Agenda item 5

UNAIDS/PCB (47)/20.28

MENTAL HEALTH AND HIV

15–18 December 2020 | Geneva, Switzerland
UNAIDS Programme Coordinating Board
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Additional documents for this item: none

Action required at this meeting—the Programme Coordinating Board is invited to:
See Decision Points in paragraph 79

- *Recognize* progress made by countries, the UNAIDS Joint Programme and other partners in supporting integrated mental health and HIV services and the potential further negative impact of COVID-19 on the mental health and well-being of people living with and affected by HIV;
- *take note* of the report on mental health and HIV;
- *recall* that PCB participants are requested to submit written comments in replacement of the debate following the 47th meeting of the PCB, as agreed through the intersessional procedure (UNAIDS/PCB (47)/20.23); and
- *call on* the Joint Programme to report back on progress at a future PCB meeting.

Cost implications for the implementation of the decisions: none

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Executive summary

1. The importance of addressing the interlinkages between mental health and HIV, substance use and HIV, as well as the common social determinants, stigma and marginalization, is being increasingly acknowledged. However, mental health and psychosocial support for people living with, affected by or at risk of HIV across the life course is seriously lacking. This lack of support poses barriers to their access to HIV testing, treatment and prevention services, and negatively impact on their overall health, well-being and quality of life.

2. There is an increasing body of evidence showing that individuals with mental health conditions and substance use, especially young people, ageing and key populations, who are not accessing mental health and substance use treatment and support have more limited access to HIV testing and care. Even when they are able to access HIV care, they are less likely to continue with treatment, leading to more severe HIV disease and even death.

3. The COVID-19 pandemic and related public health orders and lockdowns have resulted in increased distress and vulnerabilities across the world, including among women and girls, key populations, and people living with HIV and their families. This underscores the importance of investments into mental health and psychosocial support, particularly for people living with HIV and key populations. Findings from the reports from networks of people living with HIV, UNAIDS, WHO and other partners call attention to this.

4. There has been progress since the 43rd PCB meeting's thematic segment and the follow-up to the thematic segment at the 44th PCB meeting. Countries, community groups, the Joint Programme, the U.S. President's Emergency Plan for AIDS Relief, the Global Fund to fight AIDS, Tuberculosis and Malaria, and other partners have advanced their efforts and investments in support of integrated mental health/HIV and substance use/HIV strategies, policies, interventions and services for people living with, affected by and at risk of HIV, people with mental health conditions and people who use drugs and people with harmful use of alcohol.

5. However, more needs to be done to ensure wide access to and uptake of human rights-based, people-centred, holistic, gender-sensitive and age-specific services to support the physical and mental health and well-being, and sustained quality of life of people living with, affected by and vulnerable to HIV across the life course.

6. As the global HIV response moves forward, increasing attention need to be focused on people-centred integration of services. As part of people-centred and context-specific integrated approaches, the new 2025 global HIV targets include targets on service integration. These include the target of 90% of people living with HIV and key populations accessing integrated or linked HIV and mental health services. The inclusion of these targets and related actions in the forthcoming Global AIDS Strategy 2021-2026 will help increase the health and well-being of people living with HIV and key populations through holistic and integrated services, care and support. The inclusion in the Global Strategy provides an opportunity for mental health and psychosocial support to be further integrated across governments' and partners' health, social and economic strategies, recovery plans and budgets, and community support.

7. It is crucial that all relevant partners join in efforts to improve the physical and mental health and the well-being of people living with, affected by and at risk of HIV, as well as of people with mental health conditions, people with disabilities and people who use psychoactive substances.

Introduction

8. On 13 December 2018, at its 43rd meeting, the UNAIDS Programme Coordinating Board (PCB) devoted the thematic segment to "Mental Health and HIV/AIDS—promoting human rights, an integrated and person-centred approach to improving ARV adherence, well-being and quality of life".[1] It was the first-ever discussion on mental health at the PCB level. The segment was held with the increased acknowledgment of the importance of addressing:
    - the links and synergies between mental health and HIV-infection across the life course;
    - the need to adopt people-centred and human rights-based approaches in service delivery, care and support, and
    - the imperative to eliminate discrimination, stigma, violence, coercion and abuse for achieving good physical and mental health outcomes and for improving the quality of life of people living with and affected by HIV and key populations, including people who use drugs and people with mental health conditions (including those with mental, neurological, and alcohol and drug use disorders).

9. The thematic segment reviewed the evidence of the linkages between mental health and HIV and between substance use and HIV. It did so in relation to optimizing HIV prevention, HIV testing, linkage to treatment and care services to support adherence and retention in care, physical and psychosocial well-being and quality of life of people living with, affected by and at risk of HIV, people with mental health conditions and those using psychoactive substances.

10. The showcased effective integrated strategies and approaches for addressing mental health, substance use and HIV from a human rights perspective, including through greater community engagement and holistic people-centred, gender-sensitive and age-specific health care and other forms of services and support. Those efforts can catalyse progress towards the targets in the 2016 Political Declaration on Ending AIDS and the relevant Sustainable Development Goals (SDG1, SDG3, SDG5, SDG10, SDG17).

11. The thematic segment also highlighted approaches for promoting human rights in the context of mental health, substance use and HIV through the life course. They include education and training of stakeholder groups for eliminating discrimination, stigma, violence, coercion and abuse. The session called for increased collaboration to jointly address challenges and integrate mental health services and substance use treatment with HIV prevention, testing, treatment and care services and programmes.

12. At its 44th meeting in June 2019, as follow-up to the thematic segment and the further discussion on mental health and HIV, the PCB took note of the thematic segment's background note and the summary report. The PCB called on Member States to:
    - implement evidence-based, people-centred, human rights and community-based policies and programmes to promote mental health and quality of life, including by addressing stigma and discrimination (related to both HIV and mental health conditions), in the context of HIV prevention, treatment and care services; and address social determinants of mental health and HIV, including through adopting and implementing social protection policies and programmes to reduce stigma and discrimination;

    The PCB called on the UNAIDS Joint Programme to:
    - review and revise existing practices and guidelines to ensure integration of mental health and substance use treatment and prevention services into the HIV service delivery platforms, and HIV services into mental health and

substance use prevention and treatment programmes, and provide respective implementation guidance;
- take account of the intersection between mental health and HIV, and the importance of improving psychosocial well-being and quality of life of people affected and living with HIV, as part of a person-centred and human rights approach, when developing the next UNAIDS strategy for 2021–2030; and
- report back to a future PCB meeting on progress made on the integrated approach to mental health and HIV.

