Depression vs well-being: findings of express assessment of screening for depression in HIV-positive women in the EECA countries

October 2021

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This study and publication was supported by UNFPA, the United Nations sexual and reproductive health agency.

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Introduction

Focus on mental well-being of HIV-positive women

The Eurasian Women's Network on AIDS (hereinafter - EWNA) brings together leaders who advocate for the rights and support of women's initiatives in Eastern Europe and Central Asia in various areas of healthcare, combating violence, HIV-related discrimination or belonging to key populations. One of the strategic directions of EWNA is to ensure women's access to sexual and reproductive health services.

Mental well-being is an integral component of human health, along with physical and social well-being. Women living with HIV often have concomitant physical health problems, and are also in various difficult life situations, which in combination negatively affects their mental health and quality of life in general.

The Eurasian Women's Network on AIDS ***initiated for the first time an express assessment among HIV-positive women in the countries of the EECA region on screening for depression***, as one of the most common mental health problems. The study was aimed at obtaining up-to-date information on the situation of the prevalence of depression among HIV-positive women in the EECA region, as well as analysing the relationship of depression with physical health problems and life circumstances. The express assessment was carried out within the framework of the project "Strengthening the capacity of women's communities in the EECA region to monitor and protect sexual and reproductive health and rights and combat gender-based violence" with the support of the UNFPA Regional Office for Eastern Europe and Central Asia (UNFPA).

Based on ***the findings of an express assessment of screening for depression*** in the EECA region, EWNA hypothesizes that depression is a real problem for the mental, physical and social well-being of HIV-positive women. However, the problem of depression is invisible and ignored for many reasons: the lack of regular screening and subsequent diagnosis of depression, women's lack of awareness of the signs and consequences of depression, the lack of necessary services and self-help skills.

Based on the findings of an express assessment, EWNA sets an ambitious goal ***to break the vicious circle: the lack of data on depression justifies the lack of necessary services for women who need them***. To this end, EWNA will advocate for the provision of access to mental health services in the EECA region as an integral component of the healthcare system.

The impact of depression on human well-being

Global context of depression

Common mental disorders, especially depression, are extremely common and constitute a major contributor to the overall global burden of disease and disability.

Common mental disorders, especially ***depression***, are extremely common and significantly contribute to the overall global burden of disability and disease.

According to WHO, more than 320 million or 4.4% of the world's population have a depressive disorder, with more women affected by depression than men (5.1% and 3.6% respectively)[1].

Depression is often associated with acute and chronic diseases (approximately 2/3 of cases), primarily cardiovascular diseases, diabetes, oncology and chronic pain conditions[2]. Thus, it can be assumed that HIV infection, as a chronic disease, also has a high prevalence of depression. Patients who have depression and other chronic conditions tend to have more problems with adherence to treatment, moreover, their recovery may be slowed down and their condition worsened[3].

Factors influencing the state of mental well-being and the potential for depression in HIV-positive women in the EECA region

Women living with HIV often have concomitant physical health problems, and are also in various difficult life situations, which in combination negatively affects their mental health and quality of life in general.

According to the results of community-led research in Ukraine[4], the vast majority of HIV-positive women who experienced physical abuse had mental health consequences — feelings of fear, anxiety, panic attacks, depression, loneliness, and one in four women considered committing suicide. HIV-related stigma and mental health-related stigma play a relevant role both in mental health itself and in seeking help.

According to the EATG survey (2020)[5], more than half of the sample of people living with HIV reported that they felt bad about their HIV status (51.5%) and believed that HIV had negatively affected their ability to engage in relationships and social activities (55.9%) and their sex life (56%). 63.4% believe that HIV-related stigma has negatively affected their mental health.

The COVID-19 pandemic has impacted the mental health of people living with HIV, with 48.6% of the respondents reporting the negative impact of the pandemic on their mental health and 29% reporting that the COVID-19 pandemic has recovered or worsened pre-existing mental health conditions.

The survey results clearly[6] indicate the need for further research into the mental health of HIV-positive people and the availability and use of mental health services for PLHIV in the WHO European Region. In addition, they stress the importance of better defining the range of responses to mental health challenges in the region and of expanding access to, and increasing the availability and use of, response services.

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[2] Cassano P, Fava M. Depression and public health: an overview. J Psychosom Res. 2002 Oct;53(4):849-57. doi: 10.1016/s0022-3999(02)00304-5. PMID: 12377293.

[3] Kessler RC. The costs of depression. Psychiatr Clin North Am. 2012 Mar;35(1):1-14. doi: 10.1016/j.psc.2011.11.005. Epub 2011 Dec 16. PMID: 22370487; PMCID: PMC3292769.

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[5] Mental health of people living with HIV and staff of organisations working in the field of HIV in the WHO European Region]. EATG, 2020 https://www.eatg.org/wp-content/uploads/2021/06/eatg-hiv-and-mental-heatlh-survey-report-english.pdf

[6] ibid

Prerequisites for assessing the situation of depression among HIV-positive women in the EECA region

There are gaps in available epidemiological data on depression both in the world and in the EECA region, thus they do not reflect the real situation both among the general population and, in particular, among HIV-positive women. It is caused by the lack of routine diagnostics of depression, regular screenings and studies of this problem, insufficient level of knowledge and understanding of mental health and its impact on the general well-being of people.

