

Co-designing Integrated HIV, Mental Health and Gender-Based Violence Services: A Scoping Review of Participatory Approaches in Low- and Middle-Income Countries

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Systematic Review

Keywords: HIV, mental health, gender-based violence, co-design, participatory research, scoping review, low- and middle-income countries

Posted Date: October 18th, 2026

DOI: <https://doi.org/10.21203/rs.3.rs-11364584/v1>

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Additional Declarations: The authors declare no competing interests.

Abstract

Background

HIV care, mental health support and gender-based violence support services are often provided separately. People needing several services may have to repeat sharing private information, travel between providers of services, or arrange referrals without help. Involving service users in planning may help address these difficulties, although their involvement and the links between services vary.

Objective

To examine how participatory approaches have helped develop HIV services linked with mental health and gender-based violence support services in low- and middle-income countries, and what the reports show about service design, delivery and outcomes.

Methods

This scoping review followed JBI principles and PRISMA-ScR reporting guidance. PubMed-indexed records were searched through Europe PMC for publications first released between January 2020 and December 2025. Additional searches identified related reports. Eligible reports described how stakeholders helped develop or adapt HIV services linked with mental health or violence support. Protocols and background studies were discussed separately. Results were compared descriptively without combining treatment effects.

Results

The database search identified 100 records. Fifteen were selected for full-text retrieval, together with seven additional reports. Four full texts were unavailable, and two reports lacked the required service link. Sixteen reports were included. Workshops, peer involvement, community discussions, digital testing and joint planning shaped programme content and delivery. Services included psychosocial support, depression-care plans, violence screening, referral tools and relationship counselling. Participants sometimes influenced programme decisions, while other projects mainly sought their views. Few reports described a complete care pathway covering all three areas.

Conclusion

Participatory approaches can help services respond to local needs. However, their separate effect on health outcomes remains unclear. Future studies should assess who influences decisions, whether

referrals are completed, safety, costs and continued service delivery, alongside HIV, mental health and violence-related outcomes.

1 Introduction

A person attending an HIV clinic may also need help with depression, distress or violence at home. The HIV visit does not necessarily provide a safe route to that help. Separate appointments and unclear referrals can leave the person responsible for connecting services. For some, disclosure itself carries risks. Integration should reduce these difficulties while protecting the person's choice about what to share and which support to accept. Recent work shows several ways to bring services together. Depression care has been planned within routine HIV services in Uganda, while community conversations in Zambia have shaped violence screening and referral support for young women living with HIV (Ssebunnya et al., 2021; Laurenzi, Mutambo, et al., 2023). A South African programme combined a mental health intervention with pre-exposure prophylaxis, or PrEP, through a human-centred development process (Velloza et al., 2024). These are related approaches, but their service components and maturity differ.

Participation matters because service users often understand barriers that are not obvious during a clinic visit. They may know why a referral is difficult to follow, which questions feel unsafe, or when an appointment conflicts with work and family responsibilities. Bringing these experiences into service planning can help providers develop support that people can realistically use. However, asking for opinions is not the same as sharing decisions. People should have opportunities to influence priorities, review proposed changes and explain whether those changes meet their needs.

Providers also need to consider available staff, supervision and referral services. A locally preferred approach may be difficult to maintain when these resources are limited. The review therefore examines both the participatory process and the practical arrangements for delivering care. Attention is given to confidentiality, follow-up and the responsibilities of different providers, since these affect whether connected services offer meaningful support rather than additional appointments. This review asks how participatory approaches have shaped HIV services linked with mental health or gender-based violence support in low- and middle-income settings. It examines who participated, what they changed, how services were connected and what was evaluated. Two-area programmes are included because they offer useful building blocks for three-area integration. They are not treated as complete three-area services.

1.1 Statement of the problem

HIV, mental health and gender-based violence services often address related needs through separate systems. People seeking care may receive a referral without clear guidance, face repeated appointments or avoid disclosing distress and violence because they fear stigma or harm. These difficulties can leave important needs unattended. Participatory approaches have helped develop depression care in Uganda,

violence screening in Zambia and mental health support within PrEP services in South Africa. However, these programmes differ in their service components, participant involvement and evaluation methods. It remains unclear how participation influences service decisions and whether the resulting arrangements provide a connected pathway across all three areas. This review addresses that problem by examining who contributed, what changed and how care was organised. It also identifies gaps in referral follow-up, safety and sustained delivery that require further research and service planning.

