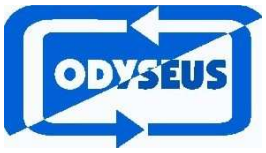
Phase 2 of the Research

MAIDS: Report on the 2nd Phase of the Research project

MENTAL HEALTH CARE FOR PEOPLE LIVING WITH HIV/AIDS



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MAIDS: Report on the 2nd Phase of the Research project

MENTAL HEALTH CARE

FOR PEOPLE LIVING WITH HIV/AIDS

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INTRODUCTION

This report presents the results of Phase 2 of a study conducted in the context of the project 'Mental Health Care of People Living with HIV/AIDS' (MAIDS). The study was carried out in 10 Central and Eastern European EU countries: Bulgaria, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia and Slovenia. The study was a continuation of the first phase of the research project, which was aimed at the identification of the needs and barriers in the area of mental health care for people living with HIV/AIDS, as well as the provision of a preliminary assessment of the system of mental health care for people living with HIV/AIDS in the countries participating in the project. The aim of the second phase research study was to provide a further description of mental health care for people living with HIV/AIDS, based on a questionnaire study conducted in care-giving institutions and organisations identified in the first phase of the study.

Aims:

The objectives of the second phase of the study were to identify mental health services in facilities providing care for people living with HIV/AIDS and to provide a description of different aspects of the functioning of individual facilities in the countries participating in the project. It included structural and organisational issues related to the services provided, such as accessibility and scope. There was a special emphasis on mental health components in care and employment of mental health professionals. Structural and organisational issues also included financing and co-operation with other institutions. All these aspects are recognised as having a substantial impact on the accessibility and quality of mental health care. The identification and description of available services allowed for the provision of a brief overview of the development of mental health care for people living with HIV/AIDS in the different Central and Eastern European countries participating in the project.

Methods and Procedures:

The phase 2 research of the MAIDS project was based on a questionnaire study. Within a framework describing legal and financial systems, a mail questionnaire (*The MAIDS Questionnaire for Services*) was elaborated and mailed to care-giving institutions. Its scope included issues related to accessibility of services (location, hours and days of operation), human resources (staff and its background), services provided, utilisation of services (number

of clients, and use of different services), co-operation with other services (networking) as well as financing issues. The *MAIDS Questionnaire for Services* was developed to be completed individually by all facilities: institutions, organisations and others providing health care for people living with HIV/AIDS in the countries participating in the study.

Facilities were identified in the 1st phase of the project and were listed by each country's project partner in the questionnaire *Outline of a Report on Infrastructure and Financing* (questions A1, A2, A3). Institutions and organisations selected for the study were:

- Centres providing antiretroviral therapy (ARV) and/or other treatment after HIV exposure;
- Diagnostic and consultation services providing HIV testing;
- Organizations, institutions and other services providing mental health care and support for people living with HIV/AIDS.

The questionnaire was sent to the partner centres in English and translated into their country's language. In the next step, partners were asked to contact all identified facilities individually and present them with information on the study and the questionnaire to be filled in. The questionnaire was developed to be sent by e-mail and to be completed individually by the facilities' representatives. Sending e-mails seemed to be the easiest and most convenient way to collect the questionnaires. However, the instruction for partners specified that if more convenient, questionnaires could be also delivered and collected in different ways, for example: by fax, post or personally. Questionnaires could also be completed through a phone or face-to-face interview. The alternative forms of filling in the questionnaire were established to collect as many questionnaires as possible, as there were many concerns about the response rate in countries participating in the project. To increase the response rate, researchers were asked to contact identified facilities and their representatives as many times as necessary and to develop with them the most convenient way of filling in the questionnaire.

Identified facilities and collected questionnaires:

The number of identified facilities, collected questionnaires and response rate varied from country to country. In total, 340 facilities were identified and 146 questionnaires were collected (see Table 1.). The overall response rate was 43%. The highest response rate and the highest number of questionnaires collected were obtained in Latvia: 46 questionnaires

collected from 47 identified facilities (98% response rate). Another country with a very high response rate was Estonia (95%), with 18 questionnaires collected from 19 facilities identified. The lowest response rate was in Romania: 11 questionnaires collected out of 74 identified facilities. A low response rate (19-20%) and a low number of questionnaires collected were also noted in Slovakia (5 questionnaires for 26 facilities) and Lithuania (6 questionnaires for 30 facilities). The lowest number of questionnaires collected was noted in Hungary. Only 3 questionnaires were collected there. The total number of identified facilities was also very low in Hungary: only 6, so the response rate reached 50% there.

Table 1. Number of identified facilities, collected questionnaires and response rate

Country	**How many facilities were identified**	**How many questionnaires were collected**	**Response rate**
Bulgaria	34	11	32%
Czech Republic	12	9	75%
Estonia	19	18	95%
Hungary	6	3	50%
Latvia	47	46	98%
Lithuania	30	6	20%
Poland	80	29	36%
Romania	74	11	15%
Slovakia	26	5	19%
Slovenia	12	8	67%
Total:	**340**	**146**	**43%**

In most countries participating in the project, the majority of the questionnaires were completed and sent back by the facility's representative (see Table 2.). It total, 97 out of 146 were collected this way (66%). The only exception was Latvia where 30 out of 46 questionnaires (65%) were collected by phone interview and 7 (15%) by face-to-face interview. In other countries questionnaires collected by phone or face-to-face interview were infrequent.

Table 2. Method of collecting questionnaires

	Completed by the facility's representative (and sent back by e-mail, fax or other)	Phone interview	Face-to-face interview	**Total number of questionnaires collected**
Bulgaria	11	X*	0	**11**
Czech Republic	6	1	2	**9**
Estonia	16	0	2	**18**
Hungary	1	0	2	**3**
Latvia	9	30	7	**46**
Lithuania	5	1	0	**6**
Poland	26	3	0	**29**
Romania	10	0	1	**11**
Slovakia	5	0	0	**5**
Slovenia	8	0	0	**8**
Total:	**97**	**35**	**14**	**146**

*Bulgaria reported 10 questionnaires completed by phone interview but they were not sent to the coordination centre and therefore could not be included in this report

The project partners specified reasons given by facilities which refused to fill in the questionnaires. In most countries, among the main reasons given were lack of time and personnel and lack of required data. Partners reported that many facilities did not provide any reasons for their refusal or simply did not respond to the attempts to contact them. Most partners also reported that in the majority of cases facilities promised to fill in the questionnaire or find time to give a phone interview, but in the end never did, in spite of many reminder phone calls and e-mails.

Accessibility of facilities: location and opening hours

Location of facilities:

The number and location of facilities providing services for people living with HIV/AIDS is an important issue, often underlying a problem of accessibility of mental health care for this group. Table 3. presents the location of three types of facilities specified in the study. Unfortunately, because of the low response rate in many countries, it is impossible to conclude on the sufficiency of facilities number and their regional distribution within countries. It is also impossible to make any comparison between countries.