13. This paper responds to the above PCB requests and presents a brief update on new developments in the efforts of countries, global and other partners (including the Joint Programme) to integrate interventions and services for people with mental health conditions, drug use and harmful use of alcohol with HIV interventions, activities and programmes. It also reports on community engagement and leadership, innovations, resource mobilization, financing and partnerships, and it discusses remaining challenges and opportunities.

14. In light of the rising distress and other vulnerabilities experienced by individuals and communities during the COVID-19 pandemic, the paper also touches on the increasing pertinence of investments for addressing mental health in the context of the COVID-19 and HIV pandemics.

15. In addition, the paper reflects on the integration of mental health and psychosocial support in the newly proposed global HIV targets for 2025. Mental health/HIV integration targets for people living with HIV and key populations were recently approved by the 2025 AIDS Targets Steering Committee and are presented in this paper. Integration of mental health and psychosocial support with HIV programmes and services is also included in the outline of the Global AIDS Strategy 2021-2026.

Mental health and HIV—an imperative and an opportunity for integrated people-centred and human rights-based strategies, interventions and services

16. The Sustainable Development Agenda puts nondiscrimination, equality and "leaving no one behind" at the core of global development. In the 2016 Political Declaration on Ending the AIDS epidemic, UN Member States committed to “people’s access to quality, people-centred health-care services in a more holistic manner, in the context of promoting the right to the enjoyment of the highest attainable standard of physical and mental health and well-being”. In the same Declaration, Member States also committed to working towards universal health coverage; to more integrated services for HIV and noncommunicable diseases, including mental health; and to addressing all health consequences of violence against women, including through providing access to mental health support. Member States also committed to the elimination of all forms of HIV-related stigma and discrimination.

17. Access to human-rights based, people-centred, holistic, gender-sensitive and age-specific prevention, testing, treatment, care and support services is essential for the physical and mental health, the well-being and the sustained quality of life of people living with, affected by and vulnerable to HIV.

18. Mobilization to address synergies and linkages between mental health, substance use and HIV builds on more than 20 years of research and programme experience from around the world. This experience shows that mental health conditions tend to be more prevalent among people living with, affected by, at risk of and vulnerable to HIV than in the overall population.[3 - 13] Depression is one of the most prevalent mental health

comorbidities and it is highly prevalent among people living with HIV. A systematic review conducted in 2015 reported depression prevalence rates as high as 80% among people living with HIV (with wide variation across studies). Depressive symptoms have been reported in many studies from sub-Saharan African countries with high burdens of HIV.[14, 15, 16, 17, 18]

19. A 2018 systematic review found that the average prevalence of depression in surveys of people living with HIV in sub-Saharan Africa was 24%, compared with about 3% in populations overall.[19 20] People living with HIV are significantly more likely to die by suicide compared to the general population.[21] In a cohort study in Switzerland, people with HIV were three times more likely than people in the general population to die by suicide.[22] According to a recent study in Asia-Pacific countries, up to 40% of adults attending outpatient HIV clinics suffer from depression. Concomitant mental illness is associated with late antiretroviral therapy (ART) initiation and lack of timely viral suppression in people living with HIV.[23] Among people in HIV care, the prevalence of drug dependence is high: 48% in a multisite study in the United States, for example.[24] HIV-associated neurocognitive disorder affects an estimated 50% of adults living with HIV, and includes asymptomatic neurocognitive impairment, mild neurocognitive disorder, and HIV-associated dementia.[25]

20. HIV prevalence among adult persons with severe mental disorders is higher than among adults without HIV.[26] Persons with schizophrenia who are HIV-positive have an over 25-fold risk of dying compared to those who have neither of these.[27] Additionally, these numbers might also be underestimations, given low rates of medical care attention among those with severe mental disorders and high rates of comorbid drug dependence.[28]

21. The consequences of such mental health conditions extend across the life course. Depression, anxiety, post-traumatic stress disorder, and/or alcohol and drug use are linked with lack HIV information and prevention, delayed access to HIV testing, poor linkage and adherence to care, and increased risk of HIV-related mortality.[29, 30, 31, 32] Management of mental health conditions and psychoactive drug use issues in the context of HIV can help improve HIV prevention, HIV treatment, adherence, longevity, physical and mental health. Strategies and programmes that integrate mental health interventions, services and support must form part of the HIV response and Universal Health Coverage.[10]

22. **Young people.** Adolescents and young people are highly vulnerable to mental health issues and psychoactive drug use. Adolescent mental health and well-being are often overlooked and untreated.[33] Approximately 50% of mental health conditions present in adulthood begin by age 14 and 75% begin by age 25. Those affect adolescents and young adults as they enter school, transition to work, experience sexual debuts and start families.[34] Depression and anxiety, account for 16% of the global burden of disease among 10–19-year-olds.[35] Suicide is among the top five causes of adolescent deaths and suicide rates are highest among adolescent girls. In 2015, in older adolescent girls, self-harm was the second leading cause of death and the third-ranked cause of adolescent death.[36, 37]

23. **Ageing**. Older people, including those living with HIV, are more likely to experience mental health and neurocognitive impairment, as well as social isolation, due to decreased social participation and engagement.[39] People living with HIV, especially those of advanced age, are at higher risk of developing noncommunicable diseases, particularly cardiovascular disease, depression and diabetes. A recent systematic review and meta-analysis of studies calculated pooled estimates for the prevalence of

noncommunicable diseases among people living with HIV in low- and middle-income countries: prehypertension (21%), hypercholesterolemia (22%), obesity (7.8%), depression (24.4%), and diabetes (1.3%–18%).[19]

24. Globally, as access to lifesaving HIV treatment increases, the number and the proportion of people living with HIV that are 50 years and older is also increasing: from 5.7 million in 2016 to 7.9 million in 2019. Eight percent people living with HIV in 2000 were older than 50 years, compared to 21% in 2019.[40] Eighty percent of people living with HIV aged 50 and older live in low- and middle-income countries, with eastern and southern Africa home to most of them. It is important to ensure that screening, prevention and treatment of noncommunicable diseases, including mental health conditions, among those depression, are provided routinely to ageing people living with HIV, ideally, through HIV service delivery platforms.[41]

25. **Key populations**. Gay men and other men who have sex with men, sex workers, transgender people, people who use drugs, people in prisons and other closed settings, and also racial and ethnic minorities are often affected by stigmatization and discriminated against, particularly where they are also criminalized. Their elevated HIV prevalence reflects their social vulnerabilities and health disparities. Given their social marginalization, vulnerability to health threats and rights violations, elevated rates of emotional distress and mental health problems are also common.[42, 43] Compounding those experiences is the stigma among many health-care providers towards people with mental health conditions.[44, 45, 46]

