including alcohol; Prisoners; Indigenous and/or local communities; Migrants, refugees or internally displaced people; Children; Women and girls; Young people
- **Has the programme been evaluated/assessed?** Yes, HRSA
- **Is the programme part of the National AIDS or Mental Health or Substance Abuse Prevention and Treatment Strategy?** Yes
- **Is the programme part of a national plan other than the National AIDS or Mental Health Strategy?** Yes, Ryan White HIV AIDS Program

BACKGROUND

The Ryan White HIV AIDS Program provides comprehensive clinical and support services for people with HIV to improve their health outcomes. Mental health services under the RWHAP are psychological and psychiatric treatment and counseling services for individuals with a diagnosed mental illness. They are conducted in a group or individual setting and provided by a mental health professional licensed or authorized within the State to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers. Psychosocial support services are support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. Access to these services is usually provided through referral from a clinician or health care worker such as a case manager. Services may be provided within the same setting as the HIV clinic (often under one roof) or patients may be referred to another setting for mental health services.

DESCRIPTION

The Special Projects of National Significance (SPNS) Program a component of the Ryan White HIV AIDS Program (RWHAP) funded a project called “Building a Medical Home for Multiply Diagnosed HIV-positive Homeless Populations”. This initiative was a multi-site demonstration project funded during fiscal years 2012-2017. The nine demonstration sites designed, implemented, and evaluated innovative interventions to improve the timely entry, engagement, and retention in HIV care and support services for homeless and unstably housed people living with HIV with co-occurring mental illness and/or substance use disorders. The interventions employed models of care focused on the development of sustainable linkages to mental health, substance abuse treatment, and HIV primary care services for homeless or unstably housed people living with HIV. The transient and unstable lives of homeless people living with HIV and co-occurring mental health or substance use disorders required coordinated efforts to engage and retain them in care by addressing their complex service needs and to ensure their adherence to treatment. Therefore, the interventions adopted a set of organizational structures characterized by integrated or co-located strategies for service provision by each demonstration site. Demonstration sites also provided intensive coordination of care and service needs to ensure retention and adherence to treatment. Integrated services were defined as the management and delivery of HIV primary care, substance abuse and mental health treatment. Demonstration sites also included access to housing resources and services for their target population through the co-location of services within an HIV primary care clinic, within a public housing facility that serves the target population, or by building a network of providers through the execution of memoranda of understanding or contracts.

RESULTS, OTCOMES AND IMPACT OF THE PROGRAMME

SPNS INITIATIVES WITH MENTAL HEALTH PERSPECTIVE Name of SPNS initiative/Name of Project/Project Period • System-level Workforce Capacity Building for Integrating HIV Primary Care in Community Health Care Settings • The MetroHealth System (MHS) HIV - Implementation of a Collaborative Care Model • 2014 -2018 Description of the Project This project provides integrated primary HIV care and behavioral health care to residents of Northeast Ohio who have been diagnosed with HIV. The MetroHealth (MHS) HIV Clinic is the largest provider of HIV care and Ryan White Part A supported care in Northeast Ohio with 1,385 unique patients seen in 2013. Depression is among the most prevalent, yet unaddressed problems identified in people living with HIV (PLWH) leading to poor self-care, poor antiretroviral adherence and poor disease outcomes. Successful treatment of depression in has resulted in improvements in other chronic diseases such diabetes and heart disease. Barriers to successfully treating depression include lack of screening, absence of regular measurement of symptoms, the need for an evidence-based protocol to guide management of depression, and significant practice variability in management of depression. Collaborative care models facilitate collaboration between primary medical care and specialty mental health care providers, incorporate self-management, a cost-effective and under-utilized intervention of depression, address all of the identified barriers mentioned above and lead to improved quality of depression care, and improved depression and chronic disease outcomes. The collaborative care model for depression transforms MHS HIV primary care delivery by integrating depression screening and treatment into the medical infrastructure, by task shifting of responsibility for depression screening and monitoring response to therapy to non-physician providers, and by decreasing overall healthcare utilization and costs for PLWH. Implementing the model optimizes HIV outcomes by improving rates of engagement in care, optimizing HIV medication adherence and result in sustained viral suppression. Essential training is provided to the clinic staff

(medical and support) on how to manage mental illness and enable a team approach to challenging patients. Contact information • Project Director Name: Ann Avery, MD • Contact Phone Numbers: 216 778 7828 • Email Address: aavery@metrohealth.org Website/Links for further/additional detail or materials

• <https://midusforhiv.org/> • <https://midusforhiv.org/testimony/patient-perception-of-the-collaborative-care-model-ccm/> • <https://midusforhiv.org/testimony/patient-perception-of-the-phq-9/>

LESSONS LEARNED AND RECOMMENDATIONS

<https://midusforhiv.org/> • <https://midusforhiv.org/testimony/patient-perception-of-the-collaborative-care-model-ccm/> • <https://midusforhiv.org/testimony/patient-perception-of-the-phq-9/>

ANNEXES

NA

V. MULTIPLE COUNTRIES

18. GLOBAL

TITLE OF THE PROGRAMME: Breaking the TB and mental health syndemic: the role of social protection- lessons for HIV

CONTACT PERSON

Name: Delia Boccia and Annmarie Isler

Title: Assistant Professor

Organisation: World Food Programme and the London School of Hygiene and Tropical Medicine

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Tel: +393429155037

Email: annmarie.isler@wfp.org, delia.boccia@lshtm.uk

- **Programme is being implemented since:** January 2018
- **End date of the programme:** Formative phase ends in December 2018
- **Responsible parties:** Government, Civil society; UN or other inter-governmental organization; Academic institution
- **Population reached:** People with mental conditions; People who use substances, including alcohol; Indigenous and/or local communities; Women and girls
- **Has the programme been evaluated/assessed?** No
- **Is the programme part of the National AIDS or Mental Health or Substance Abuse Prevention and Treatment Strategy?** No
- **Is the programme part of a national plan other than the National AIDS or Mental Health Strategy?** No

BACKGROUND

This submission is nested within a broader research program called the Social Technology Initiative, aiming to address the elimination and control of diseases of poverty through the combination of innovative biomedical interventions and social protection strategies, using Tuberculosis (TB) as tracer condition. As part of this program we aim to: 1. Explore in depth the intersection between poverty, mental health and TB 2. Unpack the pathway underlying this relationship from the social determinants to the expression of neurological and biological biomarkers; and 3. Based on the above, assess the extent to which the impact of social protection on TB indicators is mediated by mental health improvement among those receiving social protection benefits. As such, this submission fits within the 'multisectoral approaches that address the social determinants of TB and mental health'. Specifically, this submission refers to the formative phase of this program in which we aimed to address objective 1 and 2 above.

DESCRIPTION

See above

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

NA

LESSONS LEARNED AND RECOMMENDATIONS

NA

ANNEXES

TITLE OF THE PROGRAMME: Coming out Proud Program to Erase the Stigma of Mental Illness: Honest, Open, Proud Program

CONTACT PERSON

Name: Patrick W. Corrigan

Title: Distinguished Professor of Psychology

Organisation: Illinois Institute of Technology

Address: IIT, Lewis College of Human Sciences, Tech South 1C9-1, 10 West 35th Street, 14th Floor, Chicago, IL 60616

Tel: 312-567-6751

Email: Corrigan@iit.edu

19. USA, IRELAND, ENGLAND, GHANA

- **Programme is being implemented since:** 2013
- **End date of the programme:** NA
- **Responsible parties:** Civil society, Academic institution
- **Population reached:** People living with HIV; People with mental conditions; People who use substances, including alcohol; Young people
- **Has the programme been evaluated/assessed?** Yes, The HOP Program is a SAMHSA-NREPP certified evidence-based program. Also, see a sample of publications indicating the effectiveness of this stigma reduction intervention: Corrigan, P.W., Larson, J.E., Michaels, P.J., Buchholz, B.A., Del Rossi, R., Javier, M., Castro, D., Gause, M., & Rusch, N. (2015). Diminishing the self-stigma of mental illness by coming out proud. *Psychiatry Research*, 229, 148-154. W., Rossler, W., Klein, B., & Corrigan, P.W. (2014). The efficacy of coming out proud to reduce the impact of stigma among people with mental illness: randomized controlled trial. *the British Journal of Psychiatry*. Corrigan, P.W., Sokol, K.A., & Rusch, N. (2013). Reducing self-stigma by coming out proud. *American Journal of Public Health*, 103, 794-800
<http://ajphtalks.blogspot.com/2013/04/with-dr-patrick-corrigan-public.html>
- **Is the programme part of the National AIDS or Mental Health or Substance Abuse Prevention and Treatment Strategy?** No
- **Is the programme part of a national plan other than the National AIDS or Mental Health Strategy?** No

BACKGROUND

Honest, Open, Proud started as a chapter on disclosure in Corrigan and Lundin's *Don't Call Me Nuts: Coping with the Stigma of Mental Illness* (DCMN; published by Recovery Press, Tinley

Park, IL, 2001). Corrigan and Lundin, a service researcher and a consumer, respectively, were an energetic team that combined their wisdom into a practical text (DCMN) meant to address stigma change. In 2011, we began an effort to update the chapter into a stand-alone program with two overarching goals governing the task. First, we sought a panel of people with mental illness to review the program for relevance and utility, in the process asking them to try out program components. Second, we sought to do this with a collaboration of partners from around the globe. Our intent here was to construct a program with some attempt at cultural sensitivity and relevance. We have thus far received feedback from people with lived experience in Australia, Germany, Switzerland, the United Kingdom, Canada, and the United States.