It general, it can be noted that in all countries most facilities were located in the capital cities (see Table 3.). For example, in Hungary - all three collected questionnaires were from Budapest. In Poland 45% of facilities which completed the questionnaire were located in the capital city, in Romania and the Czech Republic this figure was 55%. There were also more diverse types of facilities operating in countries' capitals, usually including all three types specified in the study. It has to be noted that a facility could be included in more than one category, and this is why the total number of facilities in one location does not always equal the sum of facilities from different category types provided in a given location.

It has to be stressed that in a number of participating countries, inhabitants of capital cities constituted substantial proportion of their total populations. Moreover, prevalence of drug abuse in capital cities is usually much higher than national averages.

In Latvia, where the response rate (98%) and number of collected questionnaires was the highest, 46 facilities for people living with HIV/AIDS which sent back the questionnaire were located in 21 cities and towns covering all regions of Latvia. It was noted that 24% of these facilities were located in the capital city Riga. In Estonia, the second country with a very high response rate (95%), there were 18 facilities located in 7 cities and towns; 44% of these facilities were located in the capital city - Tallinn.

Table 3. Type of facilities providing services for people living with HIV AIDS and their location in countries participating in the project.

Country	Location (city/town)	Type of facility, institutions/organisations providing: ARV or other treatment after HIV exposure	Diagnostic and consultation services: HIV testing	Mental health care and support for PLHA	**Total number of facilities in location**
Bulgaria	Blagoevgrad	0	0	1	**1**
	Burgas	0	0	1	**1**
	Pernik	0	0	1	**1**
	Sofia	1	3	4	**4**
	Varna	1	1	1	**1**
	Veliko Turnovo	0	1	0	**1**
	Vidin	0	1	0	**1**
	Vratsa	0	1	0	**1**
	Total	**2**	**10**	**9**	**11**
Czech Republic	Brno	1	1	0	**2**
	Ceske Budejovice	1	0	0	**1**
	Plzen	1	0	0	**1**
	Prague	1	2	3	**5**
	Total	**4**	**3**	**3**	**9**
Estonia	Kohtla-Jarve	1	1	0	**2**
	Narva	1	1	1	**3**
	Paernu	0	1	0	**1**
	Paide	0	1	0	**1**
	Tallinn	1	2	5	**8**
	Tapa	0	1	0	**1**
	Tartu	1	1	0	**2**
	Total	**4**	**8**	**6**	**18**
Hungary	Budapest	0	2	2	**3**
	Total	**0**	**2**	**2**	**3**
Latvia	Bauska	1	0	0	**1**
	Cesis	1	0	0	**1**
	Daugavpils	0	1	1	**2**
	Dobele	0	1	0	**1**
	Jekabpils	1	1	0	**2**
	Jelgava	1	0	1	**2**
	Jurmala	1	0	1	**2**
	Kekava	1	0	1	**2**
	Kuldiga	1	0	2	**3**
	Liepaja	1	1	1	**3**
	Ogre	1	0	0	**1**
	Olaine	1	0	1	**2**
	Rezekne	0	1	1	**2**
	Riga	4	2	5	**11**
	Salaspils	0	0	1	**1**

(*cont. on the next page*)

Table 3. Continuation

Country	Location	ARV or other treatment after HIV exposure	Diagnostic and consultation services: HIV testing	Mental health care and support for PLHA	**Total**
(cont. Latvia)	Saldus	1	0	0	**1**
	Talsi	1	0	0	**1**
	Tukums	1	0	2	**3**
	Valmiera	1	1	0	**2**
	Ventspils	1	1	0	**2**
	Vienibas	1	0	0	**1**
	Total	**20**	**9**	**17**	**46**
Lithuania	Alytus	0	0	1	**1**
	Kaunas	1	0	0	**1**
	Kedainiai	0	0	1	**1**
	Vilnius	1	0	3	**3**
	Total	**2**	**0**	**5**	**6**
Poland	Białystok	0	0	1	**1**
	Chorzów	0	0	1	**1**
	Człuchów	0	0	1	**1**
	Gdańsk	0	1	1	**2**
	Gorzów Wielkopolski	0	1	0	**1**
	Jelenia Góra	0	1	0	**1**
	Kielce	0	1	0	**1**
	Kraków	1	0	0	**1**
	Łódź	0	0	1	**1**
	Poznań	1	0	1	**1**
	Słupsk	0	1	0	**1**
	Szczecin	0	1	0	**1**
	Warszawa	4	3	7	**13**
	Wrocław	1	2	0	**2**
	Zgorzelec	0	0	1	**1**
	Total	**6**	**13**	**14**	**29**
Romania	Bucuresti	0	0	6	**6**
	Cluj	1	1	1	**2**
	Iasi	0	0	2	**2**
	Targu Mures	1	1	0	**1**
	Total	**2**	**2**	**9**	**11**
Slovakia	Bratislava	1	3	1	**4**
	Liptovsky Mikulas	0	1	0	**1**
	Total	**1**	**4**	**1**	**5**
Slovenia	Celje	0	1	0	**1**

	Kranj	0	1	0	**1**
	Ljubljana	0	1	5	**6**
	Total	**0**	**3**	**5**	**8**

Accessibility: Working time and operating hours

Facilities' operating days and hours determine their accessibility for patients and clients. The important issue here is not only how long they are open, but also arrangements related to working time flexibility which makes it possible to use services outside usual working hours. Such arrangements allow patients and clients to use the services without interference with their professional tasks and other everyday activities. This aspect is especially important for people living with HIV/AIDS.

Table 4. presents reported opening days and hours. It shows how many days and hours a week facilities are open. Table 5. shows the accessibility of facilities outside usual working days and hours: on weekends (Saturdays or Sundays) and in the evening (after 18:00).

Table 4. Operating hours: opening days and hours a week

country	No data	How many days a week is facility open?			How many hours a week is facility open?			
		less than 5	5 days a week	more then 5	less than 15	from 16 to 30	from 31 to 45	more then 45
Bulgaria	0	0	100%	0	0	9%	82%	9%
Czech Republic	0	22%	67%	11%	22%	11%	44%	22%
Estonia	67%	0	22%	11%	0	6%	17%	11%
Hungary	0	1 (33%)	2 (67%)	0	2 (67%)	0	1 (33%)	0
Latvia	9%	9%	61%	22%	9%	37%	35%	11%
Lithuania	17%	0	67%	17%	0	17%	33%	33%
Poland	7%	38%	24%	31%	34%	21%	10%	28%
Romania	0	0	73%	27%	0	0	55%	45%
Slovakia	0	1 (20%)	3 (60%)	1 (20%)	60%	1 (20%)	0	1 (20%)
Slovenia	0	25%	63%	13%	25%	50%	13%	13%
Total:	**13%**	**14%**	**53%**	**19%**	**16%**	**22%**	**31%**	**18%**

In most countries, more than half of the facilities which completed the questionnaires were open 5 days a week (see Table 4.). The exception here is Poland, where only a quarter of facilities were open 5 days a week, while about 40% were open less than 5 days a week and 30% more than 5 days a week. In Estonia, 67% of facilities did not provide information on opening hours, therefore it is difficult to form any conclusions on operating hours of facilities there. In Bulgaria, all the facilities which completed the questionnaire were open 5 days a week. Facilities open 5 days a week are usually open from Monday to Friday. And this is the case in Bulgaria, were all facilities reported to be open 5 days a week and none to be open during the weekend (see Table 5).

