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

MENTAL HEALTH CARE OF PEOPLE LIVING WITH HIV/AIDS – RESEARCH PROJECT – PHASE II

Introduction:

The report presents the results of Phase 2 of a study conducted under the project Mental Health Care of People Living with HIV/AIDS (MAIDS). The study was carried out in 10 countries of the EU from Central and Eastern Europe, including: 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 of people living with HIV/AIDS and a preliminary assessment of the system of mental health care for people living with HIV/AIDS in countries participating in the project. In the second phase research study of the MAIDS project, a further description of mental health care for people living with HIV/AIDS was investigated, 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 was the identification of services from the area of mental health care accessible in facilities providing care for people living with HIV/AIDS and a description of different aspects of functioning of individual facilities in countries participating in the project. It included structural and organisational issues of provided services such as accessibility and scope of services with a special stress on mental health components in care and employment of metal health professionals. Structural and organisational issues included also 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 can give a brief overview on the development of mental health care for people living with HIV/AIDS in different countries from the region of Central and Eastern Europe participating in the project.

Methods and Procedures:

The phase 2 research of the MAIDS project was based on a questionnaire study. Within a frame of description of 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 filled-in individually by all facilities: institutions and organisations and others, providing health care for people living with HIV/AIDS in countries participating in the study.

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

- 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 partners' centres in English and translated into partners languages. In the next step partners were asked to contact individually all identified facilities 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 as 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 the response rate varied from country to country. In total, 340 facilities were identified and 146 questionnaires were collected (see Tab. 1.). The overall response rate was 43%. The highest response rate and most questionnaires were collected in Latvia: 46 questionnaires collected out of 47 identified facilities (98% response rate). Another country with a very high response rate was Estonia (95%), with 18 questionnaires collected out of 19 identified facilities. The lowest response rate was in Romania: 11 questionnaires collected out of 74 identified facilities. A low response rate - on a level of 19-20%, and low number of questionnaires collected, was noted in Slovakia (5 questionnaires out of 26 facilities) and Lithuania (6 questionnaires out of 30 facilities). The lowest number of questionnaires collected was in Hungary. Only 3 questionnaires were collected there. The total number of identified facilities was also very low in Hungary – only 6 facilities were identified, so the response rate reached 50% there.

Tab. 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 Tab. 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 there by phone interview and 7 (15%) by face-to-face interview. In other countries, questionnaires collected by phone or face-to-face interview were usually infrequent cases.

Tab. 2. Method of collecting questionnaires in countries participating in the project

	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

Partners from countries participating in the project 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 refusals or simply did not respond to any attempts of contacts. Most partners reported also that in the majority of cases facilities promised to fill in the questionnaire or find some time to give a phone interview but in the end never did, regardless 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 underlying often 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 in countries participating in the project. 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 – 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 one facility could be included in more then one category and this is why a total number of facilities in one location does not always equal the sum of facilities from different category types provided in a given location.

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.

Tab. 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*)

Tab. 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 make it possible to use services outside usual working hours. Such arrangements facilitate patients and clients in using provided services without interfering with their professional tasks and other everyday activities. This aspect is especially important for people living with HIV/AIDS.

Table 4. presents facilities' reported working days and hours. It shows how many days and hours a week facilities are open in countries participating in the study. Table 5. is related to the accessibility of facilities outside usual working days and hours: on weekends (on Saturdays or Sundays) and afternoons (after 18:00).

Tab. 4. Operating hours: working 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 then 5	5 days a week	more then 5	less then 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 then 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. In Estonia, 67% of facilities did not provide information

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

The most working hours a week was reported by facilities from Romania (see Table 4.). 45% of them reported to be open more then 45 hours a week and rest of them, being open no less then 31 hours. In Bulgaria, 82% of facilities reported to be open between 31 and 45 hours a week. The highest number of facilities which reported to be open less then 15 hours a week was in Slovakia (60%) and in Poland (34%).

Tab. 5. Accessibility outside usual working days and hours: facilities open on weekends and afternoons

Country	no data	Is facility open:	
		on weekend? (Saturday or Sunday)	in afternoon ? (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 working time flexibility, it can be noted that accessibility outside the usual working hours is not very high in any country (see Table 5.). In total, in 20% facilities which completed the questionnaire reported to be open during any day of the weekend, and 29% - in afternoons. The highest percentage of facilities open outside the usual working hours were in Poland: 31% of facilities reported to be open on weekends and 66% - to be open after 18:00. In Romania there was quite a high percentage of facilities open in afternoons - 36% of facilities reported to be open after 18:00. In other countries, there were quite low number of facilities reporting operating outside usual working hours. Facilities from Latvia did not specify in questionnaires their opening hours in the afternoons.