2 Literature review

2.1 Conceptual review

2.1.1 Participation and co-design

Participation covers a range of relationships. People may provide information, comment on a draft, help develop a prototype or share control over a programme. Co-design generally involves working together on design decisions rather than collecting views only once. Co-production may extend this relationship into delivery and evaluation. These terms overlap in published work, so this review looks at the activities and decisions described rather than relying on programme labels (Slattery et al., 2020).

2.1.2 Integrated services

Integration can mean delivering several forms of care in one place, coordinating providers or helping people move safely between services. It may also involve shared screening and referral procedures. Mental health support ranges from peer-led psychosocial help to structured therapy and specialist assessment. These levels should be reported separately. A supportive group is valuable, but it is not interchangeable with treatment for a diagnosed disorder.

The same distinction applies to violence responses. Information about violence, relationship counselling, safety planning, medical care and legal referrals are different activities. Laurenzi, Mutambo, et al. (2023) developed screening and referral arrangements within HIV care. Hartmann et al. (2023) adapted relationship counselling for women using PrEP into a website. Both connect HIV and violence-related needs, although neither should be described simply as a full clinical violence service.

2.1.3 Safety and unequal access

Integration can reduce repeated visits but can also expose sensitive information to more people. Digital access brings further concerns about shared phones, message visibility and data costs. Atujuna et al. (2021) described peer-led digital psychosocial support for adolescents living with HIV. Ngũnjiri et al. (2023) explored user preferences for a violence-response chatbot. These approaches require attention to confidentiality and access as part of the service design, not as details added after implementation.

2.2 Theoretical framework

This review uses three connected perspectives. First, participatory work treats people's experience as a source of practical knowledge about services. The central question is whether those experiences influence decisions. Messiha et al. (2023) describe uneven use of theory in collaborative public health work. Second, a theory of change makes the expected route from activities to outcomes explicit. Ssebunnya et al. (2021) used this approach to plan depression management in HIV care. It helps identify assumptions, such as whether a person who screens positive can actually obtain treatment.

The third perspective concerns implementation. The updated Consolidated Framework for Implementation Research draws attention to the intervention, the setting, individuals and implementation processes (Damschroder et al., 2022). A locally preferred service may still fail if staff lack time, supervision or referral options. The complex-intervention guidance discussed by Skivington et al. (2021) also encourages researchers to consider context, programme theory and uncertainty throughout development and evaluation.

Together, these perspectives support a proposed model in Fig. 2.1. Shared priorities guide service design; service capacity determines whether the design can operate; and evaluation checks both delivery and outcomes. This is an organising model developed for the review. It has not been tested as a causal model. Its feedback route matters because service users should be able to challenge a design after it enters routine use.

2.3 Empirical review

Table 2.1
Empirical review of participatory service-development reports

Study	Setting and population	Participatory activity	Service link and stage
Ampt et al. (2020)	Kenya; female sex workers	Six workshops with 42 women; message refinement	HIV, violence and rights content in WHISPER SMS; development
Atujuna et al. (2021)	South Africa; adolescents with HIV	Participatory discussions and peer-led digital groups	Khuluma psychosocial support; 52-person pilot
Shahmanesh et al. (2021)	South Africa; young people	Community workshops, youth input and peer navigation	Thetha Nami HIV, psychosocial and social-service navigation; pilot
Ssebunnya et al. (2021)	Uganda; HIV-care stakeholders	Three theory-of-change workshops; 38 participants	Depression-management pathway within HIV care; development
Laurenzi, Ronan, et al. (2023)	Four African countries; young mothers with HIV	Young mothers, peer supporters and advisers adapted content	Psychosocial component for peer support; development
Laurenzi, Mutambo, et al. (2023)	Zambia; young women and community stakeholders	Community conversations; 30 distinct participants	Screen & Support violence screening and referral in HIV care; development
Nardell et al. (2023)	South Africa; young adults with HIV	Formative interviews and staff participatory workshops	Yima Nkqo peer group for coping and treatment initiation; development
Wang et al. (2023)	China; men with HIV	Stakeholder interviews, co-design and usability testing	DBT-informed mobile mental health and adherence support; development
Ngũnjiri et al. (2023)	Kenya; vulnerable young people and minorities	Focus groups with 150 participants; user preferences	AGILE violence information and support navigation; development
Hartmann et al. (2023)	South Africa; women and PrEP users	Workshops, cognitive interviews and iterative testing	CHARISMA mobile relationship and violence-risk counselling; pilot
Pepper (2023)	South Africa; postpartum women with HIV	Ten women used Photovoice and led programme development	Community support addressing adherence barriers, including violence; development
Velloza et al. (2024)	South Africa; young women using PrEP	Four-phase human-centred development process	Mental health intervention in PrEP, with violence-referral options; development
Pulerwitz et al. (2024)	Nigeria; sexual and gender minorities	Community consultation, pilot	CBT-based stigma, mental health and HIV self-care

