Mental Health Issues and Support Structures Concerning People Living with HIV/AIDS in Georgia

Conducted by:

The Mental Health and HIV/AIDS Georgia Expert Centre, with support from Global Initiative on Psychiatry (GIP)

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Ketevan Stvilia
Nino Badridze
George Geleishvili

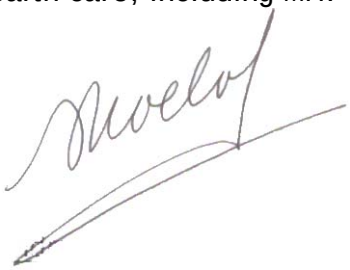
Foreword

As a Chair person of the Georgian Country Coordinating Mechanism on HIV/AIDS, TB and Malaria I highly welcome the MAIDS project that allows to develop local capacity of psychosocial services for PLHIV.

As a person who works closely with PLHIV and organizations working on HIV/AIDS issues, I well understand the need for attention to Mental Health within HIV positive people and their family members in Georgia. Along with physical health problems many of them face severe depression and have problems coping with the disease which sometimes can even play a catalytic role in HIV transmission. Of course part of the MH problems are aggrevated because of the social stigma linked to HIV/AIDS.

I believe this report would help the Government of Georgia and civil society to look more in depth to the problem and think what they can do to ensure access to health and social services for PLHIV and to improve health and quality of life.

We are ready to incorporate study findings in policy and strategy documents that we have access to through CCM's role and enforce thier implementation, but most of all, we hope that the report will serve as an advocacy tool for reducing HIV/AIDS related stigma and discrimination in Georgia. By reducing stigma we can cope more easily with the diseases. We should all do our best to integrate PLHIV into the labor force and social life. None of this will be possible without proper and undiscriminated accees to health care, including MH.



Sandra Elisabeth Roelofs
First Lady of Georgia
Chairperson of the CCM Georgia

Mission statement on Mental Health and HIV/AIDS

Mental health and HIV/AIDS

Mental illness is inextricably linked to HIV/AIDS, as a casual factor and as a consequence, while mental health treatment and support for people living with HIV/AIDS is key to both improving their quality of life and preventing the further spread of the infection. The issue is of particular concern to central and Eastern Europe and the Newly Independent States, where the AIDS epidemic is growing fast while rates of mental illness are also rising, and the limited resources and facilities available to treat both conditions pose major challenges.

Addressing the needs

The GIP Mental Health & HIV/AIDS project is a project of the Global Initiative on Psychiatry (funded by the Netherlands Ministry of Foreign Affairs from 2005 – 2008) that addresses the often-overlooked connection between mental health and HIV/AIDS. The Network supports efforts to improve the quality of life and to diminish the suffering of people with HIV/AIDS. The Network strives for increased knowledge regarding the overlap between mental health and HIV/AIDS, and promotes the development of a comprehensive system of mental health assistance to people affected by HIV/AIDS. Furthermore, it supports efforts to increase the understanding of the general public and health professionals and to decrease the stigma associated with mental illness and HIV/AIDS. The Network works through local expert centres that focus their work on research and training, advocacy and awareness building, networking and a wide variety of other interventions.

Global Initiative on Psychiatry (GIP)

GIP aims to promote humane, ethical, and effective mental health care through the world, and is particularly active in countries where mental health care is still usually substandard and where patients' human rights are frequently violated. GIP's work is based upon the underlying principle that every person in the world should have the opportunity to realize his or her full potential as a human being, notwithstanding personal vulnerabilities or life circumstances. Every society, accordingly, has a special obligation to establish a comprehensive system for providing ethical, humane and individualized treatment, care, and rehabilitation, and to counteract the stigmatisation of, and discrimination against, people with mental disorders or histories of mental health treatment.