DESCRIPTION

Why Honest, Open, Proud? Research shows those who have disclosed aspects of their mental illness report a sense of personal empowerment and an increase in confidence to seek and achieve individual goals. HOPp is a three-session group program run usually by pairs of trained leaders with lived experiences with the objective of reducing the self-stigma associated with mental illness. The three lessons include: 1. Considering the Pros and Cons of Disclosing: My identity and mental illness. Secrets are part of life. Weighing the costs and benefits of disclosing. 2. Different ways to Disclose: Five ways to come out. Testing a person for disclosure. How might others respond to my disclosure? 3. Telling your Story: How to tell a personally meaningful story. Who are peers that might help me with coming out? Review how telling my story felt. Putting it all together to move forward. A comprehensive Manual and Workbook are available at: comingoutproudprogram.org

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

Corrigan, P.W., Larson, J.E., Michaels, P.J., Buchholz, B.A., Del Rossi, R., Javier, M., Castro, D., Gause, M., & Rusch, N. (2015). Diminishing the self stigma of mental illness by coming out proud. *Psychiatry Research*, 229, 148-154. W., Rossler, W., Klein, B., & Corrigan, P.W. (2014). The efficacy of coming out proud to reduce the impact of stigma among people with mental illness: randomized controlled trial. *the British Journal of Psychiatry*. Corrigan, P.W., Sokol, K.A., & Rusch, N. (2013). Reducing self-stigma by coming out proud. *American Journal of Public Health*, 103, 794 -800. <http://ajphtalks.blogspot.com/2013/04/with-dr-patrick-corrigan-public.html>

LESSONS LEARNED AND RECOMMENDATIONS

Dr. Corrigan has spent his career addressing stigma in mental health and has been involved in many programs to change this stigma. This HOP Program came out of a accumulation of these efforts.

ANNEXES

20. ZIMBABWE AND UK

- **Programme is being implemented since:** 2008

TITLE OF THE PROGRAMME: The Friendship Bench Project

CONTACT PERSON

Name: Melanie Amma Abas

Title: Dr (Associate Professor)

Organisation: King's College London and University of Zimbabwe College of Health Sciences

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Tel: +44 (0) 7976893831

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- **End date of the programme:** Current
- **Responsible parties:** Government; Civil society; Private sector; Academic institution
- **Population reached:** Rural; People living with HIV; People with mental conditions; Indigenous and /or local communities; Women and girls; Young people
- **Has the programme been evaluated/assessed?** Yes, through a randomised clinical trial funded by Grand Challenges Canada; through qualitative evaluation also. We conducted this with local and international IRB approval and the trial was registered with the Pan African Trials registry
- **Is the programme part of the National AIDS or Mental Health or Substance Abuse Prevention and Treatment Strategy?** No
- **Is the programme part of a national plan other than the National AIDS or Mental Health Strategy?** Yes, City of Harare Health Department, Harare; the program is gradually in a transition phase

BACKGROUND

The Friendship Bench project trains lay health workers to treat depression outside of clinical settings using a technique called problem-solving therapy. The pilot work and the clinical trial were conducted in low income 'suburbs' (townships) in south Harare, Zimbabwe. Benches, placed out in the community, are the platform for the therapy. In a clinical trial of n=560 adults aged 18 and over, around 40% were people living with HIV. People who received the therapy, including those living with HIV, had improved symptoms of depression and less disability at 6 months follow-up, compared to those who received enhanced usual care. Chibanda, D., Weiss, H. A., Verhey, R., Simms, V., Munjoma, R., Rusakaniko, S., Chingono, A., Munetsi, E., Bere, T., Manda, E., Abas, M.+ & Araya, R.+ &. (2016) (+contributed equally). Effect of a Primary Care-

Based Psychological Intervention on Symptoms of Common Mental Disorders in Zimbabwe: A Randomized Clinical Trial. JAMA, 316(24), 2618-2626 Qualitative evaluation shows how the lay workers use the therapy, a process they call "Opening up the Mind" Abas, M., Bowers, T., Manda, E., Cooper, S., Machando, D., Verhey, R., Lamech, N., Araya, R. & Chibanda, D. 2016. 'Opening up the mind': Problem-solving therapy delivered by female lay health workers to improve access to evidence-based care for depression and other common mental disorders through the Friendship Bench Project in Zimbabwe. International Journal Of Mental Health Systems. 10, 1, 39

DESCRIPTION

This program is currently being implemented by municipal authorities in three cities in Zimbabwe (using existing government funds without enhancement) and also via an NGO in a district of rural Zimbabwe. Different countries are trying it although not specifically with HIV in mind. I am now working with CHAI to apply for funds to test how to implement this as part of a national strategy in Zimbabwe. Currently main partners are still the university of Zimbabwe with grants for research being used to fund evaluation. I also work on a grant to test its implementation in 16-19 year olds in Harare.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

Approximately 70,000 people so far, we estimate, in Zimbabwe, have used the Bench (both with and without HIV). We are currently working with NIMH and PEPFAR to evaluate its impact for people living with HIV, in a study of 750 people in Zimbabwe.

LESSONS LEARNED AND RECOMMENDATIONS

Low -cost, cultural acceptability, wisdom and kindness of the lay workers, as they come from the same community they know the issues, they also have status in the community due to their uniform. leadership of Dixon Chibanda and i mentored him over this between 2010 and 2015 over fundraising and publishing, Support from a community of global mental academics ie mental health specialists who understand the issues in LMIC including a team from London, Chile and South Africa.

ANNEXES

<https://mosaicscience.com/story/briefing-mental-health-zimbabwe-and-worldwide-impact-friendship-bench/>

21. MULTIPLE EAST AND SOUTHERN AFRICAN COUNTRIES

21.1 TITLE OF THE PROGRAMME: ABCD- Ask, Boost, Connect, Discuss for improved mental health of HIV+ adolescent mothers in Africa (Uganda, Kenya, Malawi, Zambia, Tanzania)

CONTACT PERSON

Name: Amy Whitting

Title: Ms

Organisation: Paediatric Adolescent Treatment Africa

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Email: amy@teampata.org

- **Programme is being implemented since:** 2018
- **End date of the programme:** NA
- **Responsible parties:** NGO
- **Population reached:** Rural; People living with HIV; People with mental conditions
- **Has the programme been evaluated/assessed?** No
- **Is the programme part of the National AIDS or Mental Health or Substance Abuse Prevention and Treatment Strategy?** No
- **Is the programme part of a national plan other than the National AIDS or Mental Health Strategy?** No

BACKGROUND

The sub-Saharan African region has the highest rate of adolescent pregnancy globally, with 28% of girls becoming mothers during adolescence [1]. Pregnant ALHIV are extremely vulnerable, facing multiple risks that may impact their own health, their capacity as parents and the health and development of their children [2]. Adolescent parenthood is associated with poor maternal mental health outcomes, including high levels of anxiety, depression and suicidality, with resulting adverse impacts on child health and development [3-6]. This may perpetuate intergenerational cycles of disadvantage and deprivation. Low-cost mental health interventions, delivered by lay health workers in low-resource settings, have been shown to effectively enhance mental health outcomes, including in the treatment of common perinatal mental health disorders such as anxiety and depression [7]. However, very few studies have assessed interventions specifically for maternal mental health among adolescent mothers living with HIV in low-resource settings. 1. Santhya, K. G. & Jejeebhoy, S. J. Sexual and reproductive health and rights of adolescent girls: Evidence from low- and middle-income countries. *Glob. Public Health* 10, 189–221 (2015). 2. Callahan, T., Modi, S., Swanson, J., Ng'eno, B. & Broyles, L. N.

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DESCRIPTION

The ABCD (Ask, Boost, Connect, Discuss) intervention aims to reduce maternal depression among young mothers living with HIV, which uses an app to assist delivery of a mental health intervention by peer supporters living with HIV. It is a co-developed package of care, consisting of four main pillars: - ASK: Peer supporter screens for maternal depression using the Edinburgh Postnatal Depression Scale [1] - BOOST: Delivery of an adapted version of the WHO-endorsed Thinking Healthy Programme [2], by peer supporters, assisted by a mobile phone app-based platform containing programme contents and 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 - 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 (Uganda, Kenya, Malawi, Zambia, Tanzania) by the NGO Paediatric Adolescent Treatment Africa (PATA). The programme is embedded within the REACH peer support intervention, which has provided support to adolescents and young people living with HIV since 2015. The programme is supported by a grant from the Gates Global Grand Challenges Exploration fund. 1. Shrestha, S. D., Pradhan, R., Tran, T. D., Gualano, R. C. & Fisher, J. R. W. Reliability and validity of the Edinburgh Postnatal Depression Scale (EPDS) for detecting perinatal common mental disorders (PCMDs) among women in low-and lower-middle-income countries: a systematic review. *BMC Pregnancy Childbirth* 16, (2016). 2. World Health Organization. Thinking Healthy: A manual for psychosocial management of perinatal depression. (World Health Organization, 2015).

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

The ABCD intervention is currently being developed, involving young mothers and peers living with HIV in focus group discussions and participatory visual design. The pilot study of ABCD will involve 34 peer supporters, each working with up to 6 young mothers, to reach a total of 200 young mothers and their children.

LESSONS LEARNED AND RECOMMENDATIONS

The ABCD programme aims to deliver a self-directed intervention, where the client may choose which particular concerns or unhealthy thoughts that apply best to her. Focus group discussions with young mothers from initial stages of intervention development showed that there is considerable variation in how young women experience their pregnancies, and which life challenges are associated with that transition. Further, focus groups showed that there is a widespread lack of discussion and basic awareness about mental health conditions, and a limited knowledge about the high incidence of mental health disorders and perinatal depression. These discussions have highlighted the need to identify sensitive approaches to introducing the topic of mental health disorders, as well as a general need to develop mechanisms for discussing stress, coping and health. Finally, with regards to app functionality and user friendliness, a main focus has been to create appealing visuals and incorporating Peer Supporter resources to facilitate delivery. These resources include tips on administering the screening and intervention tool, as well as guidance for dealing with more complex situations, where extensive training is not possible. Peer Supporter training will cover a range of content areas, communication strategies and ethics. While many topics are covered in initial training, having the opportunity to access support resources in-app during delivery of the intervention allows the Peer Supporter to feel more confident in delivery. In-app resources will include further details on for example how to convey the idea of a negative or unhealthy thought cycle to the client, and guidance on referring participants onto specialist services.