26. People in prisons and other closed settings are also vulnerable to mental health issues. A range of conditions undermine their mental health, including overcrowding, (sexual) violence, solitary confinement, lack of privacy, lack of meaningful activity, high prevalence of drug use, isolation from social networks, stigma and discrimination, insecurity about future prospects, and inadequate health services. This is manifested in the increased prevalence of depression and risk of suicide in prisons. In addition, people with severe mental disorders may be inappropriately held in prisons because of a lack of mental health services in the community.[47, 48]

27. **Humanitarian contexts**. Other vulnerable populations include people in humanitarian emergencies.[49] New WHO estimates published in *Lancet* show there are far more people living with mental disorders in areas affected by conflict than previously thought: one person in five is living with some form of mental disorder (from mild depression or anxiety to psychosis) and about one person in 10 is living with a moderate or severe mental disorder.[50] Resources for HIV prevention and for mental health care are often limited in the host countries. Migrants also face the risk of poor access to HIV prevention, treatment and care services. Immigration status, language and cultural barriers, unaffordable fees for services, and perceived or actual hostility in the new context can limit access to and utilization of services.[51]

28. **Lack of human and financial resources**. Successful HIV interventions require addressing the scarcity of mental health, neurological or substance use treatment service providers, and the linkage and integration of mental health, neurological and substance use. Globally, there are a median of only 9 mental health-care providers per 100 000 population. The rate is only 2 per 100 000 population in low-income countries compared with more than 70 per 100 000 population in high-income countries. It is estimated that 1 in every 10 people is in need of mental health care at any given time; yet there is, on average, 1 psychiatrist for every 100 000 people. Even smaller numbers of social workers and psychologists are available to meet global mental health needs.[52]

29. Less than half of the 139 countries that have instituted mental health policies and plans have aligned them with the Human Rights Council human rights resolution[1] that emphasize community-based services and the importance of respecting the autonomy, will and preferences of all persons. When mental health plans are developed, they often are not supported with adequate human and financial resources. Transitioning to care in the community needs to be accelerated to ensure uninterrupted services, and continuum of care, psychological and social support. *52,53*

30. Further investments are needed so support service-providers' task-shifting or -sharing. They include primary care staff, community health workers and peers, and health-care staff working in or with prisons and other closed settings. Adequate sustained supervision is an important for maintaining quality care. Studies from low- and middle-income countries demonstrate that a variety of providers, including lay health workers, can deliver effective, evidence-based psychological interventions such as cognitive behavioural therapy, interpersonal psychotherapy or problem-solving therapy for common mental health conditions such as depression.[54, 55, 56, 57, 58, 59, 60, 61, 62, 63] This suggests that similar skills could be transferred to HIV care providers as part of an integrated programme of care.*64, 65* Countries should develop a cadre of both specialist and non-specialist providers for prevention, treatment and care mental health conditions. In addition, countries should use the local resources that are available, including at community level, and mobilize additional resources if needed. Community-based interventions to promote mental health, well-being and quality of life should be scaled up. The WHO's "mhGAP Intervention Guide" for mental health conditions in non-specialized health settings, including those providing HIV services, should be utilized widely for evidence-informed care and treatment protocols.[66]

Mental health, HIV and the COVID-19 pandemic

31. Billions of people are affected by the COVID-19 pandemic, which is having a serious impact on people's mental health.[67] The pandemic threatens to lead to a major mental health crisis if appropriate actions are not taken,[68] highlighting the need to invest in mental health. Bereavement, isolation, loss of income, fear and the risk of not being able to get health services and support are generating mental health complications or exacerbating existing issues. Studies from Canada, China, Ethiopia and elsewhere indicate that the COVID-19 pandemic is associated with distress, anxiety, insomnia, fear of contagion, depression and insomnia, as well as increased levels of alcohol and drug use. [68 70 71]

32. COVID-19 infection itself is often characterized by mental and neurological manifestations.[73] Neurological manifestations include headaches, altered sense of smell, delirium, stroke, Guillain-Barre syndrome, and meningitis. Neurological manifestations are associated with more severe COVID-19 illness and increased mortality. COVID-19 is likely associated with long-term neurological consequences.[75, 76, 77] Increased mortality is also reported in COVID-19 patients with a preexisting psychiatric diagnosis.[74] Stress and mental health conditions (including mood disorders, drug use and harmful use of alcohol) are associated with suicidal behavior. COVID-19 survivors may also be at elevated suicide risk. Multiple cases of COVID-19-related suicides have been reported around the world.[78, 79] Mental health consequences of the COVID-19 crisis are likely to continue well beyond the pandemic itself.[70]

33. Poor mental health and food insecurity are associated with lower quality of life among people living with HIV. Globally, food insecurity has worsened during the COVID-19.

[1] A/HRC/RES/36/13

pandemic. A rapid vulnerability assessment done by the World Food Programme (WFP) and UNAIDS among people living with HIV in Tunisia found that 94% of respondents had lost income, 87% were unable to access fresh foods, and 50% wanted more information/services related to mental health and wellness support. A study in Ethiopia found that almost 39% of people living with HIV had experienced severe household food insecurity.[80]

34. Over 60% of the 130 countries surveyed by WHO reported disruptions to mental health services for vulnerable people, including children and adolescents (72%), older adults (70%), and women requiring antenatal or postnatal services (61%). Two thirds had experienced disruptions to counseling and psychotherapy; 30% reported disrupted access to medications for mental, neurological and drug use disorders; 65% to vital harm reduction services; and 45% to opioid agonist maintenance treatment for opioid dependence. More than a third (35%) reported disruptions to emergency interventions, including those for people experiencing prolonged seizures, severe drug dependence withdrawal syndromes, and delirium; around three-quarters reported at least partial disruptions to school and workplace mental health services (78% and 75%, respectively).[81] In Botswana, the lockdown measures have had a significant impact on youth-led programmes and peer support, which feature prominently in the country's HIV response. Community activities, such as teen clubs, peer education for in- and out-of-school youth, face-to-face adherence counselling and psychosocial support were halted to help control the spread of COVID-19.[82]

35. Health care, social and community workers, faced with heavy workloads, life-or-death decisions, and risk of infection, are particularly affected by psychological distress. In China, health-care workers have reported high rates of depression (50%), anxiety (45%), and insomnia (34%), while 47% of health-care workers in Canada have reported a need for psychological support.[72, 81]