Study	Setting and population	Participatory activity	Service link and stage
		refinement and group feedback	support; trial
Bernard et al. (2025)	Senegal; HIV and mental health stakeholders	Implementation mapping; 14 stakeholders in workshop	Depression screening, referral and treatment plan in HIV care; development
Dadi et al. (2025)	Nigeria; women who inject drugs	Qualitative assessment, co-creation and validation meetings	Harm reduction and violence-response package with psychosocial support; proposed services
Klymchuk et al. (2025)	Ukraine; HIV-prevention organisations	Policy co-creation, training and supervision	Mental health organisational framework across 14 NGOs; implementation report

2.4 Gap in the literature

Published work describes useful participatory designs, but it rarely follows a complete pathway across HIV, mental health and violence services. Velloza et al. (2024) examine mental health integration within PrEP care, while Laurenzi, Mutambo, et al. (2023) focus on violence screening and referrals within HIV services. Their contributions are related, yet neither establishes the performance of every component across one pathway. Reporting also leaves questions about whose priorities prevailed, how disagreement was handled and whether community influence continued after development. These concerns match the broader reviews by Slattery et al. (2020) and Grindell et al. (2022). Few mapped reports separate the contribution of participatory design from the effects of therapy, peer support or service access. Costs, referral completion and longer-term safety also need clearer assessment. Future studies should connect accounts of shared decision-making with sustained service delivery and outcomes that participants themselves consider important, including privacy, dignity and reliable follow-up.

3 Methods

3.1 Review design and reporting

The review followed the population, concept and context approach described in JBI guidance and used PRISMA-ScR reporting domains to organise the account (Peters et al., 2020). No protocol was registered, and no independent second screening or stakeholder consultation was undertaken. These departures from stronger review practice limit confidence in completeness. Protocol guidance from Peters et al. (2022) informed the reporting of the question, eligibility rules and search boundaries, but was not used to imply that a prospective protocol existed.

3.2 Eligibility criteria

The population included people living with HIV or using HIV-prevention services, their peers, community representatives and providers. The concept was participatory development or adaptation of a service linking HIV with mental health, psychosocial support or gender-based violence responses. The context was a low- or middle-income setting during the reported work. Primary reports with accessible English full text were eligible. Publication coverage began in 2020; the fieldwork itself could have occurred earlier.

Studies describing needs without a developed service were excluded, as were protocols, high-income-only reports and secondary reviews. HIV mentioned solely as background did not satisfy the service-link criterion. Clinical trials and reviews outside these rules were retained only for the conceptual sections and discussion. They were not added to the mapped-study count. Countries were considered in relation to the study setting and period rather than a single current income classification.

3.3 Selection and charting

Titles and abstracts were screened against the eligibility rules. Fifteen database records proceeded to full-text retrieval alongside the seven supplementary reports. Four full texts could not be retrieved through the available routes. Of the 18 accessible reports assessed, two described co-developed violence interventions without the required HIV service link. Sixteen reports were retained. Figure 3.1 shows the selection process; Table 3.1 lists the main reporting decisions.

Charted fields included author, publication year, country, population, participatory activity, service components, design output and evaluation stage. The extraction approach was informed by Pollock et al. (2023). Counts describe publications, not unique programmes or participants. No formal risk-of-bias assessment was conducted, and there was no pooled effect estimate. Findings were compared descriptively by service interface, participation and implementation needs. These decisions suit mapping, but they do not support conclusions about which approach is most effective (Khalil et al., 2021).