The highest percentages of facilities reported to be open more than 5 days a week were found in Poland (31%) and Romania (27%) (see Table 4.). Poland also had the highest percentage of facilities which reported to be open less than 5 days a week (38%). In two countries: Bulgaria and Hungary, no facilities reported to be open more than 5 days a week. And in 3 countries: Bulgaria, Lithuania and Romania, no facilities reported to be open less than 5 days a week. In the same countries, no facilities reported to be open less than 15 hours a week.

The highest number of opening hours a week was reported by facilities in Romania (see Table 4.). 45% of them reported to be open more than 45 hours a week and the rest of them stated being open no less than 31 hours. In Bulgaria, 82% of facilities reported to be open between 31 and 45 hours a week. The highest numbers of facilities which reported to be open less than 15 hours a week were seen in Slovakia (60%) and Poland (34%).

Table. 5. Accessibility outside usual opening days and hours: facilities open on weekends and in the evening

Country	no data	Is facility open:	
		on weekends (Saturday or Sunday)	in the evening ? (after 18:00)
Bulgaria	0	0	18%
Czech Republic	0	11%	22%
Estonia	67%	17%	28%
Hungary	0	0	1 (33%)
Latvia	9%	22%	n/a
Lithuania	17%	17%	17%
Poland	7%	31%	66%
Romania	9%	18%	36%
Slovakia	0	1 (20%)	1 (20%)
Slovenia	0	25%	25%
Total:	**14%**	**20%**	**29%**

In relation to opening time flexibility, it can be noted that accessibility outside usual working hours is not very high in any country (see Table 5.). In total, 20% of the facilities which completed the questionnaire reported being open during any day of the weekend, and 29% in the evening. The highest percentage of facilities open outside usual working hours was seen in Poland: 31% of facilities reported to be open on weekends and 66% after 18:00. In Romania there was quite a high percentage of facilities open in the evening: 36%. In other countries, the number of facilities reporting to operate outside usual working hours was rather low. Facilities from Latvia and 67% of facilities from Estonia did not specify their opening hours in the evening.

Mental health care personnel

Part two of the questionnaire was related to mental health specialists employed by facilities providing care for people living with HIV/AIDS. Facilities were asked to specify the background of their personnel working in the area of mental health care. Table 6. presents numbers and percentages of facilities employing mental health specialists. Table 7. presents the numbers and percentages of facilities employing other specialists (from the area of general health care and social assistance) who work with issues related to mental health care.

Table 6. Personnel of mental health care in facilities: mental health specialists

Country:	numbers and percentages of facilities employing following specialists in relation to mental health care:				
	Psychiatrist	Psychiatric nurse	Psychologist / psychotherapist	Addiction therapist/specialist	Socio-therapist
Bulgaria	1 (9%)	1 (9%)	3 (27%)	3 (27%)	1 (9%)
Czech Republic	5 (56%)	3 (33%)	3 (33%)	0	2 (22%)
Estonia	3 (17%)	2 (11%)	8 (44%)	1 (6%)	0
Hungary	0	0	0	0	0
Latvia	1 (2%)	7 (15%)	16 (35%)	1 (2%)	2 (4%)
Lithuania	2 (33%)	2 (33%)	2 (33%)	1 (17%)	1 (17%)
Poland	11 (38%)	1 (3%)	17 (59%)	14 (48%)	1 (3%)
Romania	1 (9%)	0	9 (82%)	1 (9%)	2 (18%)
Slovakia	0	0	0	0	1
Slovenia	1 (13%)	0	0	0	0
Total:	**25 (17%)**	**16 (11%)**	**58 (40%)**	**21 (14%)**	**10 (7%)**

In general, it can be noted that only about 50% of services in all countries employed any mental health specialist, however the percentage varied significantly from country to country. The highest rate was in Romania: 82%, it exceeded 60% also in Bulgaria, the Czech Republic and Poland.

Psychologist/psychotherapist was mentioned most often as the mental health care specialist employed in all countries (see Table 6.). In total, 40% of the facilities which filled in the questionnaire had such a specialist among their staff. The highest percentages of psychologists/psychotherapists were reported by facilities in Romania (82%, 9 facilities), Poland (59%, 17 facilities) and Estonia (44%, 8 facilities).

In relation to psychiatrists, only 17% of all facilities reported employing such specialists among their staff. The only exception where more than 50% of facilities reported employing a psychiatrist was the Czech Republic (56%, 5 facilities). In Poland 38% of facilities (11) had such a specialist on their staff. In other countries only a few facilities employed psychiatrists.

In several countries, just a few facilities reported employing a mental health specialist. In Hungary, Slovakia and Slovenia none of the facilities reported having a psychologist or

psychotherapist among their staff. None of the three facilities in Hungary reported any employed mental health care specialist. Slovakian and Slovenian facilities reported one specialist each (in Slovakia one out of 5 facilities reported employing a socio-therapist, in Slovenia one out of 8 facilities employ a psychiatrist).

In most countries, facilities reported having specialists from the area of general health and social welfare who worked in mental health care and support (see Table 7.). In general, more facilities employ such specialists than they do professionals with a mental health background. Overall, 47% of facilities reported employing non-psychiatric doctors, 45% non-psychiatric nurses and 39% social workers. All of these specialists were engaged in activities related to mental health care and support in their facilities. An especially high number of facilities with general health care specialists was reported in Estonia (72% of facilities have non-psychiatric doctors, 83% have nurses). The highest numbers of facilities with social workers engaged in mental health care and support were reported in Lithuania (67%) and Bulgaria (55%).

Table 7. Personnel of mental health care in facilities: other specialists

Country:	numbers and percentages of facilities employing following specialists in relation to mental health care:		
	Other doctor (non psychiatrist)	Non-psychiatric nurse	Social worker
Bulgaria	5 (45%)	2 (18%)	6 (55%)
Czech Republic	5 (56%)	4 (44%)	2 (22%)
Estonia	13 (72%)	15 (83%)	7 (39%)
Hungary*	1	0	0
Latvia	20 (43%)	31 (67%)	18 (39%)
Lithuania	2 (33%)	2 (33%)	4 (67%)
Poland	15 (52%)	11 (38%)	13(45%)
Romania	4 (36%)	0	5 (45%)
Slovakia	3	0	2 (40%)
Slovenia	0	0	0
Total:	**68 (47%)**	**65 (45%)**	**57 (39%)**

*percentages not calculated due to low numbers

Facilities in all countries also indicated that professionals from other backgrounds were engaged in providing mental health care. Among them were pedagogues, special pedagogues, educators (Bulgaria, Latvia, Poland); group facilitators (with non-specified background: Romania); HIV consultants and counsellors (with non-specified background: Estonia, Czech Republic, Latvia, Poland); outreach workers (with non-specified background: Czech Republic, Latvia); peer educators (Estonia, Latvia, Lithuania, Romania); public health specialists (Slovenia); networkers (Poland); legal experts and lawyers (Poland, Slovakia, Romania); economist (Hungary).