So far, the main health care efforts and services (including in the field of HIV prevention and treatment) have been focused on supporting physical health, while at the same time, mental health problems have been under-addressed and/or ignored.

EWNA shares the global advocacy ***No health without mental health!*** and formulates its strategic vision that ***the health of women affected by HIV*** *includes* ***physical, mental and social well-being***, even in the presence of HIV infection, chronic diseases and age-related processes, through access to essential medical, social and other services. In order to ensure access to the necessary services, it is important to understand the scale of the needs for such services.

Therefore, the Eurasian Women's Network on AIDS ***initiated for the first time an express assessment among HIV-positive women in the countries of the EECA region on screening for depression***, as one of the most common mental health problems.

Methodology for conducting an express assessment of the situation

Goals of express assessment

The main goal is to obtain up-to-date information on the situation of the prevalence of depression among HIV-positive women in the EECA region, including the relationship of depression with physical health problems and life circumstances.

Related goals:

1. draw the attention of HIV-positive women to the problem of depression and the need for regular screening
2. increase the capacity of EWNA leaders on mental health advocacy among HIV-positive women.

Depression screening tools

To screen for depression, two ***standard scales*** were used, which are applied in similar studies (including within the framework of the tools used in the World Mental Health Survey):

- Patient Health Questionnaire – 9
- Zung Self-Rating Depression Scale

The use of two screening scales for an express assessment contributed to the validation of the results and a more reliable picture. More information about screening scales can be found in Annex 1.

The express assessment also attempted to look at two other types of depression in HIV-positive women, namely ***maternal (postpartum) depression*** and ***suicide attempts*** as the most severe complication of

depression. Respondents were asked to share their experiences (open question, optional response of the respondent). Some of the responses to these questions are summarized in order to formulate hypotheses and determine the next steps.

Organization of express assessment

The study was carried out according to the methodology of the Community-based Women-Led Research, which EWNA has repeatedly used to assess the situation in various aspects of the life of HIV-positive women.

The express assessment took place in July-August 2021 in the form of an online survey. Women who were invited to participate in the survey:

- were HIV-positive
- lived in the EECA region
- expressed a voluntary and informed consent to be screened for depression through an online survey.

Express assessment limitations

Screening for depression among HIV-positive women was carried out for an express review and assessment of the situation, as a result of which hypotheses were identified for further discussion and advocacy. This express assessment does not pretend to be an epidemiological study, but rather identifies problem areas for future research.

HIV-positive women made a voluntary decision to participate in the express assessment, no clear sampling criteria were defined. Therefore, there is a possibility that women with severe cases of depression were not included in the number of respondents due to their well-being and unpreparedness.

This rapid assessment did not aim to examine in detail the types of depression in HIV-positive women: maternal (postpartum depression) and suicide attempts as the most severe complication of depression. The quotes provided by the respondents help to identify hypotheses for responding to and further researching these issues.

Findings of express assessment of screening for depression

General information about the participants of the express assessment

Geographical scope

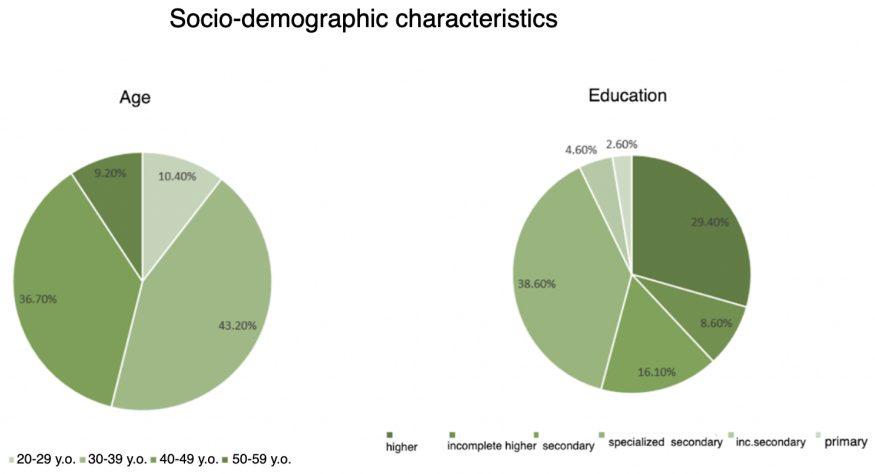
The online depression screening survey involved ***720 HIV-positive women from 11 countries in the EECA region***. Most respondents live in cities (89%).

Country	Number of respondents	
	absolute number	*%*
Armenia	18	2.5%
Belarus	11	1.5%
Georgia	14	1.9%
Kazakhstan	13	1.8%
Kyrgyzstan	6	0.8%
Moldova	35	4.9%
Russian Federation	281	39.0%
Tajikistan	10	1.4%
Uzbekistan	103	14.3%
Ukraine	182	25.3%
Estonia	47	6.5%
Total	**720**	