Table 3.1
JBI and PRISMA-ScR reporting decisions

Domain	Review decision
JBI question	Population, concept and context defined in Section 3.2
Search coverage	PubMed-indexed source plus purposive supplementary searching; 2020–2025
PRISMA-ScR selection reporting	Actual retrieval and exclusion counts in Fig. 3.1
Protocol and reviewers	No registered protocol; single AI-assisted review pass
Charting and appraisal	Descriptive charting; no formal risk-of-bias assessment
Consultation and limits	No review-level stakeholder consultation; restricted language and full-text access

4 Results

The 16 reports were published between 2020 and 2025. Most focused on African countries, while one covered China and another Ukraine. One report included Malawi, Tanzania, Uganda and Zambia. These countries do not cover all low- and middle-income settings. The countries represented partly depended on the search terms used, the papers listed in the database and the full texts available.

4.1 Characteristics of the mapped reports

Figure 4.1. Mapped reports by final publication year ($n = 16$). Counts describe this review set only.

4.2 Participation and shaped services

Workshops were used to set priorities, adapt content and judge feasibility. In Uganda, Ssebunnya et al. (2021) brought 38 stakeholders into three theory-of-change workshops. Bernard et al. (2025) used implementation mapping and a three-day stakeholder workshop in Senegal to select strategies for depression screening, confirmation, referral and treatment. The latter report shows the value of provider planning, while also raising questions about how directly service users influenced the final plan.

Some processes involved people throughout several stages. Laurenzi, Ronan, et al. (2023) adapted psychosocial support for young mothers living with HIV with input from young mothers, peers and advisers across four countries. Wang et al. (2023) combined stakeholder interviews, co-design sessions and usability testing to develop a mobile intervention for men recently diagnosed with HIV in China. The design work influenced both therapeutic content and its technical delivery.

Participation could extend beyond commenting on a service. Pepper (2023) described women using Photovoice to investigate adherence barriers and then leading a local support programme. Shahmanesh et al. (2021) developed Thetha Nami with young people and local stakeholders, linking peer navigation with health and social support. These examples show how service design can begin with daily concerns rather than a predetermined clinic problem.

4.3 Integration Process

HIV and mental health links took several forms. Khuluma provided digital peer psychosocial support for adolescents living with HIV (Atujuna et al., 2021). Yima Nkqo combined support after diagnosis with skills relevant to treatment initiation and emotional coping (Nardell et al., 2023). In Ukraine, Klymchuk et al. (2025) described an organisational framework for mental health support within HIV-prevention organisations. These reports span peer support, intervention content and organisational arrangements.

Violence-related links also varied. WHISPER incorporated HIV prevention, violence and rights information into a participatory SMS programme for female sex workers (Ampt et al., 2020). CHARISMA mobile addressed relationship barriers and violence risks around PrEP use (Hartmann et al., 2023). Dadi et al. (2025) proposed a package for women who inject drugs in Nigeria, including routes to legal, health and

psychosocial support. Information provision and referral design should not be counted as completed treatment.

Some reports addressed needs across all three areas through screening, navigation or programme content. Velloza et al. (2024) considered referral options for mental health and gender-based violence alongside the integration of a mental health intervention into PrEP services. Screen & Support linked violence identification and response with HIV care and psychosocial support (Laurenzi, Mutambo, et al., 2023). AGILE connected user preferences with a digital platform intended to provide violence-related information, counselling and referrals (Ngũnjiri et al., 2023). None of these descriptions establishes that every participant received a complete three-area clinical pathway.

4.4 Evaluation and reported values

Most design outputs were described through feasibility, acceptability, preferred content or implementation plans. Table 4.1 presents selected published values with their original purpose. They are not comparable effect sizes. For example, a rating of website usefulness cannot be compared directly with organisational adoption or acceptance of a needs assessment.