36. The COVID-19 pandemic has increased demand for mental health services and support, and for addressing stigma and discrimination. The pandemic has been associated with increased violence against women and girls,[82,83] as well as against people from LGBTI communities.[84] Emergency powers have also been misused to reduce human rights protections for vulnerable populations.[85] [86] Rapid assessments done by UN Women (and validated by national partners) across several regions have found that lockdowns were having a severe impact on women.[87] [88] [89] [90] [91] [92] [93]

37. In a recent survey on the impact of COVID-19 pandemic on people living with HIV in 12 Latin American and Caribbean countries (supported by the UNAIDS Regional Support Team), the majority of people living with HIV were concerned about their mental health (between 77% and 91%) and about HIV-related stigma (between 77% and 95%) during the pandemic. Between 27% and 62% respondents reported needing psychosocial support to deal with anxiety associated with the COVID-19 pandemic.[94] A national survey in Australia has found that transgender people have experienced thoughts of suicide or hurting themselves at disproportionately high rates during the pandemic. The study also highlights poor access to health services and a lack of specialized services for LGBT people.[95]

38. The rapid response survey implemented by the Interagency Task Team on Young Key Populations in Asia-Pacific has found high levels of anxiety about COVID-19 among young key populations and young people living with HIV. Approximately 70% of respondents reported feeling anxious or extremely anxious, 59% reported anxiety due to loss of income, and 39% were unable to work as often as usual. Among young people who reported needing mental health services, 34% had experienced delays or

disruption in access to medications and 47% had experienced delays or disruption in accessing psychosocial support as a result of the ongoing pandemic. A further 9% of respondents requiring mental health medications lacked access to those services and 14% of those needing psychosocial support lacked access to that essential service.[96]

39. UN General Assembly Resolution 74/306 (June 2020), on a comprehensive and coordinated response to the COVID-19 pandemic, encouraged Member States to "address mental health in their response to and recovery from the pandemic by ensuring widespread availability of emergency mental health and psychosocial support".[97]

40. Encouragingly, the WHO survey cited earlier found that many countries have integrated mental health and psychosocial support into their COVID-19 plans and into their country-level multisectoral mental health and psychosocial service platforms.[81]

41. Some countries have managed to use innovative approaches to ensure the continuity of services, including those for psychosocial support. In Philippines, the Department of Health, in partnership with WHO, launched a multisectoral approach for mental health, with programmes and interventions across workplaces, schools and communities aimed at high-risk groups. It also launched mental health hotlines.[98]

42. As part of the HIV response in eastern and southern African countries, the "U-report" platforms were used to quickly poll adolescents and young people and then tailor programmes to their needs. These platforms are proving useful for awareness raising, psychosocial support to individuals and groups, linkage to services and to improve organizational functioning. Health workers are being supported through virtual supervision in Kenya and technical working groups are holding weekly virtual meetings to steer the response in Eswatini. Lesotho's Ministry of Health and UNICEF, in partnership with Help Lesotho, are providing remote health counselling, COVID-19 information, and psychosocial support through teleconsultations for pregnant and breastfeeding adolescent girls and for the other young mothers and their children who participate in the "2gether 4 SRHR17 Young Mothers Programme".[99]

Critical role of community-based and -led responses, care and support

43. Community engagement, buy-in, advocacy, leadership and provision of people- and community-centred services are essential when addressing mental health conditions, drug use, harmful use of alcohol and HIV interlinkage, stigma and discrimination associated with them. The role of communities is also important in ensuring continuum of HIV and mental health care, access to HIV prevention, and support for well-being and building resilience of their own communities, including those in humanitarian and fragile settings. This is especially pertinent during the COVID-19 pandemic. Despite the challenges, many of the changes in mental health, drug use, harmful use of alcohol and HIV service and support provision implemented during the pandemic in both high-income and resource-constrained settings can and should be maintained. These include offering a spectrum of options for remote and in-person counselling, support and care; greater integration of behavioral and physical healthcare; prevention of COVID19 exposure; prescription and delivery of multi-months mental health, neurological and drug treatment; modifying safety plans and psychiatric advance directives to include new technologies and broader support systems; leveraging natural supports, and integration of digital health interventions.[100] They help to decongest health clinics, bring services closer to the people in need and increase the control that is invested in the hands of people and communities. The leadership and engagement of communities

remain critical enabler for the effective response to the HIV epidemic, human rights violations, stigma and discrimination, and now the COVID-19 pandemic.

44. For both HIV and COVID-19, women play critical roles as frontline health and community workers and community leaders, and measures are needed to enable support for women in those roles.[85]

Progress made since the 44th PCB meeting in June 2019

Development of guidance and tools

45. In follow-up to Decision Point 9.3 at the 44th PCB meeting, the UNAIDS Secretariat and WHO developed an implementation guide to support the integration of services for mental health conditions, drug dependence and harmful alcohol use into HIV service delivery settings. The guide will be published shortly. It draws on existing HIV and mental health and other service provision guidelines, including the WHO "mhGAP Intervention Guide",[66] the "mhGAP operations manual",[101] substance-use related WHO and UNODC guidelines and tools, and other WHO guidelines for HIV testing, care and treatment.

46. The WHO's "Comprehensive mental health action plan 2013–2020", which the 66th World Health Assembly adopted in May 2013,[102] was extended to 2030 at the 72nd World Health Assembly to ensure its alignment with the 2030 Agenda for Sustainable Development. The plan is intended to help countries achieve SDG target 3.4: by 2030, reduce by one third premature deaths from noncommunicable diseases through prevention and treatment, and promote mental health and well-being.

47. The action plan was developed in response to the growing burden of mental health conditions and the challenges that health systems are facing in responding to the needs of people with mental health issues. The plan is a landmark achievement which focuses international attention on a long-neglected problem and is firmly rooted in the human rights principles. Its key objectives include: (i) strengthen effective leadership and governance for mental health; (ii) provide comprehensive, integrated and responsive mental health and social care services in community-based settings; (iii) implement strategies for promotion and prevention in mental health; and (iv) strengthen information systems, evidence and research for mental health.

48. In 2019, as part of the "QualityRights" global initiative to increase access to good quality services in mental health and related areas and to promote the human rights of people with psychosocial, intellectual and cognitive disabilities, WHO launched tools to introduce and strengthen a rights-based approach.[103] The tools are available to countries on request. The main objectives of the "QualityRights" initiative are to: (i) build capacity to combat stigma and discrimination and promote a person-centered, rights-based approach; (ii) improve the quality of care and human rights conditions in mental health and related services; (iii) create community-based and recovery-oriented services that respect and promote human rights; (iv) develop a civil society movement to conduct advocacy and influence policy-making; and (v) reform national policies and legislations in line with international human rights standards.