Personnel of mental health care

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 background of their personnel working in the area of mental health care. Table 6. presents number and percentage of facilities employing mental health specialists among their staff. Table 7. presents number and percentage of facilities employing other specialists (from the area of general health care and social assistance) who work with issues related to mental health care.

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

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

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

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

Country:	Number and percentage 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%)**

In several countries, just a few facilities which participated in the study reported employing any mental health specialist. In Hungary, Slovakia and Slovenia – no facility reported any psychologist or psychotherapist among their staff members. None out of the three facilities from Hungary reported any employed mental health care specialist. Slovakian and Slovenian

facilities reported one specialist each (Slovakia – one out of 5 facilities reported employing a socio-therapist; Slovenia – one out of 8 facilities was employing a psychiatrist).

In most countries, facilities reported to have specialists from the area of general health and social welfare who were engaged in working in the mental health care and support area (see Table 7.). In general, there were more facilities employing such specialists then professionals with mental health background. Overall, 47% of facilities reported employing non-psychiatric doctors, 45% - non-psychiatric nurses and 39% - employing 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 were reported in Estonia (72% of facilities – non-psychiatric doctors, 83% - nurses). The highest number of facilities with social workers engaged in mental health care and support were reported in Lithuania (67%) and Bulgaria (55%).

Facilities in all countries specified also professionals from other backgrounds who 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 referrals

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 referrals

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

Tab 8. Number and percentage of facilities providing HIV testing and consultations and having established procedures of referrals to mental health care

Country:	HIV tests	HIV counselling:		Established procedure of referrals to mental health care:	
		before test	after test (regardless to the 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%)**

The highest number of facilities providing services related to HIV testing and counselling were in Latvia – there were 31 (67%) of facilities which reported providing HIV tests, counselling before tests and after tests, regardless of the result. In relation to facilities having established procedures of referrals to mental health, the highest number and the highest percentage of such services were located 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 were in Lithuania, where all 6 facilities which completed the questionnaire provided HIV testing and before tests counselling, 5 of them also after tests counselling. A high percentage of services providing HIV testing and counselling were also among facilities which completed questionnaires in the Czech Republic and Estonia (89% - HIV testing and before tests counselling; 78% - after tests counselling). The highest percentage of facilities providing before and after tests counselling (regardless of the results) were reported in Bulgaria (91%, 10 out of 11 facilities).

It can be noted then in 4 countries: Czech Republic, Estonia, Lithuania and Slovenia, some single facilities providing HIV testing did not provided HIV counselling after tests, regardless of the result.

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

Table 9. presents the number and percentage 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%) of facilities which completed the questionnaire reported providing antiretroviral therapy, 30 (21%) treatment after HIV exposure and 38 (26%)% somatic health care services.

Tab 9. Number and percentage 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%)**

The highest number of facilities which reported providing antiretroviral therapy were in Poland (7, which constitutes 24% of facilities which completed the questionnaire in Poland). The highest percentage of facilities which completed the questionnaire providing antiretroviral therapy were 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 a facility.

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

In Poland, there was also the highest number of facilities which reported providing somatic health care services (10 facilities). The highest percentage of such facilities were again in the Czech Republic (78%). In Hungary and Slovenia –no facilities reported providing somatic health care, in Bulgaria and Slovakia – only one facility in each of these countries.

Professional mental health care for people living with HIV/AIDS

Table 10. presents the number and percentage of facilities which reported providing professional mental health care services for people living with HIV/AIDS such as: consultations and pharmacological treatment provided by a psychiatrist; consultations and counselling provided by a psychologist; individual psychotherapy and group therapy.

In general, the highest percentage of facilities which completed questionnaires in all countries participating in the study, reported psychologist consultations and counselling (42%) among provided professional mental health care services. It was followed by psychiatrist consultations and pharmacological treatment (28%), individual psychotherapy (18%) and group therapy (10%).

The highest number of facilities which reported having in the scope of their services psychiatrist consultations and psychiatrist pharmacological treatment were in Poland (13 facilities) and Latvia (11 facilities). The highest percentage of facilities providing psychiatrist consultations and pharmacological treatment were 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 a facility.

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

Tab 10. Number and percentage 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%)**

Individual and group therapy were reported less often then counselling. The highest number of facilities which reported providing such services were in Poland (7 facilities), the highest percentage of such facilities - in the Czech Republic (67%). Group therapy were rarely reported by facilities which completed the questionnaires in all countries. The highest number of facilities providing group therapy were reported in Poland (4 facilities, 14%), in Bulgaria and Rumania (3 facilities, 27% in each of these countries). In Estonia, Hungary, Latvia and Slovakia, none of the facilities which completed the questionnaire reported providing such services.