Socio-demographic characteristics

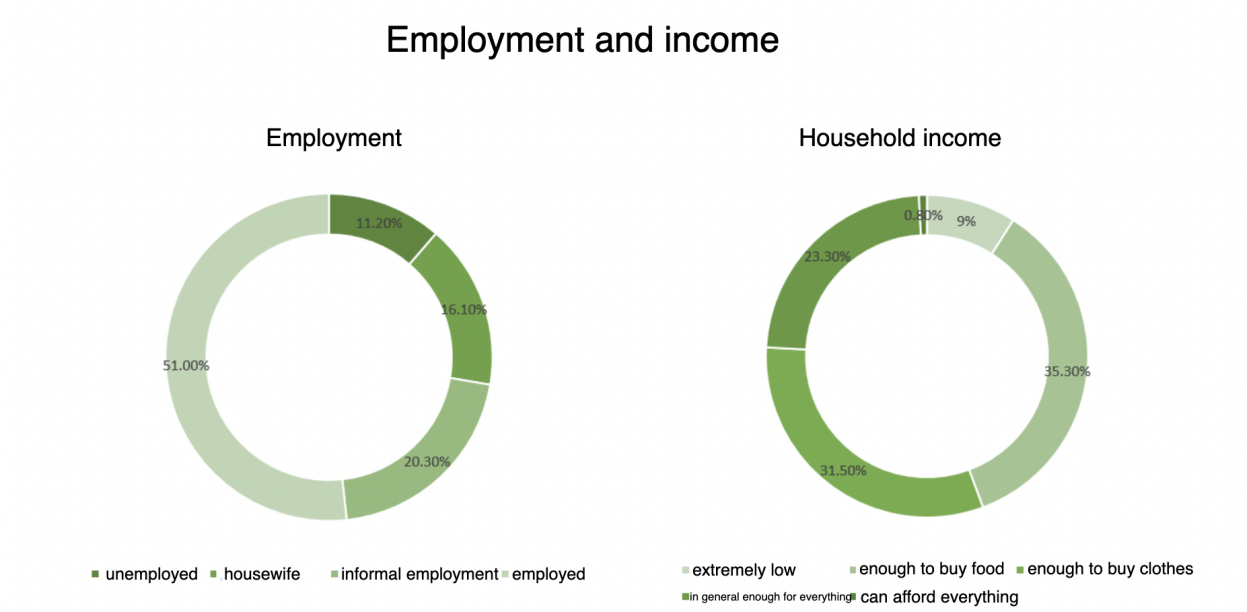
Screening participants represented ***different age groups***, predominantly in their productive life years (including 30-39 years old — 43.2%, 40-49 years old — 36.7%), as well as younger and older age groups.

More than half of the respondents have ***secondary and specialized secondary education*** (16.1% and 38.6% respectively), a third of the women surveyed have ***received higher education*** (29.4%).



Most of the depression screening participants ***have a job*** (including formal employment — 51%, informal employment — 20.3%). 16% of the women surveyed are ***housewives***. 11.2% of respondents are ***unemployed***.

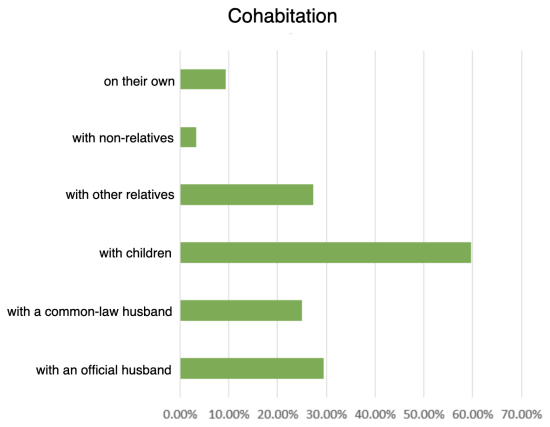
According to the level of ***household income***, the groups of respondents were distributed as follows: about a third of the respondents answered that they had enough money for food, but faced difficulties with buying clothes (35.3%), a third of the respondents said that buying food and clothes did not cause difficulties, but in order to purchase durable items (refrigerator, TV) they had to borrow money (31.5%), and one fifth of the respondents answered that, in general, they had no material problems, but buying really expensive things (car, apartment) caused difficulties (23.3%)



Cohabitation and maintenance

Most of the express assessment participants ***live with their families***. More than half of the respondents live with their children (59.7%) and have a husband (29.4% — an official husband, 25% — a common-law husband). About a third of the women surveyed live with other relatives (27.3%). One tenth of the respondents ***live on their own*** (9.3%).

Half of the respondents ***have under-age children*** (49.8%). The respondents also answered that they financially supported the elderly (12.1%), people with disabilities (7.5%) and able-bodied adults capable of self-care (14.4%).



Life circumstances and experience of violence

Some participants in the depression screening experienced difficult life circumstances and violence.

The most common ***difficult life circumstances*** are associated with the loss of a loved one (14.7%) and divorce (9.1%).

Difficult life circumstances	%
Serving sentence	1.8%
Traumatic events	6.6%
Loss of a loved one	14.7%
Divorce	9.1%
Other	4%

A third of the respondents answered that they experienced psychological ***violence*** against themselves (31.9%). Approximately one tenth of the respondents experienced economic and domestic violence (9.7% and 8.3% respectively).

