

## INPLASY

## Mental health and mental health service inequities among Black people living with HIV in high-income countries: A scoping review protocol

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**ADMINISTRATIVE INFORMATION****Support** - CIHR under SHAWNA study.**Review Stage at time of this submission** - Data analysis.**Conflicts of interest** - None declared.**INPLASY registration number:** INPLASY2026100019**Amendments** - This protocol was registered with the International Platform of Registered Systematic Review and Meta-Analysis Protocols (INPLASY) on 5 October 2026 and was last updated on 5 October 2026.**INTRODUCTION**

**Review question / Objective** This scoping review protocol aims to identify and synthesize quantitative, qualitative and mixed methods evidence on barriers, facilitators and factors shaping mental health and mental health services utilization among Black people living with HIV in high-income countries.

**Background** Black communities draw on substantial strengths, including strong social and community networks, mutual support, collective knowledge, advocacy, and longstanding community-led responses to HIV and related health inequities. (1–5) At the same time, intersecting social and structural inequities, including racism, discrimination, stigma, and socioeconomic and resource inequities, contribute to disproportionate burdens of HIV and adverse mental health outcomes among Black people, as well as inequities in access to mental health services. (6–10) A recent study reported a higher prevalence of depression among Black people in

high-income countries compared to White and Asian people. (11) This 2025 systematic review found an overall pooled prevalence of depression among Black people in Western countries (i.e. Canada, United States (US), United Kingdom (UK), and the Netherlands) of 20.2%, with a higher prevalence among Black women (24.3%) compared to White women (17.8%). (11) Alongside depression, suicidal ideation and suicide attempts were observed to be higher among Black adults and youth compared to White people. (12,13) The prevalence of diagnosed anxiety disorders among Black people is observed to be lower than White people in high-income countries. (14) However, the lower prevalence of anxiety has been hypothesized to be due to underdiagnoses from heightened mental health stigma and cultural differences in symptomology. (14,15) A recent study highlights a higher prevalence of clinically significant anxiety symptoms amongst Black people than reported previously. (14,16) In high-income countries, Black adults and youth are also disproportionately affected by mental health inequities, yet are less likely to use mental health services than White

people. (6,17–20) Black adults and youth are more likely to first access mental health services during crisis or through involuntary pathways including through the criminal justice system compared to White people, suggesting inadequate access to preventive and outpatient mental health care. (17,21–23) These mental health inequities are driven by intersecting systems of oppression, including structural racism, stigma, discrimination, colonial violence and associated medical mistrust. (6,17,24)

Mental health service use remains low among Black migrant populations in many high-income countries, shaped by intersecting barriers including culturally situated mental health stigma, difficulties navigating complex systems, language barriers, and limited access to culturally responsive care. (25,26) Black migrant people contend with additional stressors associated with migration (e.g. settlement and acculturation stress, trauma associated with migration-related experiences) and heightened socio-economic barriers (e.g., food insecurity, housing insecurity, economic and employment insecurity), while being without the support of established family and social networks to cope with challenges. (27–31) Among Black Canadian migrant youth, these dynamics may be further compounded by developmental transitions, intergenerational cultural expectations and dependence on family systems for housing, financial and immigration support. (21,32–34)

Black people are also more likely to be living with HIV compared to other people with minoritized racial identities and White people. (35) In the US, Black people accounted for 37% of new HIV diagnoses in 2023 and 39% of all people living with HIV in the US, whilst only representing ~14% of the overall population. (36) In Canada, Black people accounted for 18% of new HIV diagnoses in 2022, despite representing less than 5% of the overall Canadian population. (37,38) The disproportionate burden of HIV is especially evident among Black people who are positioned within intersecting systems of oppression. (39) For example, according to the CDC, Black gay, bisexual, and men who have sex with men in the US have an eight-times higher HIV incidence and nearly seven-times greater HIV-related mortality compared to White gay, bisexual, and men who have sex with men. (40) HIV incidence in the US among African migrant people is nearly twice that of US-born Black people. (39).

**Rationale** Much of the research on mental health among people living with HIV is oriented within a framework that places the association between mental health conditions and access to antiretroviral therapy at the forefront. (41) Extensive

existing research shows that sub-optimal mental health jeopardizes engagement in HIV care and treatment and increases risk of negative HIV-related health outcomes, including HIV mortality. (42,43) People living with HIV experience higher rates of adverse mental health conditions, including depression, anxiety and post-traumatic stress disorder, compared to those living without HIV. (42,44–46) However, research that centres mental health or mental health services as critical health inequities are notably lacking among studies with people living with HIV, with limited but growing research among Black people living with HIV. Intersecting systems of oppression, including racism and HIV-related stigma, contribute to heightened marginalization and mental health inequities among Black people living with HIV. (27,39,44,45,47,48) In the UK, a study of women living with HIV reported that Black women were more likely to experience psychological distress compared to White women but less likely to be diagnosed with depression and be prescribed antidepressants. (49)

Community interventions led by Black facilitators living with HIV that prioritize empathy, validation, and peer-navigation of health systems have been found to be acceptable and enhance engagement with conventional mental health services. (50) Interventions delivered in settings such as HIV community-based organizations, online platforms to mitigate transportation barriers, and specialized HIV clinics have been shown to effectively support mental health care. (50,51) Culturally sensitive community-based interventions that integrate recreational and lifestyle activities (e.g., exercise, photography, theatre) with facilitated discussions of thoughts and emotions have been found to improve mental health symptoms, literacy, and coping strategies. (52) Programs that are culturally responsive Black-led, and encompass intersecting structural determinants faced by Black people living with HIV are required to build trust, foster belonging, and promote healing.