ANNEXES

NA

21.2 TITLE OF THE PROGRAMME:

**READY + (Resilient, Empowered Adolescents and Young People)
(Mozambique, eSwatini, Tanzania and Zimbabwe)**

CONTACT PERSON

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Title: Lead: Programmes

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- **Programme is being implemented since:** October 2016
- **End date of the programme:** December 2020
- **Responsible parties:** We are working within a Consortium that includes one private sector partner as well as closely collaborating with Ministries of Health in the 4 countries, but the Alliance is the Lead responsible party; Government; Civil society; Private sector
- **Population reached:** We are implementing an HIV programme targeting adolescents and young people living with HIV in the 4 countries. Our package of services includes HIV, SRHR and Psychosocial support and well-being; People living with HIV; Young people
- **Has the programme been evaluated/assessed?** No
- **Is the programme part of the National AIDS or Mental Health or Substance Abuse Prevention and Treatment Strategy?** Yes
- **Is the programme part of a national plan other than the National AIDS or Mental Health Strategy?** No

BACKGROUND

Global data highlights the alarming impact of HIV on A&YP. HIV is the second largest cause of death of adolescents globally, and the first in Africa (WHO, MNCA health, accessed 2016). Recent evidence suggests that the challenges A&YPLHIV face are different and complex (Children growing up with HIV infection: the responsibility of success. Lancet 2014;383: 1355_7.). As they explore their sexual identity and form relationships, A&YPLHIV are faced with disclosure to partners; understanding options for effective contraception while on ART; safe sex, safer conception and risks of MTCT, a key driver of the epidemic. A&YPLHIV deal with multiple stresses and adversities, and are at risk of depression and suicide (Morisson M F et al, Depressive and anxiety disorders in women with HIV infection. Am J Psychiatry 2002; 159: 789_96). It is critical that the treatment and care cascade for A&YPLHIV recognises the need for

psycho-social support. In response to these challenges, the READY + programme focuses on A&YPLHIV. By promoting an environment that supports healthy choices around sexuality, it aims to: improve the physical and psychological wellbeing of A&YPLHIV; reduce their risk of STIs, unintended pregnancies, mother to child transmission, and maternal complications; and improve adherence to ART. East and Southern Africa is home to two-thirds of all A&YPLHIV (aged 15-24), with an estimated 430,000 young people acquiring HIV every year (UNESCO, Young People Today, Time to Act now. Why adolescents and young people need comprehensive sexuality education and sexual and reproductive health services in Eastern and Southern Africa. New York: UNESCO). There have been limited responses in the region around improving SRHR outcomes for A&YPLHIV (Pretorius L et al, Interventions targeting sexual and reproductive health and rights outcomes of young people living with HIV: a comprehensive review of current interventions from sub-Saharan Africa. Glob Health Action 2015, 8: 28454) and little attention to the significance of their health outcomes on the epidemic. We work in countries with some of the highest number of ALHIV and rates of adolescent HIV related deaths (Tanzania, Mozambique and Zimbabwe), and in Swaziland which has the highest HIV prevalence globally at 27% of the adult population. We chose locations within countries to avoid duplication with DREAMS and other large programmes.

DESCRIPTION

This programme is implemented by a consortium led by the International HIV/AIDS Alliance, an INGO with over 20 years experience working on HIV, health and human rights with A&YP in Southern Africa, and draws on the successful Link Up programme. Paediatric Adolescents Treatment for Africa (PATA) provides a platform to engage with A&YPLHIV and service providers through its network of 336 clinics across the region. REPSSI brings expertise to address the psychosocial needs of A&YPLHIV; as well as strong links to Ministries of Health and Social Services in the four countries, and to regional processes. The Global Network of Young People living with HIV (Y+) ensures that young people are at the centre of programme design and implementation. Alliance Linking Organisations, TACOSODE in Tanzania, CANGO in Swaziland and Africaid Zvandiri in Zimbabwe provide strong community links and reach, and REPSSI provides country level coordination in 3 countries. Communications firm M&C Saatchi World Services have worked with the in-country partners and adolescents and young people to develop a digital solution, the CATS App, to support the peer educators to support clients on the treatment adherence journey. Africaid Zvandiri provide technical assistance on its best practice peer support/CATS model. The Alliance coordinates the work of the Consortium and is responsible for (i) monitoring progress of the implementation of the programme and motivating the Programme Steering Committee (made up of representative from each partner organisation) to act thereon, (ii) the financial management of the Programme Plan as a whole, and (iii) reporting to the Embassy of the Netherlands in Maputo who are financing the programme. Our goal is that 'Adolescents and young people living with HIV are resilient, empowered and knowledgeable and have the freedom to make healthier choices around their sexual and reproductive health and rights.' Our primary focus is to develop resilience, knowledge and skills in A&YPLHIV working through families, communities, service providers and wider society to provide an environment that is safe and supportive of rights to information and access to quality SRHR services for A & YPLHIV. Building resilience in young people affected by HIV improves their ability to cope with transitions in puberty, to deal with stress, trauma and bereavement more effectively, and to make confident, informed and consensual decisions. We work in 11 regions across the 4 countries; in each district we work with implementing partners who receive sub-grants from the country leads and in 6 health facilities bringing the total to 24 facilities. Sustainability: We are constantly reviewing how to make the programme robust and financially,

politically and programmatically sustainable. To ensure ownership of the programme, READY+ was launched in each country with Ministries of Health and Education. District and Regional AIDS Coordinators and Medical Officers are part of programme activities. The introduction of CATS in health facilities was facilitated very carefully to ensure the model is clear and that CATS are adding value to the work of health providers. CATS come from the communities and health facilities where they live and access services, and through trainings and mentorship, their knowledge and skills are being enhanced for life. In the past year, the Alliance has accessed additional investments to layer on ICT interventions in Mozambique (from the SPIDER Centre in Sweden) and to support the advocacy and leadership capacity of 100 young women living with HIV in Zimbabwe (from Comic Relief) who will in turn mentor and support 1000 young CATS.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

From October 2016 to June 2018, READY+ has reached 14,019 A&YPLHIV with SRHR and HIV information in safe spaces in health facilities and community settings (e.g. church hall, school, community centre or outside under a tree). A total of 287 community adolescent treatment supporters (CATS) were trained; and CATS reached 10,703 A&YPLHIV through one-to-one visits. Within health facilities, 123 health providers were trained on how to provide integrated SRHR, HIV and psychosocial support services; and with the help of CATS, 10,794 A&YPLHIV were reached with integrated facility-based services. There is real ownership of READY+ from consortium partners, their implementing partners, CATS, the Ministry of Health and health providers. They strongly embraced the CATS model and how it supports A&YPLHIV to play an active role in caring for their peers. Across the region, young people have engaged with the READY+ brand and youthful energy and the development of the CATS app has brought innovation to the project. The identification of Y+ focal points in each country and their advocacy for A&YPLHIV has given the project visibility, enabling us to engage with other youth and SRHR programmes in the region and to drive the READY movement. The majority of the beneficiaries received HIV care services with most receiving HIV health education & treatment literacy. PSS services received include disclosure and/or stigma support and emotional/psychological counselling. Other services provided include adherence counselling, ART defaulter counselling, ART pill count and viral load monitoring. Most of the services were provided by the CATS with the exception of viral load monitoring which was offered by the clinicians.

LESSONS LEARNED AND RECOMMENDATIONS

Success factors and recommendations: a) Meaningful Engagement of A & YPLHIV in programme design and delivery and local capacity building: We work to ensure that A & YPLHIV are at the centre of programming and delivery. The CATS model is fundamental to our model where peer supporters provide care to their peers. Through trainings and mentorship, across all four READY+ countries, the capacity of 287 CATS was enhanced to reach their peers with information and health services. The capacity of health providers was enhanced to provide an integrated package of SRHR, HIV and psychosocial support services that are adolescent- and youth-friendly. The capacity of 16 implementing partners and Lead Agencies (CANGO, REPSSI & TACOSODE) was enhanced to understand and support the CATS model and the collection and analysis of data. The capacity of Y+ focal points was enhanced to gather information from A&YPLHIV for use in developing youth accountability tools. b) Alignment with national priorities: The READY+ programme contributes to the implementation of the National Strategic Plans in Mozambique, Swaziland, Tanzania and Zimbabwe. Lead Agencies, implementing partners and youth advocates are part of national AIDS councils, district AIDS councils, adolescent and/or prevention technical working groups, and Ministry of Health stakeholder meetings where they

share data, learning and information about gaps and needs in the programme. The results of READY+ are included in the national monitoring system in each READY+ country. Implementing partners share their data at district or provincial level (depending on country), which then feeds into the national system. c) Innovation: The CATS model supports young people living with HIV to assist their peers with information and health services during visits to health facilities, during group safe spaces and through home visits. The model was implemented in 2017 across the four READY+ countries, with endorsement of Ministries of Health. The CATS READY+ app, co-created with young people living with HIV in eSwatini and Mozambique, aims to help A&YPLHIV adhere to medication. Using the mobile app, young people play games that prompt them to discuss feelings about their medication and any barriers they encounter. The app is currently being piloted in the two countries. d) Collaboration with local partners: READY+ Lead Agencies partner with the Ministry of Health, local NGOs delivering services to A&YPLHIV (e.g. Baylor), family planning organisations (e.g. Family Life Association of Swaziland) and youth organisations. Local partners were introduced to READY+ at the launch of the project. Lead Agencies signed Memorandums of Understanding with the Ministry of Health in order to work in public health facilities. Lead Agencies and implementing partners collaborate with local partners as part of a referral network to deliver services. They also collaborate in technical working groups on HIV prevention, treatment and care, and adolescent health to share and inform policy. e) Collaboration with other donors: At country level, READY+'s focus on promoting the leadership of young people in advancing their own health and rights complements the work of DREAMS in Swaziland and Zimbabwe; PITCH in Mozambique and Zimbabwe; and Global Fund support to scale up access to treatment in Zimbabwe and Swaziland. Collaboration takes place through national coordinating spaces including Ministry of Health stakeholder meetings and technical working groups. Regionally, the Alliance, Aidsfonds, PATA and Y+ meet monthly via skype to coordinate support for youth networks through the youth programmes we all manage: READY+, Get Up Speak Out (GUSO), REACH and Peers to Zero.