Mental Health and HIV/AIDS Georgian Expert Center – GEC

The Center was established within the GIP MAIDS project to provide expertise, conduct, plan and organize training activities to educate main stakeholders on mental health and HIV/AIDS issues, as well as research activities to investigate the magnitude of this problem in Georgia

For inquiries regarding this report, please contact:
Public Union "Bemoni"
Mental Health and HIV/AIDS Georgia Expert Centre
16, Kavtaradze Street, 0186 Tbilisi, Georgia
Tel/Fax (995 32) 18 60 60
Email: GEC@aidsmh.ge

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We would especially like to acknowledge all of the counselors working at the Self-Support Centers in Tbilisi and in Batumi (Ajara region) run by the HIV/AIDS Patient Support Foundation who kindly agreed to arrange focus groups of PLHIV as well as to provide the facility for these meetings. We hope they will use the report to work towards better understanding the needs of PLHIV and to improve the assistance they provide to them. We are also grateful to those PLHIV who, despite strong stigma participated in the focus group discussions and contributed greatly to this study.

We would like to acknowledge the great assistance provided by the administration officials of the VCT centers and penitentiaries visited for research on VCT and PLHIV in prison.

We are indebted to GIP MAIDS project officials and the sponsor of the project, the Dutch Ministry of Foreign Affairs (TMF), whose contributions enabled the research team to complete the project. Finally, we would like to express our gratitude to GIP Research Consultant, Mrs. Katinka de Vries and to the GIP Research Coordinator for Caucasus Countries, Mrs. Jana Javakhishvili for their guidance and support throughout the study.

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral treatment
BSS	Behavior Surveillance Survey
CCM	Country Coordinating Mechanism
FG	Focus Group
FGD	Focus Group Discussion
FSW	Female Sex Worker
GFATM	Global Fund to fight AIDS, TB and Malaria
GIP	Global Initiative on Psychiatry
GoG	Government of Georgia
HAART	Highly Active Antiretroviral Treatment
HIV	Human Immunodeficiency Virus;
HCW	Health Care Worker
IDU	Intravenous Drug User
IDPs	Internally Displaced People (from regions - Abkhazia and South Ossetia)
MSM	Men having Sex with Men
MAIDS	Mental health and HIV/AIDS Project, GIP
MARP	Most at Risk Population
MH	Mental Health
MoLHSA	Ministry of Labour, Health and Social Affaires
NAC	National AIDS Center
NAPP	National AIDS Prevention Program
NSPA	National Strategic Plan of Action (on HIV/AIDS)
PEP	Post Exposure Prophylactic
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
S&D	Stigma and Discrimination
SHIP	STI/HIV Prevention Project (funded by USAID and implemented by Save the Children)
SWOT	Strengths, Weaknesses, Opportunities and Threats analysis
UNAIDS	United Nation's Joint Program on HIV/AIDS
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

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I. Executive Summary

From 2006 to 2007 the **Mental Health and HIV/AIDS (MAIDS) Project** of the **Global Initiative in Psychiatry** investigated mental health and HIV/AIDS issues in Georgia using both qualitative and quantitative methods. The research was carried out in the capital city Tbilisi, Batumi (Adjara), Kutaisi, and Zugdidi (Samegrelo), where HIV infections are more present than in other parts of Georgia. Telavi and Akhaltsikhe were examined as well even though they are considered regions with a lower prevalence of HIV. Participants included PLHIV, together with IDU PLHIV, individuals involved in care and advocacy for MH and HIV/AIDS (GO/NGO representatives), HIV positive prisoners, family members and friends of PLHIV, medical personnel and youth.

This research intended to:

- Assess the existing structure of HIV and MH services in the country. To evaluate their level of coordination and develop recommendations for improving mental healthcare services for HIV/AIDS patients and their family members and partners;

- Evaluate the use of HIV/AIDS Voluntary Counseling and Testing (VCT) in Georgia and elaborate recommendations for its improvement;

- Identify mental health problems prevalent among PLHIV and their family members.

- To identify areas of possible improvement in mental healthcare. The research targeted PLHIV in general as well as PLHIV IDU and PLHIV prison population;

- Assess the magnitude and context of HIV-related stigma in Georgia, to investigate human rights violations of PLHIV and to develop recommendations for the development of a supportive care environment.