Services provided in 2009

In the third part of the questionnaire facilities were asked to specify services provided for people living with HIV/AIDS. The results from this part will be presented in 5 parts:

1) Services related to HIV testing and consultations and established procedures of referral;
2) Treatment related to HIV/AIDS: antiretroviral therapy, treatment after HIV exposure and somatic health care;
3) Professional mental health care for people living with HIV/AIDS;
4) Professional addiction treatment for people living with HIV/AIDS;
5) Support groups for people living with HIV/AIDS and their families and partners.

HIV testing and consultations and established procedures of referral

Table 8. presents the numbers and percentages of facilities providing services related to HIV testing and counselling and the numbers and percentages of facilities which developed established procedures of referral to mental health care. In general, in all countries participating in the study, 105 facilities (72%) reported providing HIV testing, whereas 110 (75%) said they provide HIV counselling before tests and 103 (71%) provide HIV counselling after tests (regardless of whether the result is positive or negative). Around 50% of the facilities reported having established procedures of referral to mental health care: 78 (53%) for people with HIV and 70 (48%) - for people with emotional and psychological problems.

Table 8. Numbers and percentages of facilities providing HIV testing and consultations and having established procedures of referral to mental health care

Country:	HIV tests	HIV counselling:		Established procedure of referral to mental health care:	
		before test	after test (regardless tofthe result)	for people with HIV	for people with emotional and psychological problems
Bulgaria	8 (73%)	10 (91%)	10 (91%)	7 (64%)	5 (45%)
Czech Republic	8 (89%)	8 (89%)	7 (78%)	6 (67%)	6 (67%)
Estonia	16 (89%)	16(89%)	14 (78%)	12 (67%)	10 (56%)
Hungary*	2	2	2	2	1
Latvia	31 (67%)	31(67%)	31 (67%)	35 (76%)	35 (76%)
Lithuania	6 (100%)	6 (100%)	5 (83%)	3 (50%)	3 (50%)
Poland	20 (69%)	21 (72%)	20 (69%)	n/a	n/a
Romania	6 (55%)	7 (64%)	7 (64%)	8 (73%)	5 (45%)
Slovakia	4	5	5	3	2
Slovenia	4 (50%)	4 (50%)	2 (25%)	2 (25%)	3 (38%)
Total:	**105 (72%)**	**110 (75%)**	**103 (71%)**	**78 (53%)**	**70 (48%)**

*percentages not calculated due to low numbers

The highest number of facilities providing services related to HIV testing and counselling was seen in Latvia, where 31 (67%) of the facilities reported providing HIV tests and counselling before tests and after tests, regardless of the result. In relation to established procedures of referral to mental health, the highest number and the highest percentage of such services was noted in Latvia, where 35 facilities (76%) reported having established procedures both for people with HIV and for people with emotional and psychological problems. The highest percentage of facilities which reported providing HIV testing and counselling services was noted in Lithuania, where all 6 facilities which completed the questionnaire provide HIV testing and pre-test counselling, while 5 of them also provide post-test counselling. A high percentage of services providing HIV testing and counselling was also seen among facilities which completed questionnaires in the Czech Republic and Estonia (89%: HIV testing and pre-test counselling, 78%: post-test counselling). The highest percentage of facilities providing pre and post-test counselling (regardless of the results) was reported in Bulgaria (91%, 10 out of 11 facilities).

It can be noted then in 4 countries: Czech Republic, Estonia, Lithuania and Slovenia, some HIV testing services provided counselling only for HIV positive clients, not for all tested regardless to the test result, as recommended in most guidelines.

Treatment related to HIV/AIDS: antiretroviral therapy, treatment after HIV exposure and somatic health care

Table 9. presents the numbers and percentages of facilities which reported providing treatment related to HIV/AIDS such as antiretroviral therapy, treatment after HIV exposure and somatic health care. Overall, in all countries participating in the study, 24 (16%) facilities that completed the questionnaire reported providing antiretroviral therapy, 30 (21%) treatment after HIV exposure and 38 (26%)% somatic health care services.

Table 9. numbers and percentages of facilities providing treatment related to HIV/AIDS

Country:	Treatment related to HIV/AIDS:		
	Antiretroviral therapy (ARV)	Treatment after HIV exposure (EXP)	Somatic health care
Bulgaria	2 (18%)	1 (9%)	1 (9%)
Czech Republic	4 (44%)	6 (67%)	7 (78%)
Estonia	4 (22%)	4 (22%)	7 (39%)
Hungary*	0	1	0
Latvia	3 (7%)	7 (15%)	7 (15%)
Lithuania	0	0	3 (50%)
Poland	7 (24%)	7 (24%)	10 (34%)
Romania	3 (27%)	3 (27%)	2 (18%)
Slovakia	1	1	1
Slovenia	0	0	0
Total:	**24 (16%)**	**30 (21%)**	**38 (26%)**

*percentages not calculated due to low numbers

The highest number of facilities which reported providing antiretroviral therapy was found in Poland (7, which constitutes 24% of the facilities which completed the questionnaire). The highest percentage of facilities which completed the questionnaire providing antiretroviral therapy was seen in the Czech Republic (4 facilities, 44%). In Hungary, Lithuania and Slovenia none of the facilities participating in the study reported providing antiretroviral therapy, in Slovakia, there was only one such facility.

The highest number of facilities which reported providing treatment after HIV exposure was noted in Poland (7 facilities); the highest percentage was seen in the Czech Republic (67%). In Lithuania and Slovenia there were no facilities which reported providing such services, in Bulgaria, Hungary, Lithuania and Slovakia there was one facility in each country.

Poland also has the highest number of facilities which reported providing somatic health care services (10 facilities). The highest percentage was again seen in the Czech Republic (78%). In Hungary and Slovenia no facilities reported providing somatic health care, in Bulgaria and Slovakia only one facility did so.

Professional mental health care for people living with HIV/AIDS

Table 10. presents the numbers and percentages of facilities which reported providing professional mental health care services for people living with HIV/AIDS. These include consultations and pharmacological treatment provided by a psychiatrist, consultations and counselling provided by a psychologist, and individual psychotherapy and group therapy.

In general, the highest percentage of facilities which completed questionnaires reported psychological consultations and counselling (42%) among the professional mental health care services they provide. This was followed by psychiatric consultations and pharmacological treatment (28%), individual psychotherapy (18%) and group therapy (10%).

The highest numbers of facilities which reported having psychiatric consultations and psychiatric pharmacological treatment in the scope of their services were found in Poland (13 facilities) and Latvia (11 facilities). The highest percentage of facilities providing psychiatric consultations and pharmacological treatment was noted in the Czech Republic (78%). In Hungary and Slovakia, none of the facilities which completed the questionnaire reported such services. In Slovenia there was only one such facility.

The highest number of facilities which reported providing psychological consultations and counselling were noted in Latvia (19 facilities) and Poland (17 facilities), and the highest percentage of facilities providing such services were seen in the Czech Republic (67%), Poland (59%) and Bulgaria (55%). In Hungary and Slovenia there were no facilities which reported providing such services.