ANNEXES

READY Newsletter: Power of Peers

22. MULTIPLE WESTERN AFRICAN COUNTRIES

22.1 TITRE DU PROGRAMME:

Projet INCLUSIPH "Inclusion des personnes handicapées dans la réponse face au VIH (Sénégal et Guinée-Bissau)

CONTACT PERSON

Nom : Benoit Joseph WALOU

Titre : Chef de projet Régional INCLUSIPH Sénégal et Guinée-Bissau « inclusion des personnes handicapées dans la réponse face au VIH »

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- **Date de début du programme** : Avril 2017
- **Date de fin du programme** : NA
- **Responsables** : Nations Unies ou autres organisations intergouvernementales
- **Groupe(s) de population(s) atteint(s)**: Personnes vivant avec le VIH ; Femmes et filles ; Jeunes ; Personnes handicapées
- **Le programme a-t-il été évalué/analysés ?** Non
- **Le programme a-t-il fait partie de la Stratégie Nationale de Santé Mentale ?** Non
- **Le programme fait-il parti d'un plan national autre que la Stratégie Nationale de Santé Mentale ?** Oui, par le Programme Stratégique National de Lutte contre le VIH/SIDA

INFORMATIONS DE BASE

Les personnes handicapées sont ciblées dans la dernière stratégie de l'ONUSIDA 2016-2021 comme un groupe vulnérable face au VIH¹. De même, la Déclaration Régionale d'Afrique de l'Ouest et Centrale de la société civile en prélude du High Level Meeting on AIDS² et les Objectifs de Développement Durable (ODD)³ adoptés en 2015 mentionnent désormais clairement la nécessité de prendre en compte les personnes handicapées dans la réponse. Il est donc indispensable de maintenir et renforcer les efforts, les initiatives et les acquis en matière d'inclusion du handicap dans la lutte contre le VIH sur l'ensemble des 6 régions transfrontalières du Sénégal et de la Guinée Bissau. En effet, malgré une amorce concernant l'inclusion du handicap dans ces deux pays (Plan Stratégique National de Lutte contre le Sida du Sénégal inclusif⁴, début d'activités de Communication pour le Changement de Comportement (CCC) en faveur des personnes handicapées au Sénégal comme en Guinée Bissau, démarrage d'un système de suivi évaluation inclusif aux personnes handicapées au Sénégal), il est nécessaire de consolider et continuer à accompagner les deux pays dans cette dynamique et cibler des

zones transfrontalières particulièrement vulnérables face au VIH. La mutualisation et les échanges des expériences du Sénégal et de Guinée Bissau renforceront leur efficacité en matière d'inclusion du handicap dans la réponse au VIH.

Les personnes handicapées font partie des groupes laissés pour compte de la réponse face au VIH⁵. Le nouvel objectif global de « 95-95-95 » ne sera jamais atteint en 2030 sans l'inclusion de cette minorité à risque et sans une priorisation des actions en leur direction au sein des interventions nationales, régionales et communautaires.

Les régions du Sud du Sénégal et les régions du Nord de la Guinée Bissau constituent une large zone transfrontalière au sein desquelles les prévalences VIH sont parmi les plus élevées des 2 pays : Ziguinchor : 1%, Sédhiou : 1,1% et Kolda : 2,4% (versus 0,7% au Sénégal)⁶/ Cacheu : 3,7%, Oio : 5,3% et Bissau : 5,9% (versus 3,3% en Guinée Bissau). L'étude bio comportementale sur la vulnérabilité des personnes handicapées face au VIH au Sénégal de 2015, met en évidence une prévalence du VIH de 4.9% sur les régions de Sédhiou et Kolda versus 1.3 % pour la région de Dakar et 1.8 % pour le reste du pays (sauf Ziguinchor). Ces 6 régions concentrent une population de 2 430 787 personnes. Reparties en 6 régions médicales, 57 districts sanitaires (ou aires de santé en Guinée Bissau)⁷, 37 centres de traitement ambulatoires (17 pour les 3 régions du Sénégal et 20 pour les régions de Guinée Bissau), la vulnérabilité de cette zone transfrontalière est justifiée par le déplacement des populations, les pratiques socioculturelles néfastes comme l'excision⁸. L'analyse de ces régions⁹ fait apparaître notamment des facteurs communs de vulnérabilité : i) la position géographique, avec des zones transfrontalières avec un ou plusieurs pays de la sous-région (Gambie, Guinée Bissau, Guinée Conakry, Mali) et des zones enclavées (ex. Nord Sindian, Zone des palmiers, Narang, sud du département de Ziguinchor), ii) la forte mobilité des populations pour des raisons économiques et conflictuelles, iii) l'importante concentration humaine notamment dans les zones carrefour, les marchés, les zones aurifères et les sites touristiques, iv) la prostitution clandestine croissante, avec des réseaux sexuels actifs, générateurs de diverses vulnérabilités.¹⁰

Les données disponibles sur la vulnérabilité des personnes handicapées face au VIH sur ces deux pays concernent les études bio-comportementales réalisées sur la région de Dakar en 2011, Ziguinchor en 2014 et au niveau national en 2015. Toutes ont mis en valeur une prévalence du VIH, 2 à 3 fois plus importante au sein de la population handicapée face à la population générale de la région enquêtée¹¹.

En Guinée-Bissau, l'étude bio-comportementale réalisée en 2018 dans le cadre du projet Régional VIH & HANDICAP finance par le Fonds Mondial par le Cabinet Projeto Saude Bandim, montre une prévalence moyenne de 7.2% dont 8.4% chez les femmes handicapées. La PTME et la traitement ARV ont été initiée en 2005. Malgré cette prévalence importante chez cette population, le Plan stratégique national de lutte contre le VIH/Sida 2015-2020 ainsi que le plan de rattrapage national n'inclut pas le handicap.

Les données produites dans le cadre de l'enquête de 2015, met en évidence des prévalences sur la syphilis et l'hépatite B plus importantes au sein de la population des personnes handicapées enquêtées qu'au sein de la population générale ou des autres groupes cibles enquêtés¹² ; il est donc important que le projet prévoit une prévention du VIH incluant aussi la prévention et la gestion des IST.

Le problème de la coinfection TB /VIH reste un défi important pour le secteur de la santé dans la riposte face au VIH. Le projet s'assurera que le lien entre TB et VIH soit effectif dans les actions

de sensibilisation et que l'information correcte sur le système de référencement vers les sites de prise en charge soit effective. Intégrée dans les messages diffusés lors des activités de sensibilisation, activités CCC, stratégies avancées, la coinfection TB/VIH sera prise en compte tout au long du projet et permettra d'informer les populations touchées par ces activités sur les risques de contamination TB chez les personnes porteuses du VIH, les moyens de réduire l'exposition, les manifestations cliniques de la maladie, les risques de contagion. Ceci permettra d'améliorer le diagnostic précoce et la mise sous traitement de la tuberculose pour tous les patients vivant avec le VIH.

De plus, pour renforcer la synergie et la coordination des interventions des différents programmes tels que la Santé de reproduction, la tuberculose, le VIH, les acteurs issus de ces différents services seront dès que possible intégrés aux activités du projet.

Les personnes handicapées sont vulnérables face au VIH en raison i) de leur accès limité aux services de prévention du VIH. En effet, les prestataires de soins sont peu informés sur la question du handicap, les outils de CCC inclusifs et adaptés aux différents types d'incapacités sont insuffisants voire inexistants ; il y a peu ou pas de stratégies avancées réalisées pour décentraliser l'accès aux services de prévention et dépistage pour les populations handicapées et on observe le manque d'informations des personnes handicapées sur leurs droits, ii) de comportements à risque (relations sexuelles non protégées, faible utilisation du préservatif etc.), iii) de leur accès limité aux traitements, soins et services de soutien disponibles. Les structures de soins ne sont pas accessibles d'un point de vue physique, communicationnel et financier, les données sanitaires inclusives au handicap (désagrégées par type d'incapacités physiques, visuelles, auditives, de communication, mentales et intellectuelles) restent restreintes et le paquet de soins ne prévoit pas des soins liés aux incapacités développées lors de la maladie, iv) d'une stigmatisation et discrimination entravant leur accès et l'utilisation des mesures de prévention, de soins, de traitement et de soutien. Les personnes handicapées vivant avec le VIH se trouvent doublement discriminées du fait de leur statut sérologique et de leur handicap, v) d'une grande vulnérabilité face aux violences sexuelles¹³. Une analyse d'un ensemble d'études s'intéressant à la prévalence des risques de violence sur les personnes handicapées (adultes et enfants), publiée dans le journal *The Lancet*¹⁴, montre que la prévalence de la violence sur des personnes avec un trouble mental est 3,86 fois supérieure à celle concernant la population générale. La prévalence de la violence sur des personnes avec une déficience intellectuelle est 1,6 fois supérieure à celle concernant la population générale.