- Develop recommendations for MAIDS project staff and all main stakeholders in the area of MH and HIV/AIDS to improve mental health services for PLHIV and their family members, to overcome HIV/AIDS and MH related stigma and lessen discrimination of PLHIV at work and in healthcare and educational environments.

Main Findings

The need for psycho-social services for PLHIV is not adequately recognized by officials in the current healthcare system of Georgia; there are no governmental policies, documents, or programs which address the issue.

PLHIV in the penitentiary system are more frequently reported to be suffering from mental health abnormalities. However, this population has less access to MH and HIV/AIDS diagnostic and treatment services than PLHIV outside of prisons.

The physicians of the National AIDS Center take on the main burden for psychological support alongside the Community Based Organization's (CBO) staff working at self-support centers. The personnel involved in treating PLHIV are not properly trained for

psychological counseling. At the same time, mental healthcare specialists have little knowledge about the problems specific to patients with HIV/AIDS infections. There are no official training courses delivered to mental healthcare or HIV/AIDS specialists on the identification and management of specific psychiatric issues facing HIV/AIDS patients.

International organizations actively involved in other areas of HIV/AIDS response in Georgia are not participating in the provision of mental healthcare services to PLHIV or in the development of treatment capacity at local institutions, with the exception of GIP;

There are just 10 VCT units/centers in Georgia, and their geographic distribution is uneven. There are 45 HIV testing sites, which do not have any capacity for counseling. Relatively comprehensive VCT services are available in Tbilisi, Batumi, Zugdidi and Kutaisi.

The government cannot provide the appropriate monetary support for VCT. Of the 10 VCT units operating in Georgia, only one is supported by the NAPP. Other sites receive funding from GFATM and USAID projects that target high-risk behavior groups (IDUs, FSWs and MSM).

Quality of service differs considerably among treatment centers. Only a limited number of sites (5) provide quality VCT according to WHO guidelines. The majority (two thirds) of operating VCT units target Most at Risk Population (MARP) groups, including IDUs, FSWs and MSM. According to 75% of clients interviewed (N=23), VCT service are delivered in a friendly, respectful manner.

The study confirmed the existence of mental health problems among PLHIV in Georgia. The most common issues diagnosed are depression and personality disorders. Some sufferers report suicidal thoughts and a few cases with psychotic symptoms have been observed (auditory hallucinations and persecutory delusions). The assistance of psychologists/psychiatrists, as well as peer support groups and social workers is needed not only for PLHIV but also for their family members. Family members reported depression as the most frequent mental manifestation.

According to physicians at the AIDS Center, severe mental disorders are usually diagnosed during the AIDS phase- when the disease begins to affect neurology. At the AIDS phase, cognitive impairment potentially resulting in dementia may require care from both MH professionals and AIDS specialists. Although with HAART administration, dementia and depression significantly lessens. With GFATM support, all registered AIDS patients have access to ART in Georgia, including prisoners.

The vast majority of prisoners (75%) admitted the availability of small amounts of drugs in prisons; many still occasionally use drugs. About 40% of IDU prisoners report continued narcotic use in prisons and 25% began using while in prison[1]. The main mode of use is through intravenous injection.

[1] M. Tsintsadze,"Study of HIV/AIDS Prevalence and High Risk Behaviour in Penitentiary System of Georgia", 2006;

Peer support is highly valued by PLHIV, especially those PLHIV in prison. Self-support centers for PLHIV provide excellent opportunities for expanding peer networks through group counseling sessions, events, and home-based peer support initiatives.

The study also confirmed the existence of strong stigma and discrimination in the country towards PLHIV.

The study revealed that HIV/AIDS related stigma exists among healthcare workers (HCW). They lack the knowledge, experience, and skills needed for working with PLHIV. Many fear infection and universal safety precautions are not always adequately observed at medical institutions- further increasing the fear. Treatment providers lack basic, necessary safety supplies (gloves, sterilization means, etc.) and even when available they are underused and education addressing their use needs to be urgently implemented.

Young people, in Georgia, lack adequate knowledge about HIV/AIDS. They are afraid of AIDS, as well as of PLHIV; this fear contributes to the negative attitude towards HIV/AIDS patients.