Forms of experienced violence	%
Physical	6.6%
Mental	31.9%
Economic	9.7%
Sexual	1.1%
Reproductive	1%
Domestic	8.3%

The health status of the respondents

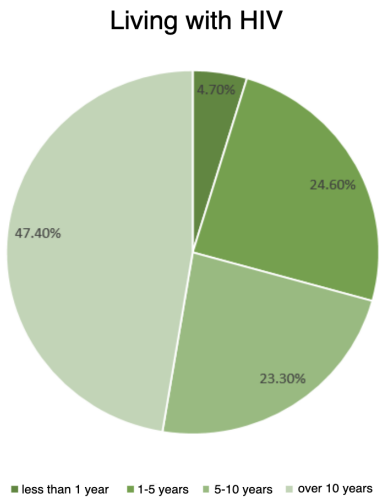
Living with HIV

Approximately ***half of the respondents have been living with HIV for more than 10 years*** (47.4%), the other half have been living with HIV for 5 to 10 years (23.3%) and 1 to 5 years (24.6%).

Almost all women ***take ARV therapy*** (705 respondents out of 720, 98%), however, they have different treatment records.

ART treatment records	%
Less than 1 year	10%
1-3 years	19%
3-5 years	18.5%
5-10 years	27.9%
Over 10 years	22.5%

2% of the respondents ***were not taking ART*** at the time of the express assessment, of which 1.3% did not start treatment and 0.7% stopped treatment.



More than half of the survey participants answered that they were ***adherent to treatment*** (60.2%), but the rest reported that they ***had missed regular medication*** (including skipping a few days — 33.7%, skipping a few weeks — 3.9%).

Physical health

Depression screening participants have a variety of physical health conditions, including chronic ones, that have been diagnosed by a doctor. 13.6% of respondents have gynaecological diseases, hepatitis and cardiovascular diseases (8.5% each), thyroid disorders (6.7%). 16.2% of women reported having a disability.

Diagnosed chronic diseases (within 12 months)	*%*
Diabetes	0.7%
Thyroid disorders	6.7%
Gynaecological diseases	13.6%
Chronic pain syndrome	2.8%
Hepatitis	8.5%
Cardiovascular diseases	8.5%
Oncology	1.3%
Autoimmune diseases	2.2%
Tuberculosis	1.8%

Mental health

Most of the survey participants answered that they did not have diagnosed mental disorders (68.8%). One third of the respondents had been diagnosed with depressive disorder (16.2%), anxiety (12.6%) or other disorders (2.3%) at some time in their lives.

The majority of respondents stated that they had not used psychoactive substances during the last 30 days (64.4%). One third of the survey participants answered that they consumed alcohol (33.6%), 4.2% — used drugs.

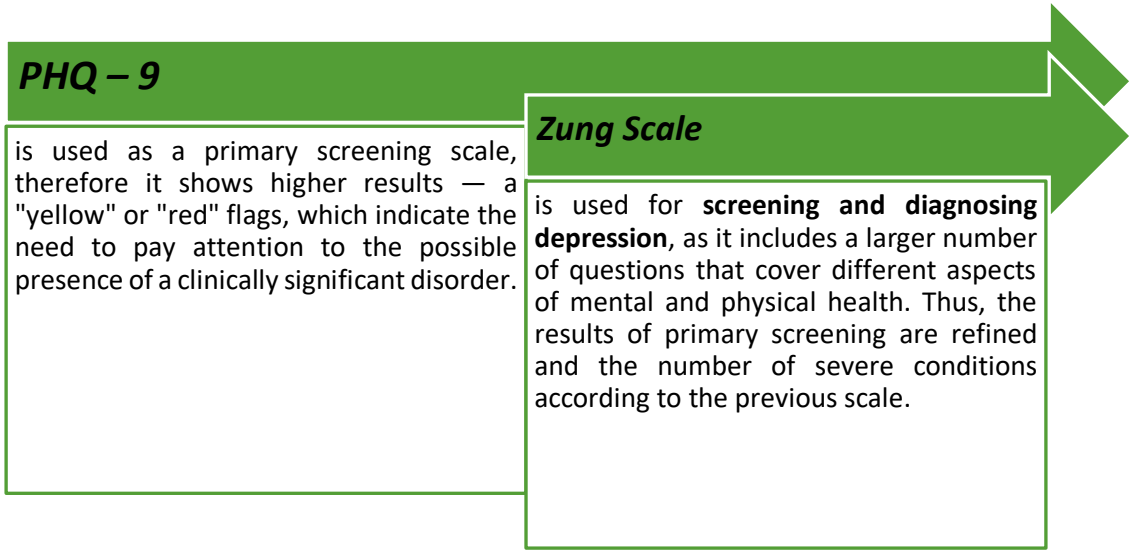
Findings of express assessment

Summarized screening results

Two standard scales were used to screen for depression (more on screening scales can be found in Annex 1):

- ***Patient Health Questionnaire*** – 9 — a multiple-choice self-report questionnaire that is used as a screening and diagnostic tool specific to depression. The PHQ-9 evaluates each of 9 related criteria based on the mood module from the original mental health assessment tools.
- ***Zung Self-Rating Depression Scale*** — the self-assessment test allows you to assess the level of depression of patients and determine the degree of depressive disorder. It considers 20 factors/questions (10 positively worded and 10 negatively worded questions) that determine the four levels of depression.

The use of two screening scales for an express assessment contributed to the validation of the results and a more reliable picture. The findings of the depression assessment display different levels of screening according to the purpose and questions of each scale.



Patient Health Questionnaire – 9 screening results

According to the Patient Health Questionnaire – 9 screening results, about ***one fifth of the respondents have signs of moderate depression*** — 10 or more points, which corresponds to the “yellow flag”. ***More than a third of the respondents noted signs that correspond to the “red flag”*** — moderate depression (15.7%) and severe depression (12.8%).