Specialised addiction treatment for people living with HIV/AIDS

Table 11. presents the number and percentage of facilities which reported providing services related to addiction treatment for people living with HIV/AIDS such as: consultations and

counselling provided by addiction therapist, individual psychotherapy, group therapy and methadone programmes.

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

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

The highest number of facilities providing individual psychotherapy in relation to psychoactive substances dependence were in Latvia (12 facilities) and Poland (8 facilities); the highest percentage of facilities providing such services were in the Czech Republic (44%). In Hungary and Slovakia – there were no facilities which reported providing such services.

Tab 11. Number and percentage 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%)**

The highest number of facilities providing individual psychotherapy in relation to psychoactive substances dependence were in Poland (6 facilities). In any country the percentage of facilities providing such services were high. In the Czech Republic, Hungary, Slovakia and Slovenia - there were no facilities which reported providing such services.

The highest number 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 number and percentage of facilities which reported providing different type of support groups for people living with HIV/AIDS and their families and partners and for people with mental disorders or dependant on psychoactive substances.

Tab 12. Number and percentage 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 to 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%)**

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 only by single facilities - only 5 facilities 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 facilities.

The highest number of facilities running all types of support groups were in Poland: 10 facilities providing such groups for different groups of people living with HIV/AIDS, 9 facilities providing support groups for their families and partners, also 9 facilities – for people dependant on psychoactive substances and 2 facilities – for people with mental disorders. Another country with the highest number of facilities providing support groups was Latvia: 7 facilities – for people living with HIV/AIDS, 9 facilities – for families and partners of people living with HIV/AIDS and for people dependant on psychoactive substances. The highest percentage of facilities providing such services were in Romania: 64% of facilities provided support groups for people living with HIV/AIDS, 36% - for their families and partners.

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

The facilities in several countries participating in the study reported also running different types of support groups, such as: support groups for MSM (Estonia), support groups for LGBT-s and for IDU-s (Latvia), support groups for sex workers (Slovakia).

In all countries, facilities specified also different types of services related to mental health care and support provided within their activity. Among them were such services 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-dependant persons (Latvia); psychological counselling provided by non-professionals (Slovakia); peer-to-peer consultations (Estonia, Latvia, Slovenia), mentoring and coaching for newly diagnosed HIV/HCV/HBV (Romania); various forms of art therapy (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 specified also services related to prevention (Hungary, Latvia, Poland, Romania), including educational and informative programmes for different groups, such as school children and youths (Romania), prison inmates (Latvia), intravenous drug users (Latvia).

Also harm reduction programmes and measures were 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 who used facilities' services within the period of one year. Table 13. presents results from the facilities which completed the questionnaires and provided information on number of clients. In total – 32% of facilities did not provide information on the number of patients and clients, in some countries – more then 50% of them did not provide such information.

Tab 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 number of patients and clients with HIV positive status was reported by facilities in Poland and Latvia. The highest percentage of patients and clients with HIV positive status

was noted in Romania, where facilities reported that more then 90% of there patients and clients were people living with HIV/AIDS; and in Bulgaria – 58%. The 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 conclude on facilities functioning in this area.

Financing of services in 2009

Part five of the questionnaire was related to financing of services in the facilities from countries participated in the study. Table 14. presents sources of financing of services related to health care and mental health care in the facilities which participated in the study. Facilities were asked to mark all sources of their financing, from the list of 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 number and percentage of facilities which marked these specified subjects to be a part, or the only source, of their financing.

Overall, the most frequently reported source of financing of health care and mental health care was countries' national health funds: 46% of facilities participating in the study reported to receive funds from this source. The highest percentage of facilities which mentioned the national health fund was in Latvia (74%) and Slovenia (63%). In relation to national and regional budgets and also local - municipal and community budgets – 35-36% of all facilities participating in the study reported receiving funds from these sources. The highest percentage – in Estonia (83% - national and regional, 56% - local), Lithuania (50% - national and regional, 50% - local) and Poland (59% - national and regional, 45% - local).

It is an interesting situation with non-national sources, such as for example UE grants or others. A similar percentage of all facilities reported to benefit 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 so were from Latvia, which is a 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 percentage of facilities mentioning this category were from Romania (45%) and Slovenia (38%). Facilities own economic activity and financing from insurance companies were two categories with the lowest percentage of reporting by facilities (respectively 10 and 8%). However, insurance companies were specified as a source of financing by 78% of facilities from the Czech Republic and 2 out of 5 facilities in Slovakia.