La prévalence de la violence sur des personnes avec une déficience non spécifique est 1,3 fois supérieure à celle concernant la population générale.

La prévalence générale des risques de violence sur les personnes handicapées, toutes incapacités confondues, est une fois et demie (1,5) supérieure à celle concernant la population générale.

L'expérience des programmes de Handicap International montre que les problématiques de violences faites aux personnes handicapées sont peu prises en compte. Les violences restent un sujet tabou au sein du sujet déjà tabou que constitue le handicap. Les communautés sont peu sensibilisées à ces problèmes, les services restent peu accessibles et les politiques publiques ne mettent pas suffisamment l'accent sur la lutte contre les violences faites aux personnes handicapées.

La vulnérabilité des femmes handicapées face aux violences sexuelles est démontrée dans le contexte régional du projet au regard des données relatives aux études réalisées en 2014 sur Ziguinchor (5,8% des femmes handicapées interrogées ont subi des violences sexuelles contre 1,3% des hommes handicapés et en 2015 (11.5% des femmes enquêtées sont concernées par des violences à caractère sexuel versus 3.9% pour les hommes enquêtés).

DESCRIPTION

Malgré la ratification de la Convention Relative aux Droits des Personnes Handicapées par le Sénégal et la Guinée Bissau, **l'accès aux services de santé et en particulier au VIH et à la santé sexuelle et reproductive reste très limité**, en particulier pour les filles et femmes handicapées. Par préjugés sociaux ou fausses croyances, celles-ci sont souvent considérées comme sexuellement inactives. Leur manque d'accès à l'information sur la santé et sur leurs droits, les expose à des comportements à risque, à des violences liées au genre et au handicap. La **féminisation de l'épidémie** observée dans la population générale en Guinée Bissau¹⁵ et au Sénégal ¹⁶ est constatée au même titre lors des études bio comportementales¹⁷. Les interactions entre la SSR et le VIH sont désormais largement reconnus et on assiste à la promotion de l'intégration au niveau politique

L'approche de Handicap International pour mettre en œuvre des services intégrés et inclusifs de prévention, de traitement, de soins et de soutien doit garantir : une approche inclusive du handicap qui répond aux besoins des personnes vivant avec tout type d'incapacité, une approche globale, inclusive du genre, qui prend en compte les droits humains fondamentaux. Toutes les activités de Handicap International reposent sur l'engagement du respect pour l'égalité de l'accès aux droits fondamentaux pour les femmes et les hommes, qu'ils soient handicapés ou non¹⁸. La politique sur le genre de Handicap International promeut la non-discrimination et la protection en assurant une égalité entre les hommes et les femmes, la double inclusion du genre avec un accent particulier sur la discrimination à l'encontre des femmes handicapées¹⁹.

Les activités proposées dans le cadre de ce projet INCLUSIPH, orientées selon une approche communautaire attentive à la prise en charge adaptée aux différents types d'incapacités et à la question du genre, seront donc complémentaires aux activités du projet Régional notamment concernant l'aspect prestation de services, la prise en compte des IST, SSR et de la coinfection TB/VIH: offres de soins, renforcement d'accès des services de prévention, dépistage et traitement pour les personnes handicapées. En évoluant sur des régions transfrontalières ce présent projet est orienté vers une approche communautaire et opérationnelle.

Les activités de Communication pour le Changement de Comportement pourront insister sur les manquements et les recommandations issues de l'évaluation juridique des gaps entre la signature de la CIDPH et sa mise en œuvre, développées dans le projet régional VIH-handicap ; ce qui renforcera le plaidoyer et la sensibilisation à la base ;

L'objectif général est de contribuer à l'amélioration de l'accessibilité aux services de santé inclusifs et intégrés en matière de VIH/sida dans 6 régions frontalières du Sénégal et de la Guinée Bissau pour le groupe vulnérable des personnes handicapées. 4 objectifs spécifiques sont proposés et une fois cumulés permettront d'atteindre l'objectif général fixé.

L'objectif spécifique 1 sera d'assurer un accès à des services VIH inclusifs au handicap intégrant les thématiques TB, IST et SSR en matière de prévention, dépistage et traitement. Les barrières physiques et communicationnelles d'accès aux structures de soins identifiées lors des précédents projets et études seront levées. Des outils CCC inclusifs et adaptés et

de reporting des données désagrégées par sexe, âge et type d'incapacités, dans des structures de santé mises en accessibilité, seront développés. Ainsi, chacune des 6 régions médicales disposera d'au moins un service VIH accessible aux personnes handicapées d'un point de vue physique et communicationnel ; une augmentation de 30% des dépistages volontaires et du retrait des résultats parmi les femmes et les hommes handicapés du début jusqu'à la fin du projet sera effective (basée sur les données disponibles lors des premières récoltes des données désagrégées par sexe, âge et type d'incapacité).

L'objectif spécifique 2 sera de renforcer les capacités des prestataires de soins sur l'inclusion du handicap dans les services de prévention et de prise en charge dans le domaine du VIH et ses thématiques intégrées (TB/IST, SSR) en matière de prévention, dépistage et traitement inclusif au handicap. En renforçant les prestataires de soins sur l'inclusion du handicap, sur les techniques de communication en langage des signes, sur les soins palliatifs communautaires et les soins de base de réadaptation fonctionnelle, au moins 80% de prestataires de soins formés maîtriseront les éléments clés de la prise en charge inclusive. De plus, au moins 90% des femmes enceintes handicapées dépistées positives sur les 6 régions seront référées et bénéficieront du paquet de soins de la PTME selon le protocole du pays.

L'objectif spécifique 3 sera de renforcer le paquet d'activités de prévention, dépistage de soins et de soutien inclusif communautaire. Le renforcement des capacités et l'implication des organisations de personnes handicapées et des associations de personnes vivant avec le VIH en terme de formation initiale sur le handicap, le VIH et ses thématiques intégrées, leur implication dans la réalisation d'activités de prévention, dépistage et prise en charge communautaire et l'évaluation de l'impact du projet sur leur qualité de vie permettra d'assurer qu'au moins 70% de la population de personnes handicapées PVVIH et PVVIH présentant des incapacités identifiées par le projet ont bénéficié d'activités communautaires de soutien. De plus, 70% de l'échantillon de personnes handicapées vivant avec le VIH et PVVIH présentant des incapacités identifiées par le projet et enquêtées déclarera avoir une amélioration de qualité de vie.

L'objectif spécifique 4 est d'assurer la bonne gouvernance, la coordination du projet et le partage d'expériences transfrontalières dans la réponse inclusive au VIH. L'intégration des équipes du projet et des bénéficiaires dans les dynamiques de rencontres sectorielles et au sein des plateformes des acteurs de la réponse face au VIH permettra de renforcer l'inclusion du handicap dans les activités transfrontalières de lutte contre le VIH-Sida. Le projet assurera que les personnes handicapées sont bien impliquées dans les instances de coordination au niveau transfrontalier.

La capitalisation et dissémination des bonnes pratiques réalisées sur le projet auprès des acteurs au Sénégal et en Guinée Bissau et lors des conférences internationales ICASA 2017 et 2019 permettra de renforcer le plaidoyer en faveur de l'inclusion du handicap dans la réponse face au VIH.

Le projet est mis en œuvre par Handicap International en partenariat dans chaque pays avec une organisation locale Santé Service Développement (SSD) au Sénégal et Cida alternag en Guinée-Bissau sous le financement d'Expertise France Initiative 5% à travers le Canal 2. Ces deux organisations locales sont connues pour leurs expériences et leurs compétences en matière de lutte contre le VIH dans leurs pays.

Le projet est mis en œuvre au Sénégal dans les trois (03) régions naturelles de la Casamance Ziguinchor, Sédhiou et Kolda et en Guinée-Bissau dans les régions de Cacheu, Oio et Bissau. L'équipe du projet est composée d'un Chef de projet basé à Ziguinchor, un chargé de projet Casamance, une chargée de projet Guinée-Bissau, quatre (04) animateurs des ONGs partenaires SSD et Cida alternag. L'équipe projet reçoit un appui technique de la part de la Coordinatrice Technique Santé et Réadaptation basée à Dakar et de la Référente Technique VIH/SIDA basé au siège à Lyon.

En vue de la pérennisation des effets du projet, les organisations des personnes handicapées et les OCB sont capacités en vue de disposer d'outils permettant de promouvoir leurs droits dans les plus hautes instances politiques et stratégiques et d'assurer leur autonomie. Ceci est fait à travers des activités de renforcement de capacité sur les thématiques suivantes : les droits des PH, la thématique de l'inclusion, les thématiques du VIH, de la SSR et de la tuberculose. Les organisations des PH sont responsables de la mise en œuvre des stratégies avancées de prévention et de dépistage. Pour la mise en œuvre, elle travaille en partenariat avec les centres de santé des régions d'intervention. A l'heure actuelle, 1638 personnes handicapées sont dépistées dont 33 cas déclarés positifs référencier et mise sous TARV.

RESULTS, REPERCUSSIONS ET IMPACT DU PROGRAMME

1. Résultats attendus

OS1: Assurer un accès à des services VIH inclusifs au handicap intégrant les thématiques TB, IST et SSR en matière de prévention, dépistage et traitement.

A1-1 Adapter et rendre inclusifs les outils CCC sur le VIH.