Patient Health Questionnaire – 9	%
No depression, minimal	21.6%
Mild depression	27.9%
Moderate depression	**21.9%**
Moderately severe depression	**15.7%**
Severe depression	**12.8%**

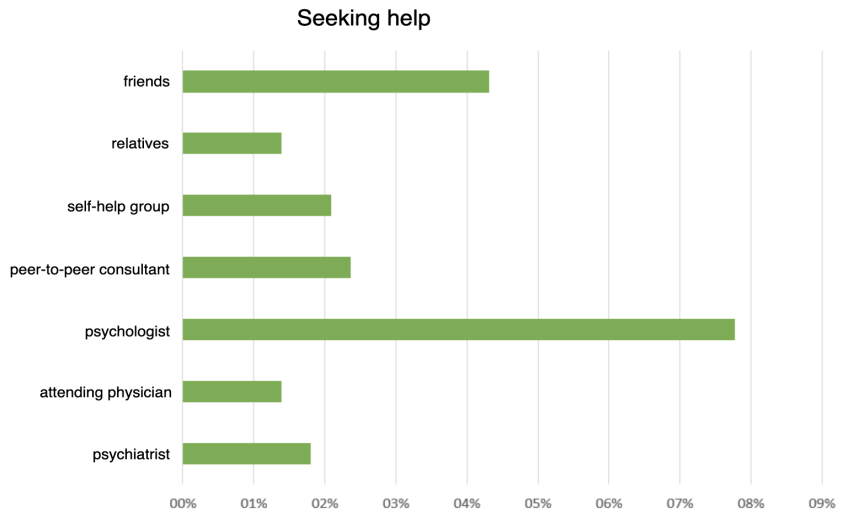
Zung Self-Rating Depression Scale screening results

According to the Zung Self-Rating Depression Scale, ***5.4% of the respondents have signs of subdepression, or masked depression,*** about ***a fifth of the respondents have a mild form of depression (20.9%).***

Zung Self-Rating Depression Scale	%
No depression	73.6%
Mild depression	20.9%
Subdepression, or masked depression	**5.4%**
Severe depression	0%

Seeking help for depression

The survey showed that ***the majority of women (81.7%) do not seek help for depression***. Those who seek help most often turn to a psychologist (7.7%) or friends (4.3%). Turning to health workers (psychiatrist and attending physician), as well as other forms of support, account for less than 2%.



Varieties and complications of depression in HIV-positive women

Depression has a wide range of symptoms and manifestations, especially in combination and depending on the state of physical health and social factors affecting women's health.

The express assessment also attempted to look at two types of depression in HIV-positive women, namely ***maternal (postpartum) depression*** and ***suicide attempts*** as the most severe complication of depression. Respondents were asked to share their experiences.

Maternal (postpartum) depression

Brief information on the factors and consequences of maternal depression

Maternal, or postpartum depression is distinguished from a large group of depressive mental disorders as a separate disease, mainly by the time of its onset, usually developing in the first year after the birth of a child. It is difficult to indicate the real number of cases of maternal depression for various reasons, including the low level of women who have given birth and sought help.

Currently, maternal depression is a relatively little-known and little-studied disease, especially in low-income countries. The psychological state of a young mother is negatively affected by an increased level of stress during pregnancy, family abuse. In the postpartum period, a woman is often in a kind of social and informational isolation, since she devotes the bulk of her efforts and time to a newborn. The development of maternal depression is fostered by both lifestyle during pregnancy (including diet, the presence of nicotine, alcohol or drug addiction, the presence of chronic diseases) and the physical state of the woman after childbirth (including the presence of postpartum sutures, difficulties in managing physical needs after childbirth, discomfort in the hospital ward). Many women are acutely aware of socio-cultural attitudes regarding motherhood, as well as painfully perceive the inevitable changes as a result of childbirth and breastfeeding.

Those women who have already experienced depression or other psychiatric disorders are most prone to develop maternal depression. Also, this disease is more common in single mothers, the unemployed, adolescent women in childbirth, in cases of unplanned pregnancy or its severe course.

The emergence and development of maternal depression affects not only the health of the woman herself, but also has a significant impact on the child. The development of this disease is fraught with maternal nutritional deficiencies and non-compliance with medical prescriptions for self-care and for the newborn. Women suffering from postpartum depression often do not adequately assess the emotional reactions of their own child, especially negative ones. Violation of the interaction between mother and child can lead to future deviations in the physical, mental and emotional development of a child.

Respondents' answers about the experience of maternal depression

The express assessment questionnaire included an open-ended question, "If you have experienced maternal depression, would you like to share your story?". Some respondents voluntarily and willingly answered this question. Quotations are given in accordance with the style of the original.

Stories of postpartum depression.

"In 2006, when I found out about my status, and later — that I infected my son while breastfeeding him. I wanted to kill all the doctors who did a caesarean section and injected me with infectious blood."

"Yes, I was very worried when I realized that under the pressure of fear of being left with small children on the street, without a livelihood, I strangled my own child in the womb and my daughter was born dead."