49. Several guidance documents and briefing have been developed to address the mental health needs of adolescents and young people.
    a. In September 2020, WHO launched the *Guidelines on promotive and preventive mental health interventions for adolescents—Helping adolescents thrive.* It provides

evidence-informed recommendations on psychosocial interventions to promote mental health, prevent mental disorders, and reduce self-harm and other risk behaviours among adolescents. The aim is to inform policy development, service planning and the strengthening of health and education systems, as well as facilitate mainstreaming of adolescent mental health promotion and prevention strategies across sectors and delivery platforms. The Guidelines recommend mental health and psychosocial interventions to be delivered to adolescents living with HIV and adolescent key populations (including LGBT adolescents) to promote positive mental health, to prevent mental disorders, self-harm and suicide, and to reduce risky behaviours.[104]

b. Research gaps on mental health and psychosocial interventions need to be filled. WHO is updating the *Consolidated guidelines for use of antiretrovirals for preventing and treating HIV-infection*. Service delivery and psychosocial interventions to improve adherence and retention in care for adolescents and young people living with HIV are a particular focus. The guidelines are expected to be launched in early 2021.[105]
c. Engaging adolescents in providing service delivery, including the provision of psychosocial support services, is an essential part of person-centred, differentiated care. WHO in 2019 developed a technical brief on peer-driven models of care to support HIV programme managers in health ministries and other adolescent-relevant line ministries in planning, implementing, monitoring and evaluating peer-based and adolescent-responsive services, including psychosocial support.[106]
d. The needs of pregnant adolescents and adolescent mothers remain a challenge. In 2019, WHO convened a learning session of global experts and stakeholders to discuss and develop advocacy points and key actions on improving the mental health and well-being of pregnant adolescents and adolescent mothers living with HIV.[107]
e. UNICEF has committed to increase its engagement with health-care facilities and school health as platforms for awareness-raising and integrated delivery of preventive and promotive interventions for adolescents, including mental health. UNICEF dedicated one of the key sections of its 2019 annual report to adolescent mental health. In November 2019, UNICEF organized the "Leading Minds" conference on mental health for children and adolescents.[108]
f. To ensure the continuity of services including mental health services and support for adolescents and young people during the COVID-19 pandemic, UNICEF in collaboration with the WHO adolescent HIV service delivery working group produced the information note *Prioritizing the continuity of services for adolescents living with HIV during the COVID-19 pandemic*. The note is aimed at policy-makers, programme managers and major funders of the health sector response to HIV who are active in contexts where COVID-19 threatens service continuity.[109]

50. Working with members of the UNODC-CSO group on drug use and HIV, UNODC in 2019 developed the technical guide on "HIV prevention treatment care and support among people who use stimulant drugs". To support dissemination of the guide, UNODC developed a training programme that addresses specific subcategories of stimulant drugs (e.g. amphetamine-type stimulants, cocaine, and new psychoactive substances). It held "train the trainer" workshops in Brazil, Dominican Republic and Viet Nam, as well as regional workshops in the Middle East and North Africa (covering Afghanistan, Bahrain, Egypt, Iraq, Islamic Republic of Iran, Morocco, Lebanon, and Tunisia), eastern Europe (Belarus, Republic of Moldova and Ukraine) and south-east Asia (China, Cambodia, Myanmar, Indonesia, Thailand and Viet Nam).[110]

51. Guidance has also been developed on specific mental health needs of women living with HIV. In 2019, UNODC worked with WHO, UNFPA, UN Women and UNAIDS to develop the technical guide on "Prevention of mother-to-child transmission of HIV in

prisons". Women in prison have a higher prevalence of mental health conditions such as self-harm and depression, as well as drug use, harmful use of alcohol, and post-traumatic and psychosocial stress than the general population.[111] The guide makes specific reference to women's' mental health issues in prison and the importance of providing mental health screening, comprehensive services, rehabilitation programmes, and strategies and support to prevent suicide and self-harm. To support the dissemination of the guide, UNODC developed a training programme. It held "train the trainer" workshops in Africa (Eswatini, Kenya, Malawi, Mozambique Nigeria, Namibia, South Africa, United Republic of Tanzania, Zambia and Zimbabwe), eastern Europe (Belarus, Republic of Moldova, Ukraine), and South East Asia (Cambodia, Indonesia, Malaysia, Myanmar, Philippines, Thailand and Viet Nam).

52. In response to the COVID-19 pandemic, WHO outlined required adaptations for mental, neurological and drug dependence treatment and other services as part of essential health services in its June 2020 interim operational guidance, "Maintaining essential health services: operational guidance for the COVID-19 context".[112] The humanitarian community, through the Inter-Agency Standing Committee, has developed multisectoral guidance (in multiple languages) for adapting mental health and psychosocial support programmes during COVID-19 in humanitarian settings .[113] WHO and the Inter-Agency Standing Committee partners also developed a range of resources on mental health and psychosocial support in context of COVID-19, for multiple age groups and in numerous languages.[69, 114]

Global advocacy and measuring of stigma, discrimination and wellbeing

53. On 10 October, 2020, WHO for the first time hosted a global online advocacy event on mental health, titled the "Big event for mental health".[115] The UNAIDS Secretariat joined the Big Event by contributing to the mental health and HIV segment which featured AIDS activists, and people living with HIV and mental health conditions.