Les outils de sensibilisation pour un changement de comportement en matière de la santé et du VIH, SSR et de la TB en particulier sont produits et mis à la disposition des animateurs, relais communautaires et les organisations des personnes handicapées pour sensibiliser leurs pairs.

Ces outils sont:

- Les boîtes à image inclusif,
- Les cartes de jeux
- Les posters pour la visibilité
- Les documents en braille sur les messages de prévention sur le VIH sont en cours de production. Des messages audios sur la prévention du VIH, sur les IST/SSR et TB sont également en cours de production au profit des personnes souffrantes de déficiences visuelles.

A1-2 Réaliser, multiplier et diffuser un aide-mémoire sur l'inclusion du handicap.

Basé sur le module de formation inclusion du handicap et autres documents développés par HI un aide-mémoire de 100 pages (format livret de poche) est conçu, traduit en portugais et multiplié en 450 exemplaires. Ce manuel de formation est conçu pour servir de référence à l'inclusion du handicap dans les services et interventions relatives au domaine du VIH/sida, ses coïnfections et de la santé sexuelle et reproductive. Cet aide-mémoire servira de guide de référence pour les prestataires de soins et autres acteurs de lutte contre le VIH dans la prise en charge des hommes et des femmes handicapés dans l'offre de services VIH, SSR et TB. Il sera distribué à 180 prestataires de soins des 6 régions du projet et 180 acteurs communautaires. Il permettra aux 30 formateurs, 180 prestataires de soins et 180 acteurs communautaires formés sur l'inclusion du handicap d'avoir à disposition les éléments synthétiques pour assurer une mise en pratique effective de l'inclusion du handicap. Cet aide-mémoire constituera aussi un support de plaidoyer dans le cadre du projet régional de HI financé par le FM.

Il sera diffusé dans les sites appropriés et partagés avec les autres acteurs de lutte contre le VIH à l'occasion de la 20^{ième} édition d'ICASA à Kigali.

A1-3 Réaliser, multiplier et diffuser un aide-mémoire sur les soins palliatifs au niveau communautaire et sur la décentralisation des soins de base en réadaptation fonctionnelle (SBRF).

Basé sur l'aide-mémoire « Santé Positive, Dignité, Prévention et Soins Palliatifs au niveau communautaire » développé par Santé Services Développement au Sénégal pour le renforcement des capacités des associations de PVVIH et sur le module des soins de base de réadaptation fonctionnelle développé par HI, un aide-mémoire de 100 pages (format poche) est conçu en 120 exemplaires.

Ce support a repris les éléments clés d'un plaidoyer pour une santé positive communautaire et des soins palliatifs communautaires en termes d'intervention préventives (escarres, infections, malnutrition...) et palliatives (la douleur, la toux et difficultés respiratoires...) liées à la maladie, ses coinfections (notamment TB/VIH), les IST et maladies opportunistes. Il est fusionné aux éléments clés de soins de réadaptation de base fonctionnelle (mobilisation passive, kits d'appui technique...). Ce livret est distribué à 40 prestataires de soins, les personnes handicapées et les personnes vivant avec le VIH.

A1-3 Mettre en place des kits d'appui technique de réadaptation fonctionnelle de base.

Cette activité est portée par HI en collaboration avec un ergothérapeute contractualisé sur 2 mois par an. Cet appui technique et spécialisé a permis, grâce à un travail avec les équipes de réadaptation fonctionnelle disponibles dans les régions couvertes par le projet, d'identifier les besoins en équipements de réadaptation (siège adapté, déambulateur, attelles, coussins anti escarres, coussins de verticalisation...) pour les personnes vivant avec le VIH présentant des incapacités préexistantes ou acquises. Cette activité liée à la confection d'équipement de réadaptation fonctionnelle de base est complémentaire à la formation des prestataires de soins sur la décentralisation des soins en réadaptation fonctionnelle.

A1-4 Réaliser des audits d'accessibilité et de mises en accessibilité physique et communicationnelle de services VIH

Cette activité est portée par HI en collaboration avec un ingénieur conseil contractualisé pour la réalisation des audits d'accessibilité et le suivi des travaux de mise en accessibilité, permettra de lutter contre les barrières physiques et communicationnelles rencontrées par les personnes handicapées dans leur accès aux services de soins. Chaque service VIH de structure ciblée par le projet (soit 40) a été audité ce qui a permis d'évaluer leurs besoins d'adaptation pour répondre aux normes d'accessibilité. 10 services VIH des structures sanitaires des 6 régions bénéficieront des travaux d'accessibilité à partir de Novembre 2018 à Avril 2019. Les 30 autres structures pourront s'appuyer sur le dossier d'audit réalisé pour assurer les travaux nécessaires lors de prochaines réhabilitations ou constructions de bâtiments.

OS2: Renforcer les capacités des prestataires de soins sur l'inclusion du handicap dans les services de prévention et de prise en charge dans le domaine du VIH et ses thématiques intégrées (TB/IST, SSR) en matière de prévention, dépistage et traitement inclusif au handicap.

A2-1 Former/recycler des formateurs et des acteurs de la santé sur les droits des personnes handicapées et l'inclusion du handicap dans les services liés au VIH.

Cette activité est portée par HI et a permis de former 30 formateurs sur l'inclusion du handicap et qui à leur tour ont formé 180 prestataires de soins et 180 acteurs communautaires sur les thématiques droits des PH, l'inclusion du handicap dans les services VIH, SSR et TB sur chacune des 6 régions pendant 5 jours.

L'ensemble des participants ont reçu un aide-mémoire de poche sur l'inclusion du handicap dans l'offre de service VIH, SSR et TB.

A2-2 Former/recycler des prestataires de soins et des acteurs communautaires sur le langage des signes

24 prestataires de soins et 24 acteurs communautaires ont bénéficié d'une formation continue sur le langage des signes. Cette activité a permis de mettre à disposition des structures, des équipes de soins (prestataires de soins, acteurs sociaux et communautaires) formées au langage des signes. Ainsi l'accès aux services de soins VIH et de ses thématiques intégrées IST/TB/SSR aux personnes présentant une incapacité auditive et/ou de communication est renforcée.

A2-3 Former et recycler des prestataires de soins sur les soins palliatifs au niveau communautaire et sur la décentralisation des soins de base en réadaptation fonctionnelle (SBRF)

68 prestataires de soins sont formés et recyclés sur les soins palliatifs au niveau communautaires et sur les soins de base en réadaptation fonctionnelle.

Sur la base des modules développés par Santé Services Développement sur les soins palliatifs au niveau communautaire et par HI sur la décentralisation des soins de base en réadaptation fonctionnelle.

Chacun des prestataires de soins est muni de l'aide-mémoire sur les soins palliatifs et les SBRF et assure les activités de soins à domicile de l'équipe mobile en soins palliatifs. Avec cet aide-mémoire, le prestataire est capable de détecter de manière précoce les déficiences chez les patients PVVIH et au besoin faire le référencement auprès d'une structure la mieux appropriée.

OS3 : Renforcer le paquet d'activités de prévention, dépistage, de soins, de soutien et prise en charge du VIH inclusif communautaire.

A3-1 Former/recycler les organisations de personnes handicapées (OPH) sur leurs droits liés au handicap, le VIH et ses thématiques intégrées.

En Guinée-Bissau, Handicap International travaille sur le renforcement des capacités des organisations de personnes handicapées notamment à travers le projet de renforcement du mouvement des droits de personnes handicapées. Ce projet, soutenu par l'UE, a démarré en janvier 2016 et s'achèvera en décembre 2018. Il se focalise sur le renforcement organisationnel et institutionnel des organisations des personnes handicapées, ainsi que d'autres organisations de la société civile. Dans ce cadre, un programme de formation et accompagnement technique est en exécution. L'animation inclusive, les droits humains, le genre et handicap, l'accessibilité universelle et le développement local inclusif font partie des formations réalisées. A un autre niveau, les organisations bénéficiaires du projet sont formées et coachées notamment sur la gestion de projets et la gestion administrative et financière d'une association.

En outre, le projet régional VIH et handicap, prévoit de former et accompagner les Organisations de Personnes Handicapées, la Fédération Nationale des Personnes Handicapées, ainsi que le réseau des personnes vivant avec le VIH sur le plaidoyer, le montage et exécution d'un plan d'action pour le plaidoyer avec l'objectif de : (1) promouvoir les droits des personnes handicapées ; (2) réduire les obstacles juridiques et (3) améliorer l'accès aux services de prévention, traitement et appui relatif au VIH/SSR aux personnes handicapées.

Le projet INCLUSIPH a bénéficié d'une part des activités de ces deux projets. Cette activité a permis de renforcer 120 membres d'OPH des 6 régions lors d'une session de formation de 2 jours pour 60 membres au Sénégal et une autre pour 60 membres en Guinée Bissau.

Une attention particulière est donnée au genre pour garantir une participation effective des femmes handicapées, renforcer leurs connaissances sur leurs droits, des questions liées aux

droits de la santé reproductive, les violences et le circuit de référencement et mécanismes de prise en charge disponible sur leurs régions. Cette maîtrise renforce leur implication et leur empowerment dans le plaidoyer sur l'inclusion du handicap et du genre dans la lutte contre le VIH.

A3-2 Formation des associations de PVVIH sur la thématique du handicap.

120 membres d'associations de PVVIH sont formés sur le handicap, 60 membres au Sénégal et 60 membres en Guinée Bissau. Ainsi, les connaissances des PVVIH sur les droits des personnes handicapées ont été renforcées et sur le lien entre le VIH et les incapacités en lien avec la maladie et autres comorbidités. Ces formations ont été attentives à la pleine participation de femmes vivant avec le VIH et a abordé notamment les questions de genre et de violences basées sur le genre. Les liens entre les organisations de personnes vivant avec le VIH et des personnes handicapées a permis de favoriser l'adhésion des personnes handicapées vivant avec le VIH à ces associations.