Table 10. numbers and percentages of facilities providing professional mental health care services for people living with HIV/AIDS

Country:	Consultations, pharmacological treatment - psychiatrist	Consultations and counselling - psychologist	Individual psychotherapy	Group therapy
Bulgaria	2 (18%)	6 (55%)	4 (36%)	3 (27%)
Czech Republic	7 (78%)	6 (67%)	6 (67%)	2 (22%)
Estonia	4 (22%)	5 (28%)	2 (11%)	0
Hungary*	0	0	1	0
Latvia	11 (24%)	19 (41%)	1 (2%)	0
Lithuania	2 (33%)	1 (17%)	2 (33%)	2 (33%)
Poland	13 (45%)	17 (59%)	7 (24%)	4 (14%)
Romania	1 (9%)	5 (45%)	4 (36%)	3 (27%)
Slovakia	0	2	0	0
Slovenia	1 (13%)	0	0	1 (13%)
Total:	**41 (28%)**	**61 (42%)**	**27 (18%)**	**15 (10%)**

*percentages not calculated due to low numbers

Individual and group therapy were reported less often than counselling. The highest numbers of facilities which reported providing such services were seen in Poland (7 facilities), the highest percentage of such facilities in the Czech Republic (67%). Group therapy was rarely reported. The highest numbers of facilities providing group therapy were reported in Poland (4 facilities, 14%), Bulgaria and Romania (3 facilities, 27% in each of these countries). In Estonia, Hungary, Latvia and Slovakia none of the facilities reported providing such services.

Specialised addiction treatment for people living with HIV/AIDS

Table 11. presents the numbers and percentages of facilities which reported providing services related to addiction treatment for people living with HIV/AIDS. These included consultations and counselling provided by addiction therapists, individual psychotherapy, group therapy and methadone programmes.

In all countries participating in the study the most frequently reported service in this field was individual therapy (39%), followed by consultations and counselling provided by an addiction therapist (31%), methadone programmes (20%) and group therapy (19%).

The highest numbers and percentages of facilities which reported addiction therapist counselling were seen in Poland (13 facilities, 45%) and Latvia (11 facilities). None or only one facility providing such services were reported in Hungary, Slovakia and Slovenia.

The highest numbers of facilities providing individual psychotherapy for people with psychoactive substances dependence were noted in Latvia (12 facilities) and Poland (8 facilities). The highest percentage of facilities providing such services was noted in the Czech Republic (44%). In Hungary and Slovakia there were no facilities which reported providing such services.

Table 11. numbers and percentages of facilities providing addiction treatment for people living with HIV/AIDS

Country:	Consultations, counselling – addiction therapist	Individual psychotherapy - addiction	Group psychotherapy - addiction	Methadone programmes
Bulgaria	2 (18%)	4 (36%)	2 (18%)	2 (18%)
Czech Republic	3 (36%)	4 (44%)	0	0
Estonia	5 (28%)	4 (22%)	4 (22%)	3 (17%)
Hungary*	1	0	0	0
Latvia	3 (7%)	12 (26%)	3 (7%)	9 (20%)
Lithuania	2 (33%)	2 (33%)	2 (33%)	0
Poland	13 (45%)	8 (28%)	6 (21%)	5 (17%)
Romania	1 (9%)	2 (18%)	2 (18%)	1 (9%)
Slovakia	0	0	0	0
Slovenia	1 (13%)	3 (38%)	0	0
Total:	**31 (21%)**	**39 (27%)**	**19 (13%)**	**20 (14%)**

*percentages not calculated due to low numbers

The highest number of facilities providing individual psychotherapy for people with psychoactive substances dependence was found in Poland (6 facilities). In remaining countries the percentage of facilities providing such services was high. In the Czech Republic, Hungary, Slovakia and Slovenia there were no facilities which reported providing such services.

The highest numbers of facilities providing methadone programmes with some special arrangements or specially designed for people living with HIV/AIDS were reported in Latvia (9 facilities) and Poland (5 facilities). In the Czech Republic, Hungary, Lithuania, Slovakia and Slovenia there were no facilities which reported providing such services

Support groups for people living with HIV/AIDS and their families and partners

Table 12. presents the numbers and percentages of facilities which reported providing different types of support groups for people living with HIV/AIDS, their families and their partners, as well as for people with mental disorders or people dependant on psychoactive substances.

Tab 12. numbers and percentages of facilities providing support groups for people living with HIV/AIDS and their families and partners

Country:	Support groups			
	for different groups of PLHA	for families / partners of PLHA	for people dependant on psychoactive substances	for people with mental disorders
Bulgaria	2 (18%)	2 (18%)	4 (36%)	1
Czech Republic*	1	0	0	0
Estonia	5 (28%)	4 (22%)	3 (17%)	0
Hungary*	2	2	1	0
Latvia	7 (15%)	9 (20%)	9 (20%)	0
Lithuania*	1	2	1	1
Poland	10 (34%)	9 (31%)	9 (31%)	2
Romania	7 (64%)	4 (36%)	0	0
Slovakia*	2	0	0	0
Slovenia*	0	0	1	1
Total:	**36 (25%)**	**32 (22%)**	**28 (19%)**	**5 (3%)**

*percentages not calculated due to low numbers

Overall, about 20-25% of facilities in all countries reported running three types of support groups within their services: for different groups of people living with HIV/AIDS, for their families and partners, and for people dependant on psychoactive substances. Support groups for people with mental disorders were provided by few facilities, only 5 in all countries (3%). Most frequently, facilities reported groups for people living with HIV/AIDS (25%), followed by groups for their families and partners (22%). Support groups for people dependant on psychoactive substances were reported by 19% of the facilities.

The highest number of facilities running all types of support groups was found in Poland: 10 facilities providing such services for different groups of people living with HIV/AIDS, 9

facilities providing support groups for their families and partners, as well as 9 facilities working with people dependant on psychoactive substances and 2 facilities working with people with mental disorders. Another country with high numbers of facilities providing support groups was Latvia: 7 facilities with groups for people living with HIV/AIDS, 9 facilities working with families and partners of people living with HIV/AIDS, and with people dependant on psychoactive substances. The highest percentage of facilities providing such services was seen in Romania: 64% of the facilities provided support groups for people living with HIV/AIDS and 36% for their families and partners.

Support groups for people with mental disorders were provided by few facilities and only in 4 countries: Bulgaria, Lithuania, Poland and Slovenia.

Facilities in several countries also reported running different types of support groups such as support groups for MSM (Estonia), support groups for LGBT-s (Lesbians, Gays, Bisexuals, Transgenders, Latvia) and for IDU-s (Injecting Drug Users, Latvia), support groups for sex workers (Slovakia).

In all countries, facilities also specified different types of services related to mental health care and support provided within their activity. Among them there were services such as:

- psychological support in crisis interventions (Slovakia);
- HIV counselling help-line (Czech Republic, Romania, Latvia, Poland),
- internet counselling (Czech Republic, Poland);
- counselling for PLHA partners and relatives (Czech Republic);
- consultations for co-dependent persons (Latvia);
- psychological counselling provided by non-professionals (Slovakia);
- peer-to-peer consultations (Estonia, Latvia, Slovenia);
- mentoring and coaching for newly diagnosed with HIV, HCV (Hepatitis C virus) or HBV (Hepatitis B virus) (Romania);
- various forms of art therapy such as painting, theatre (Romania).