II. Introduction/ Background

Mental health problems for people living with HIV/AIDS are increasingly recognized worldwide. HIV/AIDS patients report psychiatric disorders resulting from the disease itself as well as from the stigma and isolation felt after infection. In addition, some psychological conditions (cognitive disorders, addiction/substance abuse, and personality disorders) increase one's risk for HIV infection. However, on the policy level, less attention is paid to MH problems of PLHIV in Georgia. The main services for coping with MH problems in PLHIV are at the AIDS Center and self support centers of the HIV Patients' Support Foundation. Meanwhile, most MH organizations are not concerned with PLHIV. Therefore, investigation into the links between mental health and HIV/AIDS has become a theme for research seeking to improve contemporary care and treatment of those with HIV/AIDS.

This publication is prepared within the HIV/AIDS and Mental Health project of the Global Initiative on Psychiatry. The project supports HIV/AIDS and mental health programs in East European, Caucasian, and Central Asian countries. Since 2005, the Dutch government with an additional grant from the Open Society Institute has funded the project.

The key objectives of the **MAIDS Project** are to raise awareness and educate main stakeholders on mental health issues related to HIV/AIDS epidemic, to assess the magnitude, specifics and context of mental health problems among **PLHIV**, and to develop recommendations for improving the existing mental healthcare services for HIV/AIDS patients and their family members and partners. For this purpose, the Georgian Expert Center staff works in two directions: research and trainings on MH and HIV/AIDS. The research includes an overview of existing MH and HIV services available in the country and their links to each other, rapid assessment of VCT units and their accessibility and quality, measurement of stigma and discrimination in the country and its influence on problems of PLHIV, identification of MH problems of HIV positives, and recommendations for improving quality of life. The main purpose of the trainings is to support specialists (AIDS and MH specialists, GPs, etc.), family members of PLHIV, and PLHIV themselves with adequate information about MH and HIV, as well as to prepare agents capable of managing change on the governmental, institutional and personal levels.

This report is based on four studies, which were carried out by GEC research team for two years from March 2006 to November 2007.

These four studies provided insight on policy and structure issues for MH and HIV/AIDS services (chapter four), MH problems of PLHIV, and stigma and discrimination towards them (chapter five), VCT service availability and quality, client satisfaction and staff training (chapter six), MH problems of HIV positive prisoners (chapter seven), also Conclusions and Recommendations. The appendices include a stakeholder analysis matrix, questionnaires used during research, interview guides, and FGD guidelines.

HIV/AIDS and MH Situation in the Country

Georgia has a low HIV rate with an estimated HIV prevalence of 0.01 - 0.03%. By March 20, 2008, there were 1553 HIV cases registered in Georgia; the very first case was in 1989. The estimated number of people with HIV/AIDS is between 2800-3000[2]. Most of those living with the disease are 25-40 years old at the time of diagnosis, and 70% of PLHIV are male.

Despite the low prevalence of HIV infection, Georgia is considered a country with potential for developing a high incidence of HIV/AIDS infections due to widespread intravenous drug use, intensive migration to neighboring high-prevalence countries (Ukraine and Russian Federation), common socio-economic trends with the CEE/CIS region, and the increasing trend of heterosexual transmission.

Georgia's nascent epidemic is mostly among intravenous drug users. Among cumulative HIV cases with a known route of transmission, 60% are infected through intravenous drug use, 32 % through heterosexual relations, and 3% through homosexual contact (Source: AIDS Center statistics for March 20, 2008).

There are 45 HIV diagnostic labs working countrywide in Georgia providing screening of various population groups for HIV/AIDS. Out of those only nine are working on testing MARP groups, the other labs provide testing for HIV, Hepatitis B and C, and syphilis for blood donors within the National Blood Safety Program.

Georgia is a country with universal access to HIV ARV treatment, and all HIV positive people who are eligible, receive free ART. There are four sites for ART in Georgia: the National AIDS Center in Tbilisi and the regional infectious diseases hospitals in Batumi (Ajara region), Zugdidi (Samegrelo region) and Kutaisi (Imereti). Care and support services for PLHIV are very limited in Georgia. PLHIV have access to peer counseling at the HIV/AIDS patient support foundation's office in Tbilisi, Zugdidi, Batumi and Kutaisi.