A3-3 Réaliser des activités de soins palliatifs communautaires.

30 membres de PVVIH et 30 membres d'OPH des 6 régions sont formés et réalisent des activités de soutien communautaire. Les relais communautaires et les médiateurs (personnes vivant avec le VIH qui sont dans les centres de santé) réalisent des activités de soutien, d'appui et d'accompagnement psychosocial des PVVIH à travers des Groupes de parole ou des VAD avec partage. A ce jour, 70 groupes de parole sont réalisés et touchés 444 personnes vivant avec le VIH dans les 6 régions d'intervention du projet.

L'activité **visite à domicile avec partage (VAD/P)** cible une personne vivant avec le VIH ou une personne handicapée perdue de vue, et son entourage familial pour s'enquérir de son état et de ses conditions de vie en vue de lui apporter un soutien ou des soins selon ses besoins spécifiques. Au cours de ces visites, le partage se fait sur un sujet contenu dans l'aide-mémoire en soins palliatifs et en soins de base en réadaptation fonctionnelle. Cette activité se réalise à la suite de la détection au cours d'une visite à domicile avec partage d'un cas de maladie alitée avec des besoins de soins palliatifs tel que défini dans l'aide-mémoire. Ces soins sont prodigués par une équipe communautaire formée dénommée « *bénévoles en soins palliatifs* » en lien avec les sites de prise en charge du VIH où sont référés les malades. Au niveau de chaque site de prise en charge du VIH des 6 régions, le projet a aidé les prestataires de soins formés et les communautaires à former **des équipes mobiles en soins palliatifs (EMSP)** capables d'intervenir à domicile et dans les structures de santé. Ces équipes mobiles pluridisciplinaires prennent le relais des agents communautaires dans la dispensation des soins palliatifs selon les signes de gravité et de danger. Ces équipes sont coordonnées par les médecins responsables des sites de prise en charge du VIH.

A3-4 Evaluer la qualité de vie des personnes handicapées et vivant avec le VIH bénéficiaires du projet.

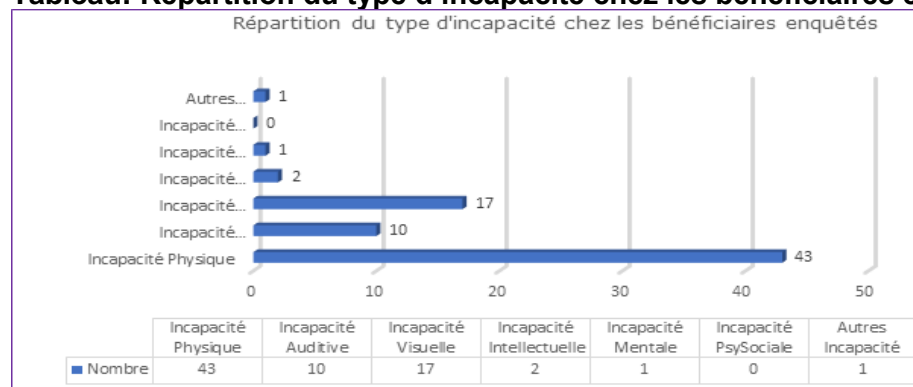
Le questionnaire Scopéo (outil et méthode de référence Handicap International pour la mesure de la qualité de vie), a permis de mesurer la situation de vie baseline auprès d'un échantillon de 80 bénéficiaires PVVIH âgés de 18 ans et plus, identifiés selon une méthode non probabiliste, sur leurs conditions de vie à deux moments distincts du cycle de projet (avant ou au début/après) en s'intéressant aux concepts liés à la qualité de vie, ainsi que ses notions connexes. Il s'agit d'une évaluation quantitative avec questionnaire individuel. L'outil questionnaire ScoPeO est composé de 3 parties pour identifier les bénéficiaires, les dimensions, les données sociodémographiques, et couvre 3 domaines (qualité de vie, sécurité perçue, participation sociale et familiale). **La qualité de vie** évaluera : i) La dimension santé physique et mentale ; ii) La dimension relations sociales et personnelles ; La dimension bien-être subjectif (état psychologique) ; La dimension besoins de base ; La

dimension bien-être matériel. **La sécurité perçue** est une seule dimension permet à l'individu d'estimer son sentiment de sécurité au travail, dans son logement, dans ses activités quotidiennes et ses déplacements. **La participation sociale et familiale** permet à l'individu de déclarer son niveau de satisfaction vis-à-vis de i) la participation à des événements familiaux ; ii) l'implication dans les décisions de la famille ; iii) la participation à des événements communautaires, iv) l'autonomie dans la prise de décision ; v) l'implication dans les décisions de la communauté.

La méthode ScOpeo est basé sur le calcul par score qui varie de 5 à 25. Quand l'enquêté a un score inférieur à 15 (moyenne théorique), sa situation de qualité de vie est considérée comme mauvaise. Par contre s'il obtient un score \geq à 15, sa qualité de vie est considérée comme bonne. Sur les différentes dimensions de la qualité, seule la dimension à la participation sociale et familiale est considérée comme bonne avec une moyenne de 16 scores/25.

Sur la base du rapport évaluation qualité de 74 PVVIH (6 n'ayant pas répondu présent)

Tableau: Répartition du type d'incapacité chez les bénéficiaires enquêtés



A3-5 Réaliser des audits communautaires du projet.

Cette activité basée sur l'outil d'audit communautaire développé par HI, permet d'évaluer, à 5 reprises, l'appréciation du projet dans sa globalité par les bénéficiaires eux-mêmes au niveau de chacune des 6 régions. Ces « audits communautaires » se veulent pratiques et participatifs sous la forme d'ateliers d'évaluation sociale. Ils ont pour objectif de donner la parole à toutes les parties prenantes afin d'exprimer leurs points de vue et d'analyser ensemble les réalisations et changements induits par le projet dans leurs communautés respectives. Un audit communautaire est en cours de réalisation et va porter sur les activités suivantes : formation OPH et prestataires de soins, soutien appui et accompagnement psychosocial des PVVIH, stratégie avancée de prévention et de dépistage et enfin activité CCC.

A3-6 Réaliser des activités CCC auprès des personnes handicapées, leur famille et leur entourage.

1 000 familles dans l'environnement des personnes handicapées sont sensibilisées grâce à la mise en place d'un plan d'action et d'une stratégie CCC inclusive. Sur la base d'un plan d'action annuel validé par HI, Santé Service Développement et de Alternag réalisent des activités CCC communautaires tenant compte des spécificités des différents types d'incapacités et du genre et des thématiques intégrées IST/TB/SSR identifiées dans la remontée des données mensuelles sur chacune des 6 régions en fonction des besoins identifiés notés par et pour les personnes handicapées. Ces activités tiennent compte des contraintes liées aux activités des femmes

(horaires, mobilité nécessaire, possibilités de concilier les activités de l'intervention avec les tâches domestiques, la garde d'enfants, etc.) permettant d'assurer une participation effective des femmes. A ce jour 747 personnes handicapées et leurs accompagnants sont sensibilisés sur les thématiques du VIH, SSR, IST et TB. Les méthodes de sensibilisations utilisées sont les causeries éducatives (regroupant les PH de tout sexe et de tout âge pour un nombre minimum de 10 personnes), les niches éducatives (regroupent les PH ayant le même sexe et plus ou moins le même âge). Ce type de méthode est préconisée pour lever les barrières d'âge ou de sexe qui peuvent entraver les discussions et la participation des plus jeunes. Les entretiens personnalisés sont utilisés pour sensibilisés de manière individuelle les PH qui ont des difficultés pour se déplacement vers les lieux de sensibilisation de masse ou ont un accès très limité à l'information sur la santé. Ces activités sont réalisées par les animateurs assistés parfois par les assistants sociaux des postes ou centres de santé. Les supports utilisés sont les boîtes à image et les cartes de jeux.

A3-7 Réaliser des stratégies avancées de prévention et de dépistage volontaire sous forme d'activités d'initiatives locales (AIL).

Les AIL ont pour objectif de faciliter l'inclusion des personnes handicapées dans l'ensemble des stratégies et interventions de riposte au VIH. Ce sont des actions communautaires menées conjointement entre les organisations de personnes handicapées et les organisations de base impliquées dans la lutte au VIH. Ces actions visent à améliorer l'accessibilité des services VIH et ses thématiques intégrées (TB, IST et SSR) liés à la prévention au VIH, au conseil et dépistage volontaire. HI et les organisations de PH et les centres de santé sont en partenariat dans la mise en œuvre des activités de prévention et de dépistage des PH. A ce jour, 1638 personnes handicapées sont conseillées et dépistées contre le VIH dont 537 femmes handicapées avec 33 cas déclarés positifs et référenciés dans les structures de PEC et sont sous traitement ARV. Cependant, il faut signaler que ceci est seulement pour les 3 régions du Sénégal. En Guinée-Bissau, jusqu'ici le dépistage n'a pas démarré à cause du manqué de kits de dépistage de masse et aussi pour rupture de stock d'ARV dans plusieurs structures de prise en charge.

A3-8 Appuyer les personnes handicapées dans l'accès aux soins de réadaptation fonctionnelle en lien avec le VIH.