The facilities reported also services related to social assistance:

- social assistance (all countries except Hungary and Slovenia);
- personal assistance for people living with HIV/AIDS (Czech Republic);
- legal advocacy (all countries except Slovenia);
- legal advocacy for foreigners (Poland);
- vocational and occupational programmes (Latvia, Poland, Romania);
- accommodation for homeless people living with HIV/AIDS (Czech Republic, Latvia).

In several countries facilities also specified services related to prevention (Hungary, Latvia, Poland, Romania), including educational and informative programmes for different groups such as school children and young people (Romania), prison inmates (Latvia) and injecting drug users (Latvia).

Harm reduction programmes and measures were also mentioned by facilities in several countries (Czech Republic, Latvia, Lithuania, Poland), including among others syringe and needle exchange (Latvia, Poland) and outreach programmes (Czech Republic, Lithuania).

Number of patients and clients in 2009

The next part of the questionnaire was related to the number of patients and clients that used facilities' services within the period of one year. Table 13. presents the results from facilities which completed the questionnaires and provided information on client numbers. In total, 32% of the facilities did not provide information on the number of patients and clients, in some countries more than 50% of them did not provide such information.

Table 13. Number of patients and clients in facilities in 2009

Country:	Patients and clients			
	HIV negative	HIV positive	HIV status unknown	Total
Bulgaria	310	427 (58%)	0	737
Czech Republic	7 914	1 440 (7%)	12 529	21 781
Estonia	9 171	657 (6%)	1 206	10 866
Hungary	-	26	-	-
Latvia	1 973	2 403 (25%)	5 159	9 535

Lithuania	620	82 (11%)	52	754
Poland	16 892	3 550 (16%)	2 016	22 154
Romania	50	1 416 (93%)	50	1 516
Slovakia	1 270	240 (6%)	2 374	3 881
Slovenia	11 508	42 (< 1%)	1	11 715
Total:	**49 708**	**10 283 (12%)**	**23 387**	**82 939**

The highest numbers of patients and clients with a HIV positive status were reported by facilities in Poland and Latvia. The highest percentages of patients and clients with a HIV positive status were noted in Romania, where facilities reported that more than 90% of their patients and clients were people living with HIV/AIDS, and in Bulgaria, where the figure was 58%. Higher percentage of HIV positive patients can indicate more specialised services which are targeted for this group. However, because of many missing data on the number of patients and clients, it is difficult to draw conclusions on the functioning of facilities in this area.

Financing of services in 2009

Part five of the questionnaire was related to financing of services. Table 14. presents sources of financing for health care and mental health care services in the facilities which participated in the study. Respondents were asked to include all their sources of financing, from a list of the following categories: the National Health Fund, national and regional budgets, local community or municipality budgets, non-national sources (e.g. UE grants and other funds), donations and fundraising, facilities' own economic activity, insurance companies. Table 14. shows the numbers and percentages of facilities which marked these sources to be one, or the only source of financing for them.

Overall, the most frequently reported source of financing of health care and mental health care was national health funds. 46% of the facilities reported receiving funds from this source. The highest percentages of facilities which mentioned the national health fund were noted in Latvia (74%) and Slovenia (63%). In relation to national and regional budgets as well as local, municipal and community budgets, 35-36% of all facilities reported receiving funds from these sources. The highest percentages were seen in Estonia (83% national and regional, 56% local), Lithuania (50% national and regional, 50% local) and Poland (59% national and regional, 45% local).

The situation regarding non-national sources, such as for example EU grants, is interesting. A similar percentage reported benefiting from such sources as from two other categories: national/regional budgets and local budgets (36%). However, it is important to note that half of the facilities which reported such funding were from Latvia, the country with the most facilities in the study and also with a high percentage (59%) of facilities reporting non-national financing. Other countries with a high percentage of facilities reporting such financing were Lithuania (67%) and Romania (45%). In other countries, it seems that facilities did not use such funds very often.

Donations and fundraising was a category mentioned by 26% of all facilities. The highest percentages of facilities mentioning this category were seen in Romania (45%) and Slovenia (38%). Facilities' own economic activity and financing from insurance companies were two categories with the lowest percentages (respectively 10 and 8%). However, insurance companies were specified as a source of financing by 78% of facilities in the Czech Republic and by 2 out of 5 facilities in Slovakia. It has to be noted that it is related to these countries health care system.

Table 14. numbers and percentages of facilities reporting different sources of financing

Country:	Source of financing of health care and mental health care						
	National Health Fund	National/ Regional	Local (community/ municipality)	Non-national (e.g. UE grants)	Donations/ Fundraising	Own economic activity	Insurance companies
Bulgaria	1 (9%)	6 (55%)	1 (9%)	2 (18%)	1 (9%)	0	0
Czech Republic	3 (33%)	1 (11%)	2 (22%)	3 (33%)	2 (22%)	2 (22%)	7 (78%)
Estonia	6 (33%)	15 (83%)	10 (56%)	6 (33%)	2 (11%)	5 (28%)	0
Hungary*	0	2	2	0	2	0	0
Latvia	34 (74%)	0	17 (37%)	27 (59%)	10 (22%)	1 (2%)	0
Lithuania	1 (17%)	3 (50%)	3 (50%)	4 (67%)	2 (33%)	0	0
Poland	12 (41%)	17 (59%)	13 (45%)	2 (7%)	10 (34%)	0	1
Romania	2 (18%)	1 (9%)	1 (9%)	5 (45%)	5 (45%)	1 (9%)	0
Slovakia*	3	3	1	1	1	3	2
Slovenia	5 (63%)	3 (38%)	3 (38%)	2 (20%)	3 (38%)	3 (38%)	1
Total:	67 (46%)	51 (35%)	53 (36%)	52 (36%)	38 (26%)	15 (10%)	11 (8%)

*percentages not calculated due to low numbers

Facilities from a few countries also specified additional sources of financing, including governmental agencies, international funds and organisations, private sponsor donations and organisation membership fees.

The data presented in Table 14. show that services for people living with HIV/AIDS are funded from variety of sources. In fact, in all countries numerous funding agencies support health care of that target group. Table 15. presents the average percentages of financing by source per country.

A diversity can be noted in the percentage shares of financing sources. It seems that in Bulgarian and Estonian facilities the main sources of financing were national, regional and local budgets. In the Czech Republic an important source of financing was the insurance companies (on average, it constituted more than half of the budgets of facilities which completed the questionnaire).

It is interesting to note that non-national sources were the most important source of financing in Romania (43% of facilities' budgets) and Lithuania (32%). Such financing was also very important in Latvia (36% of facilities' budgets), where only a slightly higher percentage of funding came from the National Health Fund (38%).

Table 15. Average percentages per financing source in the facilities' budgets, per country

Country:	National Health Fund	National/ Regional	Local (community/ municipality)	Non-national (e.g. UE grants)	Donations/ Fundraising	Own economic activity	Insurance companies
Bulgaria	3%	60%	9%	8%	0	0	0
Czech Republic	12%	4%	6%	4%	0	1%	53%
Estonia	19%	61%	5%	4%	6%	0	0
Hungary	0	42%	10%	0	0	8%	0
Latvia	38%	0	20%	36%	1%	6%	1%
Lithuania	2%	20%	21%	32%	1%	1%	0
Poland	31%	21%	19%	1%	1%	5%	1%
Romania	18%	1%	9%	43%	0	11%	0
Slovakia	41%	22%	3%	3%	1%	4%	26%
Slovenia	37%	9%	9%	8%	17%	6%	0

In the facilities in Poland, Slovakia and Slovenia, the most important source of financing was the National Health Fund. In Poland, an important share of the facilities' budgets also came from national, regional and local sources, and in Slovakia from national and regional sources and insurance companies.