Psychosocial care for PLHIV is in its early stage in Georgia. There are no mental health institutions or units for addressing this problem, however, the National AIDS Center, which is responsible for monitoring and treating PLHIV, employs a referral system for times when there is need for assistance from specialists, including psychological and/or psychiatric.

There were no psychologists working at the National AIDS Center before, but starting in 2007, HIV/AIDS patients have access to psychological counseling at the Center. However, there is no such service at the Regional AIDS Treatment Centers in Batumi, Kutaisi and Zugdidi.

Interviews with administration at both governmental and nongovernmental institutions working in the mental health field in Georgia revealed that these facilities have never knowingly treated a patient with HIV/AIDS. Although, there is no routine HIV testing for patients with mental disorders, in very few cases, psychiatrists have suspected HIV

[2] Country Estimation Data generated by SPECTRUM, The National AIDS Center

infections and sent blood for testing to the National AIDS Center; but, so far, these tests have not revealed HIV infections among patients of these facilities.

Physicians and the VCT staff of the AIDS Center[3] indicate that there is an increased demand for psychological assistance for PLHIV, especially at the time of an HIV positive diagnosis. The second phase for psychological crisis arises when the patient needs support in starting his/her ART treatment.

[3] Physicians of AIDS Center interviewed for the study: Lali Sharvadze, Marina Dgebuadze, Maia Mepharidze

III Study design and Methodology

The study covered several different regions in Georgia. The cities with higher prevalence of HIV like Tbilisi, Batumi, Zugdidi and Kutaisi were chosen as well as eastern cities with lower HIV prevalence – Telavi and Akhaltsikhe for comparison purposes.

The study design included in depth interviews with PLHIV, stakeholders, and professionals working on HIV and MH problems, Focus Group Discussions (FGDs) with health care workers, PLHIV, and their family members and friends, and a survey among health care providers and youth.

The research team consisted of three members:

Research Coordinator -	**Ketevan Stvilia,** M.D., M.S., Head of the AIDS Prevention Department, Infectious Diseases, AIDS and Clinical Immunology Research Center
Research Assistants:	**Nino Badridze,** M.D., M.P.H., Head of Epidemiological Department, Infectious Diseases, AIDS and Clinical Immunology Research Center
	Giorgi Geleishvili, M.D., Ph.D., Psychiatrist, Tbilisi Psycho-Neurological Dispensary

GIP Research Consultant Mrs. Katinka de Vries and GIP Research Coordinator for South Caucasus Countries Mrs. Jana Javakhishvili guided the research team throughout the study.

Qualitative methodology was used for the study and there are both conceptual and practical reasons for using this type of research. The primary conceptual reason is that it promotes more in-depth responses, and therefore a greater understanding of issues can be acquired. Qualitative research is a needed tool for generating intervention ideas; this was one of the main objectives of the research component of the MAIDS project. Focus group discussions, if applied well, are a cost-effective method for gathering data in a relatively short time span (one to two weeks).

The methodology included:

- Desk Review: Published literature as well as web articles on HIV/AIDS, mental health issues, intravenous drug use, and HIV problems in prisons[4] were reviewed.

- Individual interviews with key informants;

Individual in-depth interviews were conducted with key informants (program coordinators at Ministry of Labor, Health and Social Affairs, and physicians at the National AIDS Center and Institute of Psychiatry of Georgia) in charge of treatment and care for PLHIV. In-depth interviews were conducted among PLHIV as well. The tools for

[4] see the list of references at the end of the report

interviewing stakeholders, medical personnel, and PLHIV were made by the research team using the WHO and UNAIDS toolkit.

- FGDs and interviews with PLHIV and their family members as well as with HCWs on MH problems

FGDs of various groups were organized: non-IDU and IDU (including those attending methadone substitution treatment centers) PLHIV; family members and friends of PLHIV; health care providers. The number of FG participants varied from 5 to 10. Monetary incentives (approximately 10 USD) were supplied in order to recruit PLHIV and their family members/friends. The money essentially covered the cost of transportation to and from the focus group site and a meal.