Table 4.1
Selected published values and their interpretation

Source	Published value	Meaning
Ssebunnya et al. (2021)	38 participants; 3 workshops	Design participation, not treatment response
Laurenzi, Mutambo, et al. (2023)	30 distinct participants	Returning participants were not counted again
Shahmanesh et al. (2021)	6,871 approached; 6,141 (89%) accepted assessment	Assessment acceptance, not clinic attendance
Hartmann et al. (2023)	Usefulness mean 4.54 out of 5	Website pilot rating; not PrEP adherence
Bernard et al. (2025)	48 strategies considered; 46 included in final plan	Strategy counts, not patients treated

Pulerwitz et al. (2024) evaluated a community-adapted group programme addressing internalised stigma, mental health and HIV self-care among sexual and gender minorities in Nigeria. Its delayed-intervention design requires care because changes in the waiting group complicate simple attribution. More generally, these reports do not isolate the effect of participation from the therapy, peer support or service changes produced through participation.

5 Discussion

5.1 Participation and local relevance

The mapped reports suggest that participatory work can change concrete service decisions. People influenced language, privacy arrangements, session content and referral options. The contribution was clearest when authors explained what changed after consultation. It was less clear when participation appeared mainly as a description of the development process. This distinction reflects the reporting concerns raised by Slattery et al. (2020) and Grindell et al. (2022).

The review also shows that stakeholder composition affects the kind of service produced. A provider workshop can clarify operational responsibilities, but may miss concerns that people hesitate to raise in clinical settings. Community-led work can reveal those concerns, while still needing professional input on treatment and safety. The task is to connect these forms of knowledge and report how decisions were made. Attendance counts are a poor substitute for this account.

5.2 Integration needs a functioning pathway

Adding a screening question is only the beginning. A positive response must lead to an appropriate offer of help, with consent, clear responsibility and follow-up. Otherwise, integration may identify unmet needs without reducing them. Velloza et al. (2024) addressed this problem by examining implementation barriers while adapting the intervention. Bernard et al. (2025) focused on the separate steps needed to move depression care into routine HIV services.

The broader review by Nwogwugwu et al. (2025) also describes varied approaches to mental health integration in African HIV care. This supports a cautious interpretation: integration is a service arrangement whose performance depends on staffing, supervision, treatment access and local referral capacity. Klymchuk et al. (2025) further draw attention to organisational policies and staff support. A programme cannot depend indefinitely on motivated individuals compensating for missing resources.

5.3 Clinical benefit and the contribution of co-design

Related trials show why integrated care deserves further testing, but they answer a different question from whether co-design causes better outcomes. Safren et al. (2021) tested task-shared cognitive behavioural therapy addressing depression and HIV adherence in South Africa. L. K. Murray et al. (2020) evaluated the Common Elements Treatment Approach for intimate partner violence and hazardous alcohol use in Zambia. Their results concern the interventions studied, not an isolated participatory-development effect.

Qualitative work by S. M. Murray et al. (2021) explored how couples experienced changes during that Zambian intervention. It offers useful ways to think about relationships, coping and the conditions supporting change. Keeping these distinctions clear avoids overstating what the mapped development studies establish.

5.4 Gender power and safety

People may avoid a service because using it could reveal HIV status, sexuality or violence to a partner or family member. Service convenience cannot be assessed apart from this risk. Confidentiality should

cover waiting areas, records, group membership, phone messages and referral communication. Participants need safe ways to decline questions or leave a programme without having to justify themselves.

5.5 Implications for practice and research

An integrated pathway should specify who responds to urgent distress or violence, who provides routine support and who checks whether referrals were completed. Peer workers need supervision and manageable responsibilities. Specialist support remains necessary when needs exceed peer or primary-care capacity. The proposed model in Fig. 2.1 places these service requirements between design decisions and outcomes, rather than assuming that a preferred design can deliver itself.

Future evaluations should examine participation as well as the intervention. Useful measures include which decisions changed, whose priorities were adopted, who was absent, what participation cost and whether community members retained influence during delivery. Clinical and service outcomes should be measured separately. Retention in HIV care, symptom change, referral completion, safety and service-user priorities are all relevant, but none should stand in for the others. Longer follow-up is needed to determine whether programmes remain available after initial project support ends.