"I don't quite understand what is meant by maternal depression? If this is postpartum, then yes, I had a very severe depression. But then I did not know that it was depression and that it was almost natural for a woman to experience after childbirth and that it was associated with hormonal changes. Then I was just scared of my thoughts. Such hopelessness that there were thoughts that it would be better if my daughter had not been born, because both she and I were waiting for some terrible torment and thoughts of murder and suicide. They horrified me. And I knew that something was not normal with me. But I did not turn to anyone for help. Actually, this is the first time I'm sharing this. I was both scared and ashamed. I was afraid that everyone would think I was crazy."

"At that moment I was in prison and depression was constant."

"Yes, the birth of a child was a very difficult period in my life. If I were now with myself at that moment, I would explain what is really important, and what you just need to give up on. I would have rested more and was just with the child."

"I was worried, but not for long, a couple of months after giving birth."

"I worry from time to time. My son has ASD[7]. There was a two-year period of severe depression after the death of a daughter in childbirth."

"The loss of a child was very painful for me. Besides that, the uterus was amputated and I will not give birth again."

"Sometimes two small children are tiring me out, it's even hard to talk. I just want to close myself in a room and sit for at least 20 minutes in deep silence."

"I don't know if this is maternal depression, but when the child is somewhere at the age of 6 months I have no desire to do anything, there is no great love for the child, the child is more left on her own (my daughter is 1.1 years old) due to frequent fatigue and lack of sleep."

"Yes, I experienced maternal depression when I gave birth to my son and after 5 days he died."

"There was no depression, just lack of sleep."

"I suffered after the birth of my first child. I didn't have enough time to do everything I used to do. My body has changed a lot. From a beautiful slender 18-year-old girl, I turned into a zebra (burgundy stretch marks, 0.2 to 2 cm wide all over my body, starting from the chest and ending with the lower leg). My husband wasn't exactly supportive. There was no one around to help me. To take the baby in the stroller outside for

[7] Autism spectrum disorder

at least an hour ... 24/7 I was with the child and it was very difficult, I took it out on an innocent child. Now the girl is almost 18, and I am happy that I was able to overcome that condition…"

"Yes, my youngest daughter is 1 year old, she is the 4th child in the family. This state is hard to describe, there is a mixture of feelings and emotions. Simultaneously joy and chagrin or mood swings. I console myself that this condition passes, and it is easier to endure if there is a loving and close person nearby. Answering the questions above, I have realized that I am still depressed.:(."

"I was depressed only while in the hospital (terrible conditions for women)."

"Complete apathy, I didn't want to do anything except sleep and hear nothing."

"I was always tired; the feeling was that everyone just needed something from me. I didn't feel supported or taken care of. I felt sorry for myself. I cried a lot."

"Only now, when my son began to grow up, I start to pull myself together. I have more energy to live."

"I was depressed. Senior disabled child with severe MR[8]. So difficult and painful."

Stories about the current state of depression, including in connection with feelings about children

"I have two disabled children, my middle son is HIV-positive with moderate mental retardation and a younger son with a severe disability, CP[9], spastic quadriplegia. And while I was not seriously ill with leptospirosis, I took care of his health and found opportunities for this, and now, I myself need help and I cannot go where I need to go without being accompanied. I see a rollback in the development and health of my son, and it kills me, so much energy and work go away irrevocably and every day it gets worse for both him and me, and I don't know how to cope with this. Maybe in the city it would be easier to get out of this situation, but in the village without a car and money, you can only watch and cry from helplessness, living in the hope that God will take pity on us, on me. Because I can't stand this anymore and I can't do anything with myself, because I'm afraid that my children will end their days in orphanages or hospice."

"I still live with this depression and I want help."

"I want to share this with my children, but I can't, I'm afraid that it will be stressful for them."

"I have 4 children and my husband has 5. Every year 6 children spend summer with us. I am often crushed. Husband doesn't help much."

"When I'm depressed, I often drink alcohol."

"My son is 19 years old and I am worried about him and his lifestyle and some indifference to his health."

"The eldest son is a disabled child with a severe MR. Depression for years. With a younger one, motherhood is different."

"I'm worried about not being able to get along with my teenage daughter."

"Over one and a half years, I applied for psychological help on the Internet. I received 4 sessions with a psychologist online. But now there is no time and money to work on my mental health."

"I'm afraid for my children."

[8] Mental retardation

[9] Cerebral palsy

"I am very worried about my daughter's reaction and her further attitude towards me after revealing my status to her."

"Yes, I was depressed. Because I can't get pregnant. My husband does not want to be treated; he was diagnosed with infertility. Sometimes I focus too much on pregnancy."

"I am constantly worried for my children, I have a fear of revealing my diagnosis to them, fear that neighbours and acquaintances will find out. There were refusals in medical care in connection with the diagnosis, so there was a huge fear of getting sick and so on."

"My daughter has a neuropsychiatric disorder."

"I have a hyperactive child... Sometimes I'm just exhausted. In addition, I always work to provide my child with everything necessary and pay for the rent."

"I am a mother who has been living with HIV for 10 years, but when my smallest princess fell ill, the long-awaited daughter, with Type 1 diabetes on insulin. Long time of depression and rejection of reality (((I was no longer thinking about my illness, I had to get together and learn to live with diabetes, accept it. But it's still not that simple. Only now I understand my mother, when she cried for a very long time, after she found out about my illness. Now I can say with confidence that the illness of children, parents, etc. is a tough time for every woman! Especially when I myself do not have a simple illness…"

"I miss my mom. And I always think about her."