The HIV/AIDS Patients Support Foundation, which provided office space for FGDs in order to minimize potential ethical threats (like disclosure of participants' HIV positive status to the public) recruited participants for the group discussion. Participation in FGDs was voluntary and the foundation staff made sure that PLHIV had full information regarding the discussion topics and made informed decisions regarding participation.

- For evaluation of VCT services, the research team applied UNAIDS's *Tools for Evaluating HIV Voluntary Counseling and Testing* (May 2000), with a few changes (the elements on counseling TB patients and pregnant women were omitted, as at the time of study such services were not available). The research activities included *individual interviews* with stakeholders, direct observation by research team members during counseling sessions (pre and post), mystery (dummy) clients – three persons specially trained to act as VCT clients who visited six VCT sites and received counseling and testing.

- A *semi-structured questionnaire* was administered to counselors (15 persons) to assess their job satisfaction. *Client Satisfaction* was measured through a special questionnaire for clients attending VCT sites (23 people took part in the survey).

To measure HIV related stigma and discrimination a combined focus group discussion, quantitative study-survey methodology was applied. Focus group discussions assessed the peculiarities and magnitude of the problem among PLHIV and medical personnel.

Two focus groups with PLHIV (15 participants in total, average duration of FGD one hour and twenty minutes) were conducted in Tbilisi (10 participants), the capital city, and Zugdidi (5 participants) in western Georgia at the self-support centers operating under the umbrella of the HIV/AIDS Patients Support Foundation.

FGDs with HCWs were held at the Maternity Hospital N3 in Tbilisi (total number of participants -16) and at the Infectious Diseases, AIDS and Clinical Immunology Research Center (8 participants) among them, physicians and nurses of Infectious Diseases Department (3 participants) and 5 participants from the AIDS Department. The rationale behind organizing FGDs with medical personnel of the National AIDS Centre, gynecologists, and pediatricians was the potential experience of the FGD participants in treating HIV-positive patients. Another important group of medical specialists to interview would have been primary health care physicians, but at the time of the study Georgia was going through a sector-wide reorganization of the primary health care

system and the potential role for primary health care physicians in the future was not clear. In addition, the research team took into account comments from National AIDS Centre officials, that the involvement of primary health care specialists in HIV positive cases is minimal in Georgia.

- A quantitative study was carried out among health care workers and young people to measure HIV-related stigma and attitudes towards PLHIV.

  For the youth study, the UNAIDS Knowledge, Attitude and Practice (KAP) survey tool was used (UNAIDS, 2006). The surveys were conducted in five cities of the country- all of which differ in HIV prevalence: Tbilisi, Kutaisi, Zugdidi (relatively high HIV prevalence areas), and Telavi and Akhaltsikhe (low HIV prevalence areas). Considering the large interest of young people in participating in the survey on HIV/AIDS-related stigma, no monetary incentive was offered.

  For the youth survey, the research team recruited 350 university students from 17 to 25 years old (see table 1 in appendix 5); in addition a survey among 170 hospital staff members was conducted (see table 2, appendix 5). The survey instrument was a self-administered questionnaire adopted from the UNAIDS youth KAP assessment tool (see appendix #3). Although, it has been recognized that the study subjects selected could result in slightly biased results because, in general, university students may be more informed about HIV/AIDS issues than youth in general.

Picture 1. Training on Qualitative Research Methodology, Public Health Education AAF/OSI Seminar. Salzburg, 2006

IV Policy and structure of MH and HIV/AIDS

MH and HIV/AIDS services exist as two independent structures within the Georgian healthcare system. Unfortunately, the lack of connections and coordination between the two structures creates obvious problems for specialists as well as for service users. The MH system contains GOs like mental hospitals and psycho-neurological dispensaries, NGOs, and one private mental hospital.

Figure #6
Distribution of MH institutions in the country

Organization of AIDS Services
A Country Coordinating Mechanism (the CCM) for HIV/AIDS currently operates in Georgia and, in April 2007, it became the coordinating authority for all HIV/AIDS programs implemented in Georgia.