6 Conclusion

Participatory approaches helped develop HIV services that responded more closely to local mental health and violence-related needs. Service users, peers and providers contributed to changes in programme content, digital delivery, screening procedures, referral arrangements and programme management. The clearest reports explained how participants' views influenced specific decisions. However, most programmes connected HIV care with one other area of support. A complete clinical pathway covering HIV, mental health and gender-based violence was seldom established in the mapped reports.

These findings suggest that participation can improve the relevance of service design, but its value also depends on what happens after development. People need clear routes to support, providers who understand their responsibilities and follow-up when referrals are made. Staff training, supervision, adequate resources and protection of sensitive information are necessary for these arrangements to work. Community involvement should continue during delivery so that problems can be identified and services adjusted as needs change. Further research should examine whether co-designed services remain available over time, provide safe care and improve outcomes that service users consider important. It should also distinguish the contribution of participation from the effects of therapy, peer support and better access to care. Co-design offers a useful approach to developing connected services, although its separate contribution to clinical improvement remains uncertain. Its practical value will depend on turning shared decisions into reliable care that respects people's choices and addresses their needs.

7 Recommendations

1. HIV services should establish clear links with mental health and gender-based violence providers, assign referral responsibilities and follow up to confirm that people receive support.
2. Service users and peer supporters should remain involved in programme decisions, delivery and evaluation so that services continue to respond to local needs.
3. Providers should receive regular training, supervision and adequate resources, with clear procedures for confidentiality, informed consent and responding to urgent needs.
4. Future studies should assess safety, referral completion, continuity of care and health outcomes, while examining how participatory design contributes to these results.