"Of course, I'm worried. I have to work and at this time the child has to be left alone."

"I take it out on my baby almost constantly, although I understand that he is not to blame, but I take it out on him."

Suicide

Brief information about the problem of suicide

Suicide is a major public health problem, as each completed suicide has long-term consequences for the families and communities of the deceased. Suicide attempts leave a significant impact on the mental and physical health of the individual. Suicide occurs in all regions of the world, with higher rates in low- and middle-income countries. According to WHO, "given the sensitivity of suicide – and the illegality of suicidal behaviour in some countries – it is likely that under-reporting and misclassification are greater problems for suicide than for most other causes of death".

While the link between suicide and mental disorders (in particular, depression and alcohol use disorders) is well established in high-income countries, many suicides happen impulsively in moments of crisis with a breakdown in the ability to deal with life stresses, such as financial problems, relationship break-up or chronic pain and illness. In addition, experiencing conflict, disaster, violence, abuse, or loss and a sense of isolation are strongly associated with suicidal behaviour. Suicide rates are also high amongst vulnerable groups who experience discrimination.

Significant gender differences in suicide rates have been investigated. Women are more likely than men to have suicidal thoughts. Women also show higher levels of non-fatal suicidal behavior and are more likely to attempt suicide as a manifestation of self-harm. The most important risk factor for suicide is a previous suicide attempt.

Respondents' answers about the experience of suicide attempts

The express assessment questionnaire included an open-ended question, "If you have had an experience of attempting to end your own life (suicide), would you like to share your story?". Some respondents voluntarily and willingly answered this question. Quotations are given in accordance with the style of the original.

Stories of suicide attempts

"I used to have a lot of suicide attempts. When I felt bad, I immediately decided to commit suicide. I thought that I was here (on Earth) by mistake. I even wrote poetry in that spirit:

Why did I come into this world?

Maybe I got the wrong door?

An evil idol reigns over everything here,

And people here are not people, but animals...

These were my thoughts. And I took pills or overdosed. But I was brought to my senses. Once I ended up in the ICU…"

"Due to an overdose of pills (tranquilizers and antidepressants), I drank several doses at a time."

"Could not accept my status, this was the only reason."

"Yes, but I'm afraid to commit it."

"When I found out that my son was +[10] , I tried to hang myself twice, threw myself under a car. Relatives were constantly keeping an eye on me."

"In 2017, I made two suicide attempts in four months, my mother saved me, her professionalism as a doctor. In 2021, thoughts of suicide occupy about 70% of all my thoughts."

"It was 8 years ago when I first learned about my status."

"Yes, there was a case, a year later, when I found out about the diagnosis of my younger son, I tried to hang myself, my husband saved me, then I went to a psychologist and never returned to this attempt."

"Yes, when I felt like no one needed me."

"I attempted twice when I was on drugs. I realized that I no longer wanted to live my life at that time. I slit my wrists. Some passer-by called an ambulance."

"I slit my wrists. Not to kill, but just to hurt myself."

[10] HIV-positive

“I've had a few parasuicides, but that was a long time ago. As of today, I have been taking antidepressants for more than a year and I cannot even think about suicide — I am raising my son alone. However, I cannot tell that I have good emotional health.”

“I wanted to die because my husband was constantly beating, humiliating, insulting, and hating me, he was calling me a whore, garbage dump, shit, he wished I was raped, thrown under the bridge and died. I can't stand it anymore.”

“Yes, I drank a lot of pills, but they managed to pump me out in the hospital.”

“As soon as I found out about my status and saw the reaction of my parents, I did not want to live.”

“Yes, following the death of my husband, I took Phenazepam together with alcohol.”

“I committed several suicide attempts as a teenager, mostly due to bullying by peers. I still remember those situations.”

“There was a period when I stopped taking ARV therapy to bring death closer (about 5 years ago, for several months).”

“Twice. The first attempt was when I used drugs, I tried to quit many times, it didn’t work out, I lost loved ones, I felt guilty before other loved ones, I couldn’t find a way out and I was very tired. The second attempt was when I was pregnant and they told me that I had HIV, that the child would not live up to a year, that I had 5 years left, and at that time my father was diagnosed with a malignant tumour.”

“I can’t die, but I have already come up with a death plan and maybe it’s only a matter of time.”

“Yes, I had a suicide attempt, but then I was not yet HIV-positive. It's just that my boyfriend, with whom I was going out for more than a year, said that he had children and he did not need me. I jumped from the eighth floor. I was drinking alcohol at that time and was not quite sober.”

“I attempted it when I was a teenager, I had relationship issues, I was very upset and drank several ampoules of anaesthesia medication. I felt that I was fading away and flying to the stars, at that moment my consciousness protested to leave, the thought suddenly arose that I was not ready yet, it was too early for me, and I regained consciousness. After that day, I didn’t have such desires, the idea that I still have a lot to do does not leave me to this day.”

“I wanted to, when I found out about my status.”

Conclusions and hypotheses

Based on the findings of screening for depression, it can be concluded that ***at least a quarter of the participants in the express assessment have experienced depressive episodes of varying severity***.

Most of the respondents suffer from ***mental distress***, which can contribute to the development of severe forms of depression, especially in the presence of chronic diseases and difficult, crisis life circumstances.