Previous knowledge syntheses have been useful in understanding the experiences of Black people in differing social and structural contexts such as migration status, living with HIV, and mental health. For example, one review examined settlement experiences and HIV care among migrant people living with HIV from sub-Saharan Africa in high-income settings, with limited attention to mental health. (53) Another systematic review has focused on how living with HIV alongside co-occurring mental health conditions influences HIV care outcomes and is restricted to a single high-income country (i.e., United States). (54) A systematic review and meta-analysis quantifies the prevalence of depression among Black people in high-income

countries, yet does not situate depression within the broader context of HIV or mental health service inequities. (11) Lastly, a systematic review that does address mental health inequalities among Black, African, and Caribbean populations in the UK, does not center the experiences of people living with HIV. (6) Previous reviews on mental health tend to focus on either mental health outcomes or mental health service inequities. (20,55,56) Moreover, many studies often measure diagnoses rather than symptomology and may not adequately represent experiences of sub-optimal mental health due to underdiagnosis, cultural differences in symptomology, underreporting, and mental health stigma. (11,14,17,57,58)

To our knowledge, no research synthesis has focused on mental health outcomes and mental health services of Black people living with HIV in high-income countries. Synthesizing current research can help elucidate the current breadth of knowledge available, identify gaps in knowledge, and inform culturally responsive mental health care services among Black people living with HIV. Therefore, the proposed scoping review aims to identify peer-reviewed quantitative and qualitative literature among Black people living with HIV that outlines the facilitators, barriers and factors shaping mental health and mental health services utilization.

## METHODS

**Strategy of data synthesis** This scoping review will follow the methodology outlined by the Joanna Briggs Institute (JBI) (67). A comprehensive search strategy will be developed in consultation with a research librarian. The search will be conducted in early 2026 across the following databases: MEDLINE (Ovid), EMBASE (Ovid), PsychInfo, and CINAHL.

**Eligibility criteria** Given that this scoping review focuses on literature from high-income countries, including non-peer reviewed publications, reviews, other synthesizes (i.e. grey literature such as, reports from government agencies, health authorities, and non-governmental organizations) would have substantially increased the scope and complexity of the review. Therefore, to ensure feasibility, the review was limited to peer-reviewed literature.

Inclusion criteria:

1) include Black people living with HIV only (i.e., the population must include those who identify as African, Black or Caribbean descent and is inclusive of all genders).

2) study is set in a HIC defined by the Organization for Economic Cooperation and Development (OECD).

3) include an assessment of mental health (e.g., depression, anxiety, PTSD, BPD, symptomology) and/or mental health services (e.g., utilization, frequency of utilization) as a study outcome with multivariable modelling for quantitative papers.

4) published in English due to reviewer capacity.

5) published in or after 2015.

6) one of the following primary research study designs: experimental/quasi-experimental, cohort study, cross-sectional, case-control, mixed-methods, qualitative.

Exclusion criteria:

1) non-peer reviewed articles (e.g., conference proceedings, commentaries, editorials, abstracts).

2) non-human study.

3) other study design (e.g., literature syntheses, including systematic, scoping, rapid, or narrative reviews)

4) study population is not contemporary (i.e., before 2015)

5) conducted outside of HICs.

## Source of evidence screening and selection

Title, abstract, and full-text screening will be completed by two research assistants (SP, BL) using established criteria. Articles will be assessed by both reviewers at all stages, and conflicts will be resolved between the two reviewers through reaching consensus. If consensus cannot be reached, the lead investigator (KD) will be consulted.

**Data management** References will be screened and managed using Covidence. (68) Extracted data will include study characteristics (e.g., setting, sample criteria), mental health outcomes, mental health services, reported associations, and key findings. The extraction table will be updated iteratively to ensure completeness. A PRISMA flow diagram will illustrate results across review stages.

**Reporting results / Analysis of the evidence** A data extraction template highlighted in Table 1 will be used to compile data within Excel. Extracted data will be summarized to detail mental health outcomes and mental health services examined across articles, common measurement tools used, and predominant study settings within included literature. For articles reporting multivariable associations between barriers and facilitators of mental health or mental health services among Black people living with HIV, findings will be summarized according to the factors examined, outcomes assessed, and direction of associations. Qualitative findings will be synthesized thematically

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to identify key themes, concepts, and patterns related to the experiences of Black people living with HIV and mental health outcomes and service inequities. Mixed-methods findings will be synthesized in accordance with the quantitative and qualitative synthesis approaches described above. Findings across study designs will subsequently be considered together to identify overarching patterns and important gaps in the existing evidence. This review will also identify recommendations to suggest policy and interventions in efforts among Black people living with HIV.

**Language restriction** Articles screened and evaluated will be restricted to those published in English due to the lingual capacities of reviewers.

**Country(ies) involved** Canada.

**Keywords** Mental health, Black people, HIV, mental health services,.

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