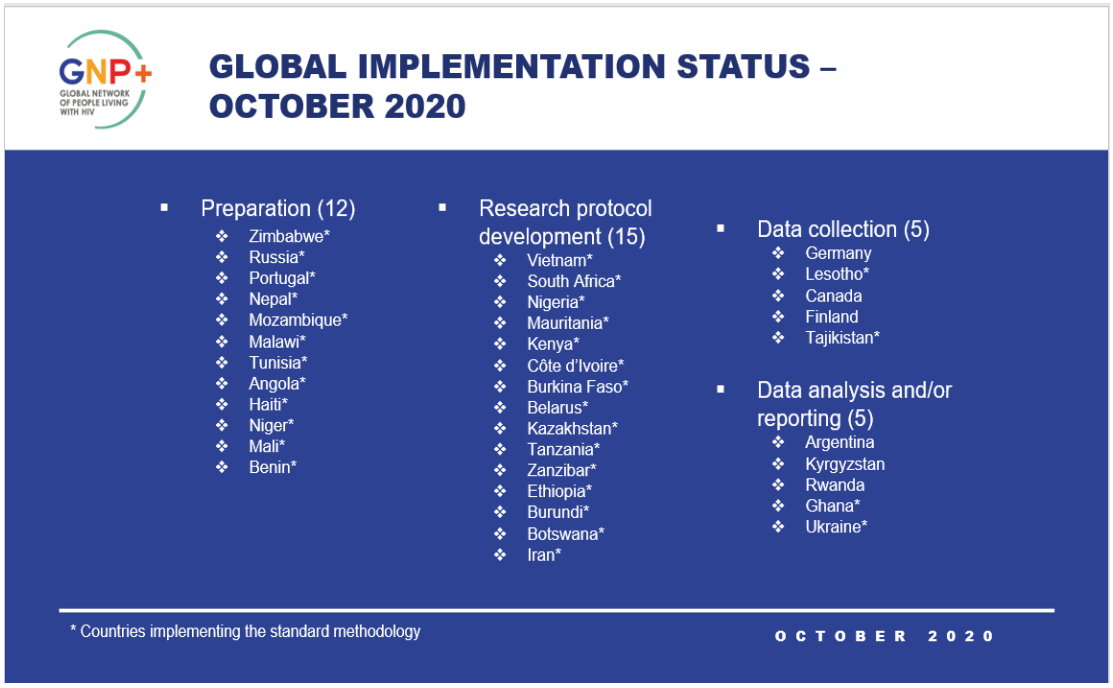
54. Stigma Index 2.0 methodology revision and implementation. The People Living with HIV Stigma Index (hereafter, Stigma Index) is the world's largest social research project that is implemented by people living with HIV themselves. It monitors HIV-related stigma and discrimination across different domains of life, with particular attention to related stigmas that affect the diverse populations of people living with HIV. The project provides evidence for advocacy to address key barriers to HIV treatment, prevention, care and support. The Stigma Index is coordinated by the International Partnership of GNP+, ICW, and UNAIDS. Funding for the Stigma Index research is provided by PEPFAR, USAID, Global Fund, as well as some national governments and other bilateral donors.[116]

55. The revision of the Stigma Index methodology was undertaken with the following aims: (i) to enable the gathering of data that allows comparisons across settings and time; (ii) to support the assessment of stigma reduction interventions for people living with HIV, consistent with the UNAIDS global goal of zero stigma in the HIV response; and (iii) to provide data on HIV-related stigma and discrimination that is gathered with the necessary rigour.

56. Earlier in 2020, with the UNAIDS and PEPFAR support, a revised sampling methodology for Stigma Index 2.0 was developed to ensure the ability to measure and compare manifestations of stigma and discrimination. There was particular focus on intersectional stigma based on gender and gender identity, age, sexuality, occupation in sex work and drug use, and on corresponding mitigation interventions, across countries

and within countries over time. The Stigma Index 2.0 questionnaire also includes a question about the mental health of people living with HIV.

Table 1. Status of the implementation of Stigma Index 2.0, 2020



57. The LGBTI Global survey on happiness, well-being, and HIV vulnerability. In 2019, UNAIDS partnered with researchers at Aix-Marseille University, the University of Minnesota, and the LGBT+ Foundation to conduct a large global survey on happiness, well-being and HIV vulnerability among lesbian, gay, bisexual and transgender (LGBT) people.[115] The purpose was to inform public health actions and HIV response with a focus on LGBTI communities at global, regional and country levels. The survey is seen by LGBTI communities as a crucial effort to improve understandings of how LGBTI people live worldwide.[116] There was strong engagement of communities in the survey, with over 115 000 responses from 197 countries and territories. The data are currently being analysed and findings will be released in a series of publications involving community and academia partners.

58. Early results[117] informed by multilevel modelling suggest that LGBTI individuals are at increased risk of acquiring HIV if they face stigma. Mental well-being of participants living with HIV is significantly poorer than among people not living with HIV. Depression, anxiety and HIV are mutually reinforcing and occur in wider social contexts of stigma.[118] It was found that social and economic inequalities are associated with poorer mental well-being in LGBTI individuals; those living with HIV tend to experience increased burdens of depression and anxiety. Preliminary findings also suggest that pervasive stigma and mental health issues are associated with barriers to access to and engagement in health care. The likelihood of never taking an HIV test was almost twice higher among LGBTI individuals who experienced severe anxiety and depression than among people without those mental health conditions.

59. Furthermore, two additional surveys conducted in April and May 2020 and in October and November 2020 showed that the COVID-19 crisis increases the socioeconomic[119] and HIV vulnerability of LGBT population.[120]

New funding commitments and resource mobilization for mental health, substance use and HIV service integration

60. PEPFAR**.** The PCB thematic segment on mental health and HIV in December 2018 informed PEPFAR's decision to fund and include mental health and HIV as a new technical area in the 2019 Country Operational Plan (COP) Guidance,[121] in addition to the resilience-building and support activities for adolescent girls and young women in the DREAMS initiative, and the implementation of Stigma Index 2.0. Mental health has remained a focused area of the PEPFAR also in the COP 2020 cycle.[122]

61. In the 2019 COPs, the following mental health interventions, programmes and services have been implemented by the implementing partners with PEPFAR support:[123]
    - Botswana, Eswatini, Namibia, and Zambia integrated the "Common Elements Treatment Approach" into primary health care, antenatal care and HIV service delivery sites. This is an integrated, evidence-based mental health treatment approach, which lay providers alongside a clinical supervisor. It is designed for low-resource settings.
    - The Asia region, South Africa, Ukraine and the western hemisphere-Caribbean region were supported by HRSA/SAMHSA technical assistance programmes on substance use and mental health intervention training for providers.
    - Burundi, Cameroon and Malawi offered mental health evaluation and services that are focused on priority populations, including military personnel and people incarcerated people.

62. In the 2020 COPs, PEPFAR will be supporting a wider range of mental health interventions and services,[123] including in Angola (psychosocial support services for people living with HIV, using the Mentor Mothers peer-led model); Botswana (adherence and psychosocial support groups and interventions, including for adolescents and youth; stigma and discrimination reduction among service providers); Burundi (mental health and psychosocial support for key populations and orphaned and vulnerable children); and Cameroon (mental health screening for people living with HIV, stigma and discrimination reduction among health-care workers, the "Positive Health, Dignity and Prevention" model with integrated HIV, mental health and other services).