Tab 14. Number and percentage of facilities which reported following 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%)

Facilities from a few countries specified also additional sources of financing, among them were: some governmental agencies, international funds and organisations, private sponsors donations and organisations' membership fees.

Table 15. presents an average of the percentage of specified sources of financing in facilities' budgets in countries participating in the study. The table presents an average of the percentage share in facilities' budgets in a given country.

A diversity can be noted in facilities from countries participating in the project as an aspect of percentage share of financing sources in their budgets. It seems that in Bulgarian and Estonian facilities, the main source of financing were national, regional and local budgets. In the Czech Republic - an important source of financing were the insurance companies (on average, it constituted more then 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 for facilities from Romania (43% of facilities' budgets) and Lithuania (32%). Such financing was also very important in facilities from Latvia (36% of facilities' budgets), only a slightly higher percentage share in the facilities' budgets in this country came from the National Health Fund (38%).

Tab 15. Average of the percentages of the following finance sources in the facilities' budgets

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

Co-operation with other facilities, organisations and institutions

In part six of the questionnaire facilities reported their co-operation activities with other services, organisations and institutions in relation to care of patients and clients with HIV/AIDS. The facilities specified all their co-operation contacts and scope of their collaboration, frequency and way of communication. Table 16. presents how many facilities which participated in the study co-operated with other services, institutions and organisations, and how many of such contacts they had. Table 17. presents frequency of facilities' contacts with their co-operation partners. The next presented aspect of the facilities co-operation was

on methods of communication with their partners. Table 18. presents the most frequent method of contact with their co-operation partners reported by facilities which completed the questionnaire.

Overall, it can be noted that 16% of facilities participating in the study did not report any co-operation contacts with other services, institutions or organisation in relation to care of patients and clients with HIV/AIDS (see Tab.16.). 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 in Poland – 8 facilities (28%). On the other hand, all facilities participating in the study from the Czech Republic, Estonia, Romania and Slovakia specified at least one co-operation partner.

Only 13% of facilities reported co-operating with 5 or more organisations or institutions. The highest percentage of facilities with the most frequent contacts were in Poland (21% facilities with 5 or more contacts) and Romania (18%). Also in these two countries, facilities with 3 or more co-operation partners constituted more then 50% (55% in Poland and 54% in Romania). All facilities in the Czech Republic and almost all in Estonia reported to have between 1 and 4 co-operation contacts.

Tab. 16. Number and percentage of facilities which co-operated with specified number of other organisations or institutions in relation to care of patients and clients with HIV/AIDS

Country:	Number of facilities' co-operating contacts with other organisations/institutions:			
	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%)**

The results presented in table 17. are related only to facilities which reported having any co-operation contacts with other organisations and institutions and shows how often they contact

with each other. In general, almost 40% of all facilities contacted with their partners less then once a month. Facilities which reported having contacts 3 times a month or more often, constituted 32% .

The most frequent contacts with their co-operating partners – more then 2 times a month, was reported by facilities from Estonia (59%), Bulgaria (53%) and Poland (51%). The least frequent (less then one a month) – by facilities from Latvia (70%) and Slovakia (55%). In facilities from Bulgaria, Estonia, Poland and Romania, 75% of contacts with their co-operation partners was at least on the level of once a month.

Tab. 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 then 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 contacts 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 by facilities which participated in the study.

It can be noted that the most often reported form of contact was a 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 contacts. The facilities from six countries participated in the study: Bulgaria, Czech Republic, Estonia, Poland, and Slovakia - reported method of contacts with their co-operation partners in the same order: most frequent form – personal contacts, second – phone and third – e-mails. And facilities from Hungary, Latvia, Lithuania and Romania – e-mails and personal contacts equal in first place and phone in second. Facilities from Slovenia reported personal contacts most frequently, e-mails in second place and phone in third place.

Tab. 18. Most frequent method of facilities' contact with their co-operation partners in relation to care of 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 participated in the study were: meeting during seminars, conferences, educational events 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 in general did not reach 50% and in a few countries was lower then 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. It could be the result of differences in countries' health care and social care systems and in countries' needs but also it could be the result of some misunderstandings in the selection procedures of the facilities for the study among the partners of countries which participated in the research.