Co-operation with other facilities, organisations and institutions

In part six of the questionnaire facilities reported on their co-operation with other services, organisations and institutions in relation to care for patients and clients with HIV/AIDS. The facilities specified all their co-operation contacts and the scope of their collaboration, as well as its frequency and communication methods used. Table 16. shows how many facilities co-operated with other services, institutions and organisations, and how many contacts they had. Table 17. presents the frequency of contact with their co-operation partners. The next aspect of co-operation was methods of communication with their partners. Table 18. presents the most frequent methods of contact with their co-operation partners reported by facilities which completed the questionnaire.

Overall, it can be noted that 16% of the facilities participating in the study did not report any co-operation with other services, institutions or organisation in relation to care of patients and clients with HIV/AIDS (see Table16.). There is an especially high percentage of facilities which did not report any such professional contacts in Lithuania (67%) and Bulgaria (45%). A high number of facilities with no contacts was also seen in Poland, 8 facilities (28%). On the other hand, all facilities in the Czech Republic, Estonia, Romania and Slovakia specified at least one co-operation partner.

Only 13% of the facilities reported co-operating with 5 or more organisations or institutions. The highest percentages here were noted in Poland (21% facilities with 5 or more contacts) and Romania (18%). It was also in these two countries that facilities with 3 or more co-operation partners constituted more than 50% of the total (55% in Poland and 54% in Romania). All facilities in the Czech Republic and almost all in Estonia reported having between 1 and 4 co-operation contacts.

Table 16. numbers and percentages of facilities co-operating with other organisations or institutions in relation to care of patients and clients with HIV/AIDS

Country:	Number of co-operating partners:			
	None	1 or 2	3 or 4	5 or more
Bulgaria	5 (45%)	4 (36%)	1 (9%)	1 (9%)
Czech Republic	0	5 (56%)	4 (44%)	0
Estonia	0	12 (67%)	5(28%)	1 (6%)
Hungary*	2	0	1	0
Latvia	4 (9%)	22(48%)	13 (28%)	7 (15%)

Lithuania	4 (67%)	2 (33%)	0	0
Poland	8 (28%)	5 (17%)	10 (34%)	6 (21%)
Romania	0	5 (45%)	4 (36%)	2 (18%)
Slovakia*	0	3	1	1
Slovenia	1 (13%)	4 (50%)	2 (25%)	1 (13%)
Total:	**24 (16%)**	**62 (42%)**	**41 (28%)**	**19 (13%)**

*percentages not calculated due to low numbers

The results presented in Table 17. are related only to facilities which reported co-operating with other organisations and institutions, and shows how often they contact each other. In general, almost 40% of all facilities contacted their partners less than once a month. Facilities which reported having contacts 3 times a month or more, constituted 32%.

The most frequent contacts with co-operating partners (more than twice a month) were reported by facilities in Estonia (59%), Bulgaria (53%) and Poland (51%). The least frequent contacts (less than one a month) were reported by facilities in Latvia (70%) and Slovakia (55%). In facilities in Bulgaria, Estonia, Poland and Romania, 75% of contacts with their co-operation partners was at least on the level of once a month.

Table 17. Percentage of frequency of facilities' contacts with their collaboration partners in relation to care of patients and clients with HIV/AIDS

Country:	Frequency of contact			Total number of facilities which collaborated with other institutions
	Less than once a month	Once or twice a month	Three times a month of more	
Bulgaria	24%	24%	53%	6
Czech Republic	45%	15%	40%	8
Estonia	7%	34%	59%	18
Hungary	0%	33%	67%	1
Latvia	70%	27%	4%	42
Lithuania	50%	0	50%	2
Poland	18%	31%	51%	21
Romania	23%	30%	47%	11
Slovakia	55%	9%	36%	4
Slovenia	44%	50%	6%	7
Total:	**39%**	**28%**	**32%**	**120**

The results presented in Table 18. are related to the methods of contact between facilities and their co-operation partners. In the questionnaire, facilities were asked to specify how they contact their co-operation partners. The three suggested forms of contacts were: e-mail, phone and personal contact. Facilities could also specify different methods. Table 18. shows which method of contact was most frequently reported.

It can be noted that the form of contact reported most often was personal contact. In fact, it was most frequently reported by facilities from all countries. However, in 4 countries (Hungary, Latvia, Lithuania and Romania) it was equalled by e-mail contact. The facilities from six countries (Bulgaria, Czech Republic, Estonia, Poland and Slovakia) reported methods of contacts with their co-operation partners in the same order; most frequent: personal contacts, second: phone, and third: e-mail. In Hungary, Latvia, Lithuania and Romania e-mail and personal contacts came equal in first place and phone in second. Facilities from Slovenia reported personal contacts most frequently, e-mail in second place and phone in third place.

Table 18. Most frequent methods of contact with their co-operation partners in relation to care for patients and clients with HIV/AIDS

Country:	Most frequent method of contact: e-mail, phone, personal contact		
	1st choice	2nd choice	3rd choice
Bulgaria	personal contact	phone	e-mail
Czech Republic	personal contact	phone	e-mail
Estonia	personal contact	phone	e-mail
Hungary	e-mail; personal contact	phone	
Latvia	e-mail; personal contact	phone	
Lithuania	e-mail; personal contact	phone	
Poland	personal contact	phone	e-mail
Romania	e-mail; personal contact	phone	
Slovakia	personal contact	phone	e-mail

Slovenia	personal contact	e-mail	phone
Total:	personal contact	phone	e-mail

Among other methods of contacts mentioned by facilities there were: meetings during seminars, conferences, education and other professional public events, traditional postal correspondence and official letters and reports.

Conclusions and limitations

It has to be noted that one of the limitations of the study was the modest response rate, which on average did not reach 50%, and in a few countries was lower than 30%. However, there were two countries: Latvia and Estonia, where the response rate was especially high and reached over 90%.

Another limitation of the study was the large variation in the number of identified facilities for the research. This could be the result of differences in countries' health care and social care systems and countries' needs, but it could also be the result of misunderstanding on the part of the project partners coordinating the research in each country regarding the procedures for selecting facilities for the study.

Moreover, response rates indicate what proportion of services approached, eventually took part in the survey. We still do not know what was a coverage rate, in other words what proportion of relevant services were actually approached. Therefore inter-country comparison and conclusions should be cautiously treated.

In relation to accessibility of the facilities it was noted that in most countries the highest numbers and the greatest diversity of facilities was found in the capital cities. In general, facilities were located in larger towns and cities. Such a situation can mean less access to services for people living with HIV/AIDS outside large cities and national capitals.