63. Other projects will operate in Dominican Republic (psychosocial and adherence support, community-based interventions for reduction of stigma and discrimination among facility-based and community health workers); Ethiopia (faith-based organizations and religious leaders providing psychosocial support for people living with HIV); Kenya (enhanced psychosocial and mental health support for adolescents living with HIV); and Malawi (psychosocial and mental health support for adolescents living with HIV via teen clubs, and expansion of health care and lay service provider cadres, and training psychosocial and mental health support for health-care providers at high-volume HIV clinics).

64. Also in development are interventions in Namibia (continued implementation of mental health interventions at high-volume HIV treatment sites); South Africa (mental health support services for people starting HIV treatment); Sudan (psychosocial support for linkage to HIV care, and psychosocial support for adolescents and children, and for survivors of gender-based violence); Ukraine (psychosocial support to people living with HIV), Viet Nam ("one-stop-shop" clinics that provide mental health and substance use services); Zambia (psychosocial support for HIV treatment and PrEP adherence); and Zimbabwe (integrated HIV and mental health and substance use screening, treatment and support, including the Friendship Bench model).

65. In the Asia Regional Programme, services for the psychosocial, economic and social protection needs of children will be provided in India. Stigma Index 2.0 implementation and subsequent interventions will be supported in Angola, Botswana, Democratic Republic of the Congo, Liberia, Mali, Myanmar, Nepal, South Africa and Zambia.

66. The Global Fund to fight AIDS, Tuberculosis and Malaria. In 2019, the Global Fund expanded its funding policies to more explicitly include mental health and substance use services for children, adolescents and adults living with HIV, adolescent girls and young women, key populations and their partners. The recommended services include referrals to risk assessment, risk reduction counselling, mental health and substance use screening and care services, addressing stigma, discrimination and violence, including sexual identity development, depression and trauma, and others.[124, 125,126] Following advocacy and support from the Joint Programme, civil society organizations and others partners, many across all the regions have included integrated mental health and HIV interventions and services in their Global Fund funding requests as part the "Window 1–4" allocations (pending final approvals and grant negotiations).

67. Community-led efforts and support during the COVID-19 pandemic. Many countries and communities have managed to put in place additional people- and community-centred services and support systems during the pandemic. For example, Phenomenal Positive Youths in Lusaka (a community organization of young people living with HIV) is active in the multisectoral risk communication community and is addressing issues of mental health, stigma and discrimination among young people.[127] In Zimbabwe, "e-peer support" groups provide adherence and psychosocial support to more than 8 000 children, adolescents and young people living with HIV, with the support of Africaid and trained community adolescent treatment supporters and young mentor mothers.[82] In many countries of Asia-Pacific region, eastern Europe and central Asia, people on opioid substitution therapy have been provided with multiweek community-delivered and take-home supplies of methadone and other opioid substitution therapy medicines. They are also benefiting from flexible opening hours at opioid substitution therapy clinics, and psychosocial and transportation support.[128]

68. These community-based and -led responses to COVID-19, HIV and mental health challenges underline the critical role of communities, including community-based organizations and community workers. They must be supported in their work to protect and enhance the quality of life of people living with, affected by and at risk of HIV, and of people with mental health conditions and substance use issues.

Integration of HIV and mental health in the next phase of the HIV response

69. For the first time, specific targets for the integration of mental health and HIV approaches have been included in global HIV targets for 2025. As endorsed by the Steering Committee, the targets for 2025 are as follows.
    - *Overall integration target*. Adoption of people-centred and context-specific integrated approaches that support the achievement of 2025 AIDS targets and result in at least 90% of people living with HIV and individuals at heightened risk of HIV infection being linked to services for other communicable diseases, noncommunicable diseases, sexual and gender-based violence, mental health and other services they need for their overall health and well-being.
    - *Population-specific integration targets*:
        - People living with HIV: 90% have access to integrated or linked services for HIV treatment and cardiovascular diseases, cervical cancer, mental health, diabetes diagnosis and treatment, education on healthy lifestyle counselling, smoking cessation advice and physical exercise.

- gay men and other men who have sex with men: 90% have access to HIV services integrated with (or link to) sexually transmitted infection, mental health and intimate partner violence programmes, sexual and gender-based violence programmes that include post-exposure prophylaxis, and psychological first aid.
- sex workers: 90% have access to HIV services integrated with (or link to) sexually transmitted infection, mental health and intimate partner violence programmes, sexual and gender-based violence programmes that include post-exposure prophylaxis and psychological first aid.
- transgender people: 90% of transgender people have access to HIV services integrated with or linked to STI, mental health, gender-affirming therapy, intimate partner violence and sexual and gender-based violence programmes that include post-exposure prophylaxis , emergency contraception and psychological first aid.
- People who inject drugs: 90% have access to comprehensive harm reduction services integrated or linked to hepatitis C, HIV and mental health services.

70. Integration of mental health and psychosocial support with HIV services and interventions, including those led by communities, has been included in the annotated outline of the Global AIDS Strategy 2021-2016 (UNAIDS/PCB (47)/20.36). This prioritization will help ensure that the health and well-being of people living with HIV will be addressed through holistic and integrated services, care and support. The Strategy provides an opportunity for mental health and psychosocial support to be integrated across governments' and partners' health, social and economic strategies, recovery plans and budgets, and community support.

Conclusion and way forward

71. We cannot end the AIDS epidemic unless we ensure mental health and well-being throughout the life course and especially among the most vulnerable people and communities. Countries should address the social determinants of mental health, drug use, harmful use of alcohol and HIV by developing and passing laws that promote social protection, child protection and gender equality, and that combat discrimination (including against people using drugs and other key populations, and people with mental health conditions). Stigma reduction policies and plans, antipoverty strategies and other addressing the social and structural factors, including violence, that drive the epidemic are urgently needed. Coordinated implementation of multisectoral interventions is needed at the sociopolitical level, in communities and the health sector to address vulnerabilities associated with HIV, drug use, harmful use of alcohol, being deprived of liberty, and mental health conditions.

72. Mental health, including for children, adolescents, adults and older adults living with, affected by and at risk of HIV, people who live with mental health conditions, people with use drugs, people with harmful use of alcohol, people in prisons, and other vulnerable groups, will remain a serious concern even as countries emerge from the COVID-19 pandemic and embark on social, economic and health systems recovery. Mental health should be fully considered across governments' health, social and economic responses and recovery plans and budgets, and community support.