In relation to the accessibility of the facilities in the study it was noted that in most countries the higher number and the greatest diversity of facilities was in the countries' capital cities. In general, facilities were located in rather bigger towns and cities. Such situation can determine a lower accessibility for services for people living with HIV/AIDS outside large metropolises 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, the flexibility of working time seemed to be a problem in many facilities. Unfortunately, it means that people living with HIV/AIDS who are fully employed could have limited access to health care, mental health care and support. However it can be noted that in several countries there are facilities which provide their services also outside working hours – on afternoons and weekends. The highest percentage of such facilities were observed in Poland. It can be concluded that for some of them, the flexibility of opening hours was possibly a priority, as also the highest percentage of facilities in Poland reported working less then 15 hours a week. It seems that some kind of balance between long working hours and flexibility of opening hours should be established to provide accessibility for clients and patients.

It can be concluded that in many countries components of mental health are not sufficiently included in the health and social care of people with HIV/AIDS. In most countries employment of mental health care specialists in facilities were 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 employed

psychiatrists was low or very low in all countries, in general not reaching even 20%; only in the Czech Republic exceeding 50%. There is a similar situation with 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 addiction specialist consists of 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. There is a positive sign in this situation – it means that mental health aspects of people living with HIV/AIDS were taken into account in health care and social care; however a lack of mental health specialists in the facilities' staff member teams is quite obvious. Such a situation can determine limitations for people living with HIV/AIDS in receiving professional care and support in their emotional and psychological problems.

It was noted that only about 50% of facilities which participated in the study had established procedures of referrals to mental health care for people with HIV and for people with emotional and psychological problems. In relation to patients with HIV/AIDS such established procedures of referrals 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 designed not only for people with HIV positive results but also for people who during consultations showed any symptoms of mental health problems. The highest percentage of services with established procedures of referrals to mental health care were 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 can be given here as an exception as 78% of facilities there reported having in their scope of services psychiatrist consultations and treatment and 67% - 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% - psychiatrist consultations and treatment and 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 services was group therapy, both in relation to general mental health and dependency on psychoactive substances. It can be especially surprising in connection with the fact that group forms of therapy are usually much cheaper in comparison to individual psychotherapy – and facilities in most countries participating in the study often experience financial problems in providing professional care.

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 such groups were organised by facilities in all countries participating in the study. Facilities mentioned different target groups of support groups, such as sex workers, MSM, LGBT-s IDU-s. However, overall, only about 20% of 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 the mental health aspect can often be underestimated or even neglected in care and support for people living with HIV/AIDS. It is also possible that mental health problems remained in many societies as a kind of taboo subject, which is even harder to talk about then addiction or sexual identity and therefore designated only to specialised services.

In relation to budgets and financing of services related to mental health care in facilities which completed the questionnaire, a diversity between countries can be noticed. It can be concluded that it is a result of differences in countries' systems and solutions in relation to financing such services. It can be observed that in three countries: Latvia, Romania and Lithuania, a significant share in the facilities budgets consisted of non-national sources such as EU grants and other funds. It can be concluded that in some of them financing of mental health care of people living with HIV/AIDS from their national – central, regional or local budgets, could be not on a sufficient level. A positive side of this situation is that many of the facilities from these countries have the necessary skills and knowledge to apply and use such funding. This is an expertise which facilities form these countries could share with other facilities working in the same field in neighbouring countries, which seem not to use such funds very often.

Co-operation between facilities significantly increase the effectiveness of their services. Maintaining close and frequent contacts with other facilities operating in the same or related

fields gives the possibility of providing continued and more complex care for patients and clients and to exchange experience and knowledge. The facilities which participated in the study differed significantly in aspects of having co-operation contacts with other services, institutions and organisations. However 16% of them did not report co-operation with any other facility. Most of them (42%) co-operated with only one or two institutions or organisations. There were countries were facilities reported co-operation more frequently, however, it can be concluded that in all countries it is a very important task to increase the number of facilities co-operating with each other in relation to care of people living with HIV/AIDS. Also in relation to 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 their contacts, as usually there is a feeling that e-mails and phone contacts have started to displace traditional face-to-face contacts. It is a very important issue that people still prefer and maintain personal contacts as it often can 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. It could by a reason 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 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 specified. It has to be remembered that the situation with HIV/AIDS epidemics differs significantly among countries which participated in the study. Therefore all actions must be tailored to the countries' and communities' special needs. Here is a summary of recommendations based on conclusions from the study:

1. Regional spread: in several countries participating in the study the increasing 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.

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

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

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

6. Support groups: development of providing support groups for people living with HIV/AIDS and their families/partners and support groups for other target groups. It is necessary to place special attention on 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 for facilities in applying for grants and other findings, both from national, EU and other sources.

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 then one facility. Developing system solutions increasing co-operation attitudes instead of competition between facilities working in the area of care for people living with HIV/AIDS and related fields.