The facilities from most countries reported that their operating days and hours were very close to the traditional working week days and usual working hours. Although the majority of facilities which completed the questionnaire reported usually being open many hours a week, flexibility of opening hours seemed to be a problem in many facilities. Unfortunately, this means that people living with HIV/AIDS who are fully employed, may have limited access to

health care, mental health care and support. However, it can be noted that in several countries there are facilities which also provide their services outside working hours, i.e. in the evening and during weekends. The highest percentage of such facilities was observed in Poland. It can be concluded that for some of them, flexibility of opening hours was possibly a priority, since the highest percentage of facilities that reported working less than 15 hours a week was also found in Poland. It seems that some kind of balance between length and flexibility should be established to provide better access for clients and patients.

It can be concluded that in many countries mental health care is not sufficiently included in the health and social care for people with HIV/AIDS. In most countries employment of mental health care specialists in facilities was relatively low. The exception was Romania, where 82% of facilities which completed the questionnaire had a psychologist or psychotherapist among their staff members. However, the percentage of psychiatrists was low or very low in all countries, in general not even reaching 20%. Only in the Czech Republic did this figure exceed 50%. There is a similar situation regarding addiction specialists. Facilities which completed the questionnaire rather rarely reported employing such a specialist, with the exception of Poland where the percentage of facilities employing an addiction specialist was almost 50%.

Most facilities reported that in the area of mental health, some help and support was usually provided by non-mental health specialists, such as non-psychiatric doctors and nurses and social workers. This is positive because it means that the mental health of people living with HIV/AIDS is taken into account in health care and social care, but at the same time a lack of mental health specialists on the facilities' staff teams is quite obvious. Such a situation can lead to people living with HIV/AIDS receiving less professional care and support for their emotional and psychological problems.

It was noted that only about 50% of the facilities had established procedures of referral to mental health care for people with HIV and for people with emotional and psychological problems. In relation to patients with HIV/AIDS, such procedures are highly important, as usually they facilitate admission to treatment and support. Such procedures are especially important in services providing HIV testing and counselling, and should be put in place not only for people with HIV positive results, but also for people who showed symptoms of

mental health problems during consultations. The highest percentage of services with established procedures of referral to mental health care was observed in Latvia (76%).

In relation to professional mental health care for people living with HIV/AIDS, it can be noted that in general, the percentage of facilities providing such services is not very high, although 42% of all facilities participating in the study reported providing psychological counselling. The Czech Republic is an exception, since 78% of the facilities there reported having psychiatric consultations and treatment in their range of services, and 67% have psychological counselling and individual psychotherapy. Quite a high percentage of different services could be also observed in Poland, where almost 60% of facilities provided psychological counselling and 45% provided psychiatric consultations and treatment, as well as addiction therapist counselling. In five countries (Bulgaria, Czech Republic, Latvia Poland and Romania) there were some special arrangements or specially designed methadone programmes for people living with HIV/AIDS.

The most rarely reported mental health service was group therapy, both in relation to general mental health and to dependency on psychoactive substances. This is especially surprising given the fact that forms of group therapy are usually much cheaper than individual psychotherapy, and facilities in most countries participating in the study often experience financial problems.

Support groups are very important forms of mental health aid for people living with HIV/AIDS and also for their families and partners. It was noted that different kinds of groups were organised by facilities in all countries participating in the study. Facilities mentioned different target groups, such as sex workers, MSM, LGBT-s IDU-s. However, overall only about 20% of the facilities reported providing such services. Additionally, an especially low percentage of support groups was noted for people with mental disorders. Again, it can be concluded that mental health aspects are often underestimated or even neglected in care and support for people living with HIV/AIDS. It is also possible that in many societies mental health problems remain a taboo subject, which is even harder to talk about than addiction or sexual identity, and is therefore only designated to specialised services.

In relation to budgets and financing of services related to mental health care, a diversity between countries can be noted. It can be concluded that this is a result of differences in countries' financing systems and solutions. It can be observed that in three countries (Latvia,

Romania and Lithuania), a significant share of the facilities' budgets is made up of non-national sources such as EU grants and other funds. It can therefore be concluded that in some of these countries financing of mental health care for people living with HIV/AIDS from national (central, regional or local) budgets, might be insufficient. A positive side of this situation is that many facilities have the necessary skills and knowledge to apply for and use such funding. This is an expertise which they could share with other facilities working in the same field in neighbouring countries, which do not seem to use such funds very often.

Co-operation between facilities significantly increases the effectiveness of their services. Maintaining close and frequent contacts with other facilities operating in the same or related fields allows the facilities to provide continued and more complex care for patients and clients, and to exchange experience and knowledge. The practices of facilities which participated in the study differed significantly in terms of co-operation with other services, institutions and organisations. However, 16% of them did not report any co-operation with other facilities. Most of them (42%) co-operated with only one or two institutions or organisations. There were countries where facilities reported co-operation more frequently, but it can be concluded that in all countries it is important to increase co-operation between facilities in relation to care for people living with HIV/AIDS. The same is true regarding the frequency of their co-operation.

It was interesting to note that facilities in most countries reported personal contact as the most frequent form of contact, as usually there is a feeling that e-mails and phone contacts have started to replace traditional face-to-face contacts. It is very important that people still prefer and maintain personal contacts, as this can often make their work more interesting and efficient. Of course, it is obvious that in many situations e-mails and phone calls are much easier and relevant – especially in relation to international co-operations. This could be one of the reasons why facilities from Latvia, Lithuania and Romania, which reported using non-national funds and maintaining contacts with international organisations, reported e-mail contacts more frequently than facilities from other countries.

Recommendations

On the basis of the conclusions derived form the research study, some recommendations to increase the effectiveness of functioning of facilities providing care for people living with HIV/AIDS can be formulated. It has to be remembered that the situation concerning

HIV/AIDS epidemics is very different from one country to another. Therefore, any effort must be tailored to the special needs of the countries and communities. A summary of recommendations based on the conclusions of the study is presented below.

1. Regional spread: in several countries participating in the study increasing the regional spread of facilities for people living with HIV/AIDS is an important issue.

2. Working hours: to increase flexibility of opening hours to make facilities accessible for people living with HIV/AIDS outside usual working hours, including weekends.

3. Specialists of mental health care: increasing employment of mental health specialists in facilities providing care for people living with HIV/AIDS, especially psychiatrists, and depending on countries' needs also a group of professionals specialised in addiction treatment.

4. Referral to mental health care: developing guidelines for facilities in the area of established procedures of referral to mental health care for people living with HIV/AIDS and for people with mental disorders.

5. Specialised mental health services: increasing the scope of mental health care services in facilities and developing forms of group therapy.

6. Support groups: development of support groups for people living with HIV/AIDS and their families/partners and for other target groups. It is necessary to pay special attention to support groups for people with mental disorders.

7. Financing: facilities specialising in care for people living with HIV/AIDS should be provided with stable funding, including funding for somatic, mental and social care and support. Special training in applying for grants and other funding, from national, EU and other sources, should be provided.

8. Networking: increasing co-operation between facilities working in the area of care for people living with HIV/AIDS and in the related fields. Supporting projects and programmes provided by more than one facility. Developing system solutions which enhance co-operation instead of competition between facilities working in the area of care for people living with HIV/AIDS and related fields.

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