73. In order to integrate mental health into HIV prevention, treatment and care services with mental health services and to promote people-centred, gender sensitive, age specific and human rights approaches, service delivery and strategies, well-being and quality of life, a number of key actions need to be taken and the investments should be made[1,2] Integrated approaches is considered as a way to reach universal health coverage[170] and

seen by the Lancet Commission on Global Mental Health and Sustainable Development as one of seven key actions for improving mental health across populations.[171] Integration of HIV and mental health policies, interventions and services implies acknowledgment of and investments in addressing the bidirectional links between mental health and HIV. It also reflects the shared values of increasing individual agency and reducing disparities in access to quality services, care and support.

74. The role of communities in engaging and leading in responding to HIV, mental health conditions, neurological issues, drug use or harmful use of alcohol issues, and now the COVID-19 pandemic is critical. The communities and networks of people living with HIV, key populations, youth and women's groups have three decades of experience of implementing community-based people-centred and stigma reduction programmes and support in the context of HIV, which countries can tap into to further inform and support community-based public health responses to mental health, neurological and substance use issues, and COVID-19.

75. To additionally address the effects of COVID-19 on women and girls, and other vulnerable groups, integrated services that adapt services for survivors of violence and other human rights violations in the context of COVID-19 are also needed. Integrated HIV, mental health and COVID-19 services need to also reach populations in closed (e.g. prison), humanitarian and emergency settings to protect their health and well-being. Health and community workers and other service providers—in or outside health facilities, among them those providing HIV, mental health, neurological and substance use services, should be provided with mental health and psychosocial support and counselling.

76. The shortage and lack of capacity of human resources for the provision of mental health and substance use services need to be urgently addressed by countries and development partners. Countries should develop, build capacities of and train a cadre of both specialist and non-specialist providers for prevention, treatment and care for mental health conditions and substance use services using the local resources available, including at community level, and mobilize additional resources if lacking. Investments should be made into scaling up of community-based and community-led interventions to promote mental health, human rights, non-discrimination, well-being and quality of life. Countries should identify which tasks should be shifted and which cadres of providers should be trained and mobilized to deliver care, as well as organize sustained supervisory systems and identify resources at regional and national levels for sustainability.[172]

77. There are several "unknowns" about the links between mental health and HIV, between HIV and noninjecting drug use, and regarding the measurable impact of integrated mental health, neurological, substance use and HIV strategies and interventions on HIV and other outcomes. It is important to address the gaps in our knowledge and programming on mental health conditions, drug or harmful use of alcohol treatment in the context of HIV through additional research and implementation science.

Proposed Decision Points

78. The Programme Coordinating Board is invited to:
    - *Recognize* progress made by countries, the UNAIDS Joint Programme, and other partners in supporting integrated mental health and HIV services and the potential further negative impact of COVID-19 on the mental health and well-being of people living with and affected by HIV;

- *take note* of the report on mental health and HIV;
- *recall* that PCB participants are requested to submit written comments in replacement of the debate following the 47th meeting of the PCB as agreed upon through the intersessional procedure (UNAIDS/PCB (47)/20.23); and
- *call on* the Joint Programme to report back on progress at a future PCB meeting.

Annex 1: Tables

Table 1. HIV, mental health and substance use: justifications for linkages and integration of services, interventions, programmes and strategies

Mental health conditions
• Affect around 971 million people globally,[129] and occur commonly and disproportionately among the 38 million people living with HIV; • Are associated with increased risk of HIV, especially when severe, and people with severe mental health disorders have a high prevalence of HIV in the Americas, Europe, Africa, and Asia;[130] • Lack or delay in access to HIV information, prevention, testing, linkage and adherence to care;[131, 132, 133, 134] • There is a strong relationship between mental health and adherence to HIV treatment for women. Women living with HIV are impacted by depression, anxiety, stress, a lack of self-esteem, motivation to go on living, and self-stigma that influences women's health-seeking behavior and adherence to HIV treatment;[135] • Depression treatment can improve adherence to care and HIV outcomes;[136] • Are sometimes associated with increased mortality due to HIV.[137, 138, 139, 140, 141]
Alcohol and drug use issues
• Approximately 283 million people are affected by harmful use of alcohol, and high-risk patterns of alcohol use increase risk of HIV infection;[142] • 3% of HIV deaths are attributable to alcohol;[143] • HIV infection is highly prevalent among people who use drugs (an estimated 1.4 million people who inject drugs are living with HIV);[144] • Around 35 million people live with substance use and who require treatment services;[144] • Substance use (especially injection drug use) increases the risk of HIV transmission;[145, 146] • People with substance use, including drug and harmful alcohol use, have poor HIV treatment outcomes;[147, 148] • People with substance use, including drug and harmful alcohol use, lack access to HIV testing and treatment, and adherence to HIV care and treatment;[132, 148, 149, 150,151, 152, 153] • Approximately 20% of new HIV infections outside of sub-Saharan Africa are associated with injection drug use, but political and social barriers to care alongside scarcity of services for drug treatment persist;[144] • There is evidence that drug treatment is associated with an increase in ART coverage and adherence to ART.[154]
Suicide
• An estimated 800 000 people die annually by suicide, and mortality due to suicide is elevated among people with HIV;[22,155, 156] • Rates of suicidal ideation or attempts ranged from 13% to 17% among people living with HIV in three African studies;[57, 158, 159] • Targeted strategies to reduce risk for suicide and suicide deaths benefit people living with HIV.[160, 161]
Stigma and discrimination
• Social stigma, including among health-care service providers, affects mental well-being and can limit provision and uptake of HIV prevention, treatment and care services. Laws and policies also shape risk and protection for key and marginalized populations. Criminalization of homosexuality, sex work and/or drug use, and the refusal to sanction prevention practices, such as needle exchange or condom provision in prisons, all hinder HIV prevention;[162] • Key populations, people living with HIV and people with mental health conditions often experience multifaceted stigma and the effects of interlocking systems of discrimination.[163, 164] Stigma associated with HIV—and marginalized identities—has been linked to anxiety, depression, poor self-esteem and poor adherence to HIV care;[165] • In prison settings, where there is an increased prevalence of mental health issues, awareness of, training on, and access to services for, mental health is often limited or entirely lacking;

- Stigma remains a barrier to accessing drug dependence treatment, mental health care and HIV services;[166, 167]
- Suicidal ideation and suicide attempts are often associated with social exclusion for living with HIV and key populations.[168] Community, health system and interpersonal factors associated with suicide risk can accumulate in communities vulnerable to HIV or living with HIV.[169] Those factors include stigma associated with help-seeking, limited access to mental health services, living in the context of war or displacement, acculturation pressures, experiencing discrimination, isolation, poor social support, punitive laws and discriminating policies and practices.[169]

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