Particular attention and response should be directed to such manifestations as ***maternal depression*** and ***suicide*** attempts as the most severe complication of depression. These problems are hidden and tabooed by socio-cultural and legal norms. It is possible to organize timely assistance and support if there is an understanding of the real scale of these problems.

Based on the findings of the express assessment of the situation on depression in the EECA region, EWNA states that depression is a real problem for the mental, physical and social well-being of HIV-positive women.

However, the problem of depression is invisible and ignored for many reasons:

- lack of regular screening for depression by medical professionals, primarily primary care physicians and treating specialists;
- lack of follow-up of severe cases of depression and referral for care;
- unavailability or limited list of services for various forms of depression (severe and moderate), primarily psychotherapy;
- lack of awareness among women about the signs and consequences of depression, self-screening tools;
- lack of self-help and mutual support skills in women with depression, especially mild and moderate forms.

Hypotheses for further study of the mental health situation of HIV-positive women

1. The impact of depression on adherence to treatment, both ART therapy and for other existing diseases, and care for one's health in general.
2. The relationship between common non-communicable chronic diseases in HIV-positive women and depression. Perhaps women do not know / do not attach due importance to some non-communicable diseases (cardiovascular diseases, endocrine system disorders, etc.).
3. To study the level of anxiety disorders in HIV-positive women as a separate mental health issue and in combination with depressive disorders.
4. To analyse how the diagnostics of mental disorders associated with the use of psychoactive substances is carried out in countries.

Priority responses to help HIV positive women with depression

1. To launch and provide information support for a self-screening campaign for depression among HIV-positive women in the countries of the EECA region.

2. To examine the “journey of a patient with depression” in order to explore current practices for identifying, diagnosing and providing services for depression.
3. To raise awareness of women who have given birth to a child about the nature and signs of maternal depression, providing assistance in understanding and overcoming this condition.
4. To apply the suicide prevention strategy approaches, taking into account the specific situation of HIV-positive women and the socio-cultural context of countries.

Annexes

Annex 1. Depression screening tools

To screen for depression, two standard scales were used, which are applied in similar studies (including within the framework of the tools used in the World Mental Health Survey).

Patient Health Questionnaire PHQ-9

Patient Health Questionnaire – 9 is a multiple-choice self-report questionnaire that is used as a screening and diagnostic tool specific to depression.

The PHQ-9 evaluates each of 9 related criteria based on the mood module from the original mental health assessment tools[11]. The questionnaire also contains the tenth question on how much the problems made it difficult for the patient to do their job, take care of the house, or get along with other people.

The interpretation of screening results assesses the severity of the patient's condition. The result is evaluated in scores: 5 scores mean mild, 10 — moderate, and 15 — severe level of the disorder. The last question, about the patient's subjective assessment of the severity of their condition, is not used to calculate PHQ scores or make a diagnosis, but rather describes the patient's overall assessment of the deterioration in their life associated with a particular symptom.

10 scores or higher are considered a "yellow flag" meaning that attention should be paid to the possible presence of a clinically significant disorder; a score of 15 or higher is a "red flag" indicating that active treatment is probably justified in this case.

A full clinical interview and a series of tests are required to diagnose depression based on screening results.

Thus, the PHQ-9 questionnaire is both sensitive and specific in its results, which has led to its recognition and widespread use, both in the primary healthcare system, clinical settings, as well as in research.

The Russian version of PHQ-9 was used to conduct an express assessment of screening for depression among HIV-positive women in the EECA region.

Link:
https://www.phqscreeners.com/images/sites/g/files/g10060481/f/201412/PHQ9_Russian%20for%20Russia.pdf

[11] Patient Health Questionnaire was created on the basis of the Primary Care Evaluation of Mental Disorders, PRIME-MD, which was developed and validated in the early 1990s to efficiently diagnose five of the most common types of mental disorders presenting in medical populations: depressive, anxiety, somatoform, alcohol, and eating disorders. The original PRIME-MD tool proved to be effective, however, it was time consuming to make a diagnosis, making it difficult to use for screening. As a result of extensive research, improved PHQ questionnaires have been created for various aspects (including a 2-item depression scale, 4-item anxiety and depression scale, 15-item somatic symptoms scale, adolescent depression scale, etc.)

Zung Self-Rating Depression Scale

The Self-Rating Depression Scale was designed by Duke University psychiatrist William W.K. Zung. It allows us to assess the level of depression for patients diagnosed with depressive disorder.

The test takes into account 20 factors / items that determine the four levels of depression. There are ten positively worded and ten negatively worded questions in the test. Each question is scored on a scale of 1-4 (based on these replies: “never”, “some of the time”, “good part of the time”, “most of the time”).

The scores range as follows:

- 25-49 Normal Range
- 50-59 Mildly Depressed
- 60-69 Moderately Depressed
- 70 and above Severely Depressed

The Russian version of the Zung Scale, adapted by T.I. Balashova (Bekhterev Psychoneurological Research Institute), was used to conduct an express assessment of screening for depression among HIV-positive women in the EECA region.

Eurasian Women’s Network on AIDS (EWNA) brings together women leaders in Eastern Europe and Central Asia region where it is the only organisation uniquely dedicated to protecting the rights of women living with and vulnerable to HIV – developing and strengthening their potential, and making women's stories visible and voices audible and meaningful, including in decision-making processes at multiple levels.

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