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Figures

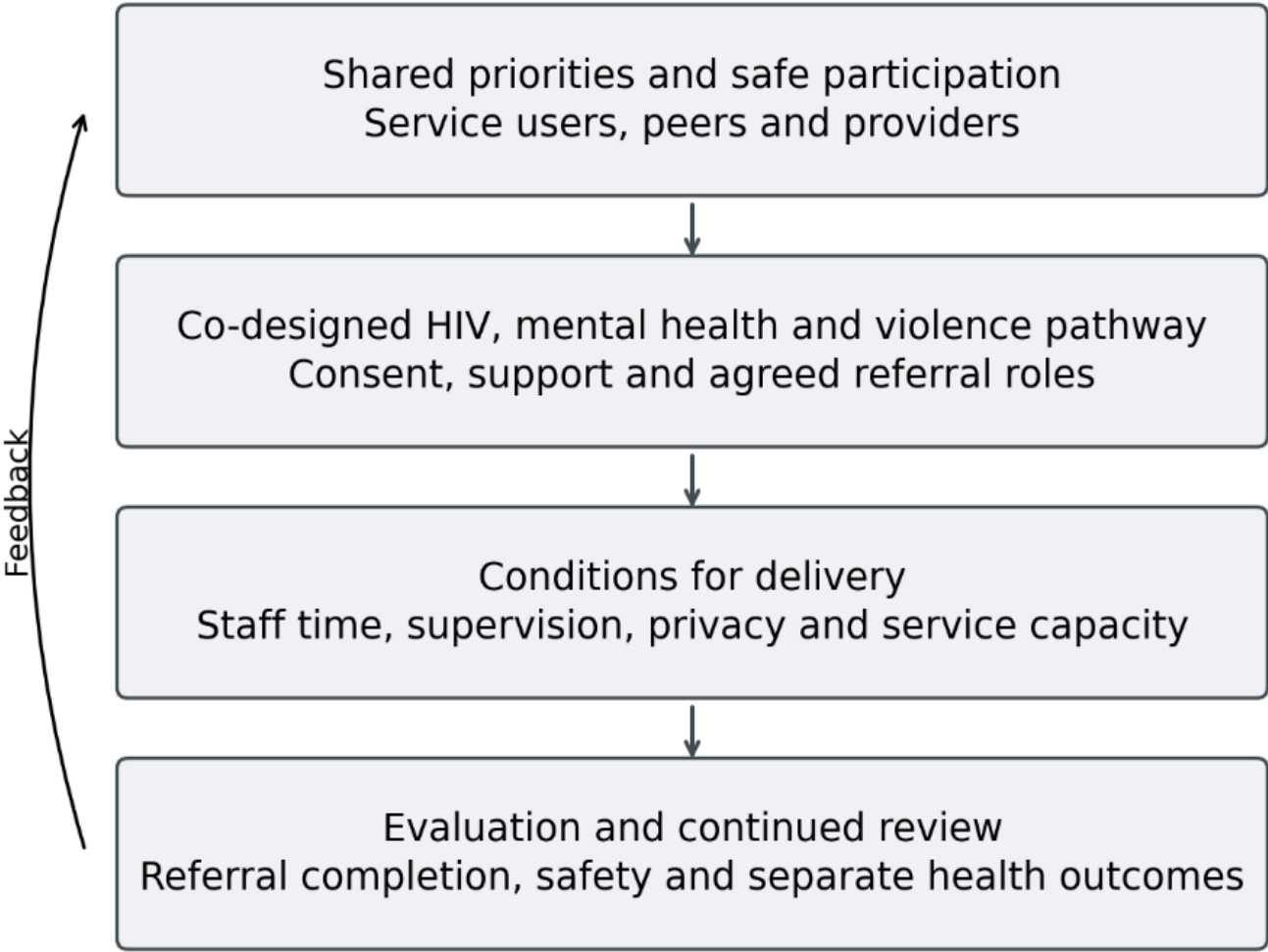


Figure 1

Figure 2.1. Proposed model linking participation, service delivery and evaluation. Author-developed; not a tested causal model.