Les prestataires de soins formés en activité sur la décentralisation des soins de base en réadaptation fonctionnelle pourront détecter, prévenir et référer rapidement l'installation de la déficience en lien avec la maladie VIH. Des kits d'appui techniques sont mis à leur disposition. Cette activité, est mise en œuvre par Santé Service Développement et Cida Alternag, permettra d'accompagner les bénéficiaires identifiés vers les structures de protection sociale en vue de prendre en charge les frais des soins de réadaptation. Le paquet de soins de la prise en charge du VIH actuellement disponible au Sénégal et en Guinée Bissau ne prévoit aucun appui en termes de soins de réadaptation alors que certains PVVIH en ont besoin avec l'apparition d'incapacités au cours de la maladie. La nécessité d'appuyer les bénéficiaires pour prévenir, limiter et soulager l'installation définitive des incapacités est indispensable pour l'amélioration de la qualité de vie de ces patients. Le projet pourra appuyer les déplacements des bénéficiaires vers les services de réadaptation fonctionnelle ainsi que les coûts engendrés par ces soins spécialisés. Un consultant en réadaptation ergonomique est recruté es ten train de mener des consultations auprès des patients PVVIH et envisage dans les prochains jours se rendre au domicile des patients pour une étude de l'environnement immédiat de ces patients et voir les adaptations qui pourront y être faite pour faciliter leur mouvement dans la maison. Depuis le démarrage de la mission, 79 patients PVVIH sont consultés au Sénégal et en Guinée-Bissau. Un premier rapport est en cours de production.

OS4: Assurer la bonne gouvernance, la coordination du projet et le partage d'expériences transfrontalières dans la réponse inclusive au VIH.

A4-1 Participer aux rencontres sectorielles trimestrielles du cadre transfrontalier de gestion de la riposte au VIH.

Participation de 5 partenaires du projet aux rencontres trimestrielles.

Ces rencontres organisées dans le cadre du projet FEVE 3 (ENDA Santé/Coopération Luxembourgeoise), permettent d'inclure 5 partenaires et bénéficiaires du projet de Guinée Bissau et du Sénégal afin d'assurer l'inclusion opérationnelle du handicap dans la réponse face au VIH à un niveau régional. Un interprète en langage des signes est mis à disposition si une personne présentant une incapacité auditive et/ou de communication participe à ces réunions. Le projet a déjà participé à une première rencontre transfrontalière organisée à Kolda en Novembre 2017. Une autre rencontre est programmée pour Novembre 2018 en Guinée-Bissau.

A4-2 Participer à la plateforme semestrielle sous régionale des 2 CNLS des acteurs de la réponse face au VIH des deux pays.

Participation à la plateforme réunissant 5 partenaires/bénéficiaires du projet sont réalisés au cours du projet.

Ces rencontres organisées dans le cadre du projet Key Population Challenge Fund de l'USAID, permettent d'inclure 5 partenaires du projet de Guinée Bissau et du Sénégal afin de renforcer l'inclusion opérationnelle du handicap dans la réponse face au VIH à un niveau national.

HI coordonne cette activité. Dans cette optique une journée scientifique sur la réponse au VIH/Sida organisée par le CNLS doit se tenir du 02 au 5 Décembre 2018 à Dakar, journée à laquelle, le projet souhaite participer. Une séance de travail est programmée dans ce sens par l'équipe du projet pour déterminer le contenu des documents à partager lors de cette rencontre des acteurs de lutte contre le VIH au Sénégal.

A4-4 Mise en place d'un comité de pilotage annuel.

Le comité de pilotage inter pays est organisé, et se réunit de façon annuelle pour réaliser des revues du projet et le suivi de recommandations stratégiques et techniques. Ce comité de pilotage, porté par HI, est organisé à trois reprises. Il réunit 16 participants dont la composition et les termes de références sont définis en début de projet. Il réunit également les représentants des régions médicales ciblées, le CNLS et SNLS, les Fédérations de Personnes Handicapées, les organisations régionaux, les réseaux des PVVIH et les membres du consortium.

A4-5 Produire un outil de capitalisation des expériences.

1 outil de capitalisation commun des bonnes pratiques du projet est réalisé.

Un outil de capitalisation dont la forme sera définie en comité de pilotage (film, brochure, dossier, poster) sera réalisé et permettra de recueillir les bonnes pratiques réalisées sur le projet et de faire du plaidoyer sur l'inclusion du handicap dans la réponse face au VIH auprès des autorités, partenaires et bailleurs auprès desquels l'outil sera diffusé.

V. Pérennisation et durabilité

Le projet se veut pérenne et durable car i) il a été **élaboré de manière participative avec les différents parties prenantes**. La conception du projet INCLUSIPH a été réalisée sur base des leçons apprises et des succès du projet ACCESS. Ce présent projet a été conçu en collaboration directe avec les bénéficiaires, acteurs du consortium et partenaires afin d'identifier de la façon la plus pertinente et précise possible leurs besoins en matière d'inclusion du handicap dans la réponse face au VIH, ii) **les membres du consortium sont solides et reconnus**. Fort de son expertise sur le VIH et le handicap et de son travail en réseau avec les

organisations de personnes handicapées, **Handicap International/Humanité & Inclusion** conduit le projet en partenariat avec **Santé Service Développement** au Sénégal et **Alternag** en Guinée Bissau, deux associations nationales reconnues par les autorités sanitaires et les bénéficiaires pour la qualité de leur approche communautaire. Ces associations seront encore opérationnelles sur les zones d'intervention ciblées après le projet. Elles pourront assurer également un suivi. Riche d'expériences en matière d'activités de sensibilisation sur le VIH/IST/TB et la SSR, de dépistage volontaire, de prise en charge psychosociale et médicale, de soutien des PVVIH et de soins palliatifs communautaires, Santé Service Développement est une association nationale de lutte contre le Sida créée en 1992. Présent sur les 14 régions administratives au Sénégal, son maillage au sein des 3 régions de Ziguinchor, Sédhiou et Kolda et leurs districts, permettra de toucher au plus près les personnes vulnérables au travers des communautés et des familles. Créée en 1991, l'ONG Alternag (Association Guinéenne d'Etudes et Alternatives) a mis en place le projet CIDA (Centre d'Information, Dépistage, Conseil et Appui en SIDA) en 2001 sur Bissau qui réalisera les activités opérationnelles. Sous récipiendaire du Fonds Mondial, l'association a déjà élaboré des outils CCC adaptés à des personnes présentant une déficience visuelle, auditive et de communication dans le milieu scolaire spécialisé. L'association prévoit de créer une antenne sur Farim (Région de Oio) dès septembre 2016 afin de décentraliser leur action au plus proche de la communauté

ENSEIGNEMENT TIRES ET RECOMMANDATIONS

Le projet INCLUSIPH « inclusion des personnes handicapées dans la réponse face au VIH » est en cours de mise en œuvre. Il me semble prématuré de tirer les leçons/enseignements par rapport aux actions du projet. Toutefois, il est prévu d'organiser un audit communautaire qui est une sorte de mini évaluation dont l'objectif est de recueillir les points de vue des bénéficiaires et partenaires du projet sur les actions du projet, de voir si celles-ci répondent à leurs attentes et préoccupation en matière de santé et du VIH, SSR et TB en particulier. Cet audit sera l'occasion pour les parties prenantes d'exprimer leurs avis et impressions par rapport aux actions déjà réalisées et de voir ensemble les solutions ou les nouvelles stratégies à envisager pour un meilleur succès du projet. Il est prévu de réaliser à chaque étape un audit communautaire. Au total 4 audits seront réalisés avant la fin du projet.

ANNEXES

NA

23. MULTIPLE WESTERN AND EASTERN EUROPEAN COUNTRIES

TITLE OF THE PROGRAMME: ChemSex Round Table (Switzerland and Germany)

CONTACT PERSON

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- **Programme is being implemented since:** 2018
- **End date of the programme:** NA
- **Responsible parties:** NGO; Civil society, Private sector; Academic institution
- **Population reached:** Trans; People living with HIV; People with mental health conditions; People who use substances, including alcohol; Indigenous and/or local communities; Migrants, refugees or internally displaced people; Children; Women and girls; Young people
- **Has the programme been evaluated/assessed?** No
- **Is the programme part of the National AIDS or Mental Health or Substance Abuse Prevention and Treatment Strategy?** No
- **Is the programme part of a National Plan other than the National AIDS or Mental Health Strategy?** No

BACKGROUND

The Berlin ChemSex Network brings together addiction-, queer- and AIDS- counseling centers, HIV specialist doctors, therapists, community organizations, self-help initiatives, as well as outpatient and inpatient addiction treatment facilities that are confronted with the topic of chemsex as well as sexualized substance use. It would seem desirable to broaden the spectrum of participants to include politics, research and donors. ChemSex generally refers to a global gay sex culture characterized by the use of certain substances such as crystal methamphetamine, GHB / GBL, mephedrone, and ketamine, as well as harmful consumption patterns, and is mainly organized through online contact pages. But more often sexualized use of substances is presented also in other subcultures.

DESCRIPTION

In addition to focusing on harmful consumption, resulting in multiple health, mental and existential problems, the network also seeks to provide advice, information, harm reduction and support for substance use in general. It explicitly excludes a general judgment of sexualized drug use. We are developing algorithms for professionals as much as for local low-threshold workers and activists, we are implementing workshops around body work, case discussions, lectures about meaning of sexuality, shame, stigma and running open microphones with the title "let's talk about sex and drugs" with local drag queens.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

The network aims to connect and improve existing services, clarify communication and treatment pathways with guidelines, provide internal and external training, promote sexuality, health and substance use skills, research and collect relevant data and formulate common positions vis-à-vis political, educational, non-governmental and other bodies.

LESSONS LEARNED AND RCOMMENDATIONS

The developing network already supports professionals in their guidance and clients on their paths. Newspapers and radio stations made interviews which inform and activate the community. The community starts to open up for crucial topics feeling invited to ask more questions to professionals that listen better and know their networks deeper.

ANNEXES

<http://www.tbcoalition.eu/>