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## **Living positive with HIV in Botswana: a self-help intervention for people living with HIV and depressive symptoms**

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## **Propositions**

1. Integration of depression screening and treatment into HIV care improves both mental health and HIV related outcomes.
2. Successful and sustainable implementation of psychological interventions in HIV care will fail without alignment between health system capacity, provider training, and community acceptability.
3. Without cultural adaptation, self-help interventions in LMICs will be ineffective or even counterproductive, regardless of evidence from high-income settings.
4. Booklet-based interventions, while seemingly outdated, are the most practical and equitable solution for bridging the mental health care disparities in low-and-middle income countries.
5. Men living with HIV remain underrepresented in mental health intervention research, limiting understanding of gender-specific barriers to psychological care.
6. The withdrawal of HIV funding in low- and middle-income settings reflects a willingness to tolerate preventable morbidity and mortality once HIV is no longer politically beneficial.
7. Persistent stigma around mental health care makes any attempt to integrate psychological services into HIV care impossible.
8. Male multiple concurrent sexual relationships function as a major amplifier of heterosexual HIV transmission in Botswana, without which current HIV infection levels would be unlikely to persist.
9. When basic needs are not met, such as hunger, it is impossible to address emotional concerns.
10. Efforts to increase uptake of health services among men in Botswana will remain ineffective until masculine norms are treated as central, rather than marginal, determinants of health behaviour.