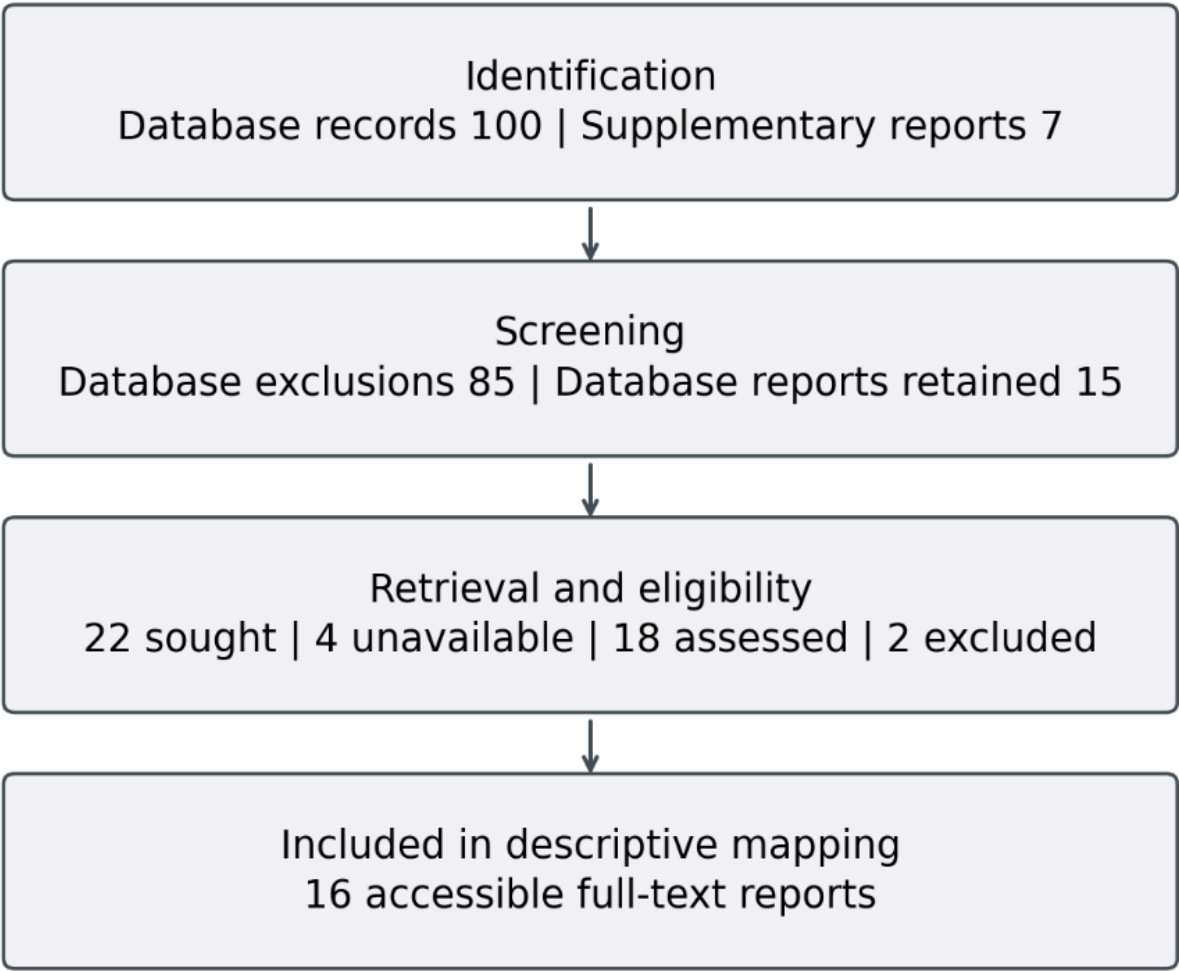


Figure 2

Figure 3.1. Selection flow for the bounded search. The two accessible exclusions lacked the required HIV service link.

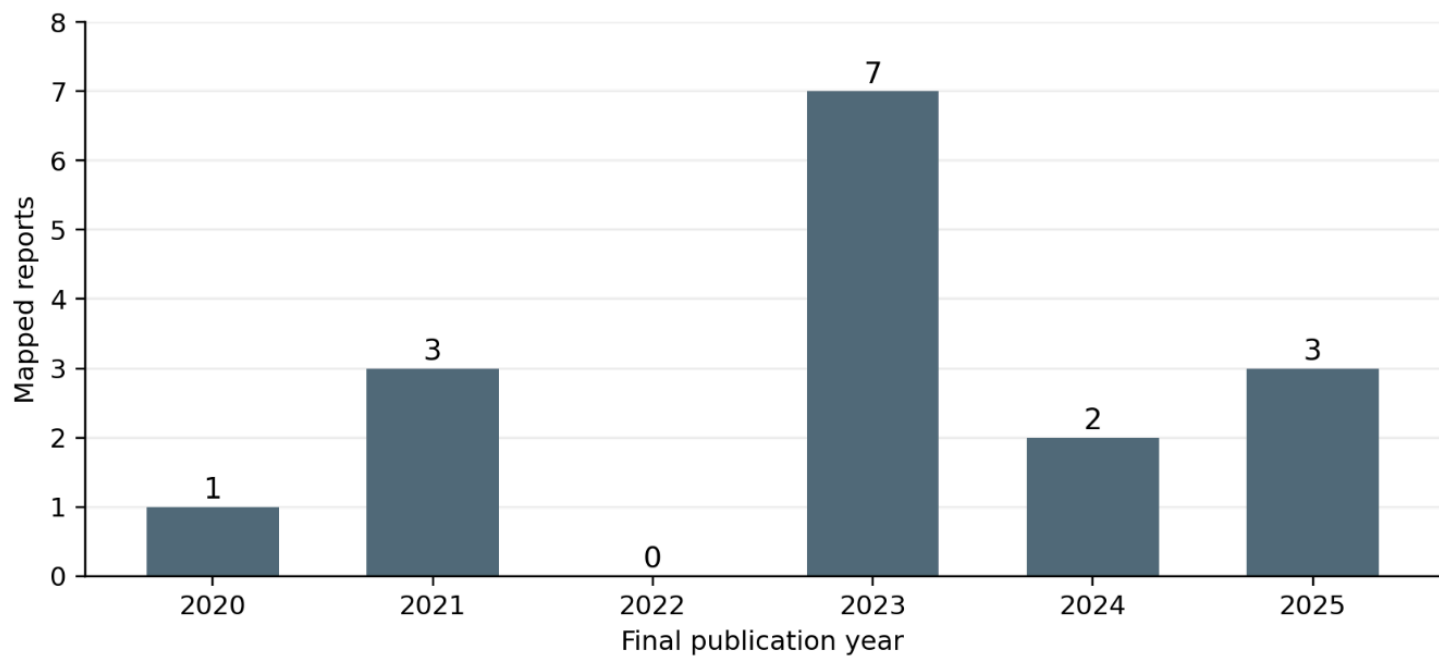


Figure 3

Figure 4.1. Mapped reports by final publication year (n = 16). Counts describe this review set only.