The Infectious Diseases, AIDS, and Clinical Immunology Research Center is a leading governmental organization working in the area of HIV/AIDS counseling and treatment. The center is responsible for the treatment and monitoring of all HIV/AIDS patients and training of medical personnel in HIV/AIDS care.

Within the most recent changes in the AIDS control system of Georgia, a concern related to the disease surveillance system has arisen. In general, the inclusion of HIV/AIDS surveillance into the overall disease surveillance system ran by the NCDC is a positive step towards the strengthening of communicable and non-communicable disease surveillance in Georgia. However, by concentrating data at one institution without developing effective mechanisms for maintaining active surveillance of HIV and including a second generation surveillance system, HIV case detection will be negatively affected and it will also become more difficult to follow up with HIV positive people and offer counseling, diagnostic, treatment, care and support services. The GFATM round 6 grants (2007-2009) includes a component on HIV surveillance,

which, if used effectively may support the building of a new HIV surveillance system tailored to changes made in the overall disease surveillance system in the country.
There are over 60 labs where it is possible to do HIV/AIDS blood analysis. The staff is trained by AIDS Center's professionals. VCT is provided in a limited number of centers in Tbilisi and some towns of Western Georgia.

Policy and Legislation
At present, Georgia does not have a solid mental health policy or a mental health strategic plan. However, a national program, with stationary and ambulatory parts, does exist. The national mental health program includes a plan for financing services and improving the quality of treatment and care provided to patients with mental health problems.

Since 2006, the Mental Health NGOs' coalition has been actively creating the country's mental health policy and strategic action plan. In November 2007, GIP – Tbilisi, the Parliament's Committee on Health and Social Issues, and the Georgian Mental Health Coalition joined together to create a task force, to support work directed towards expanding a mental healthcare policy. In 2007, a new law on psychiatric care was enacted. The law addresses the rights of patients, confidentiality issues, and quality of services.

A draft of amendments on the HIV/AIDS law is ready and will be presented to the Parliament in early spring of 2008. The amendments support further liberalization of the legal environment for PLHIV. People with HIV are no longer required to inform healthcare providers about their HIV positive status.

Figure 7. Geographic Distribution of VCT sites in Georgia

Financing:

The state budget for mental healthcare increased from 5.2 million to 8.3 million GEL[5] over the last 3 years (2005 -2007). For 2008, 8.3 million GEL is set aside for mental healthcare- although this has not been enacted yet.

The government of Georgia ranks HIV/AIDS as a top public health issue in Georgia; however, in 2007, the number of screenings was limited to 9000. In addition, the UN theme group supported HIV counseling and testing for 2500 people in MARPs. As for external, financial support, the largest monetary assistance for HIV response is from GFATM, with an annual budget of around 2 million USD per year. USAID has been working to implement their SHIP project through partner organization Save the Children Foundation, targeting IDUs and FSWs with an annual budget of about 800 000 USD.

With relatively little money (about 380 000 USD in 2006), considerable technical support is provided by UN agencies: UNAIDS, WHO and UNICEF.

Strengths of MH and HIV/AIDS services:

- Legislation already exists to support mental healthcare, entitled *Law on Psychiatric Care;* The Law on HIV/AIDS was adopted as early as 1995. Currently a group of experts is working on a second revision of the HIV/AIDS Law.
- Currently, NGOs are actively involved in intensive work to develop the Mental Health Policy.;
- There are a number of nongovernmental organizations currently implementing pilot projects on such areas as psycho-social rehabilitation, mobile outreach services, training programs for mental health professionals, advocacy projects, researches, etc.;
- Two family and consumer associations have been formed in the field of MH, and staff providing mental health services interact with these associations;
- Well-trained and experienced personnel work in the mental health field (about 450) and HIV/AIDS facilities (up to 260);
- There are several government health programs addressing the issues, including the HIV/AIDS Prevention Program, the AIDS Treatment Program, the Blood Safety Program, and the Prevention of Mother to Child Transmission of HIV Program.
- There is a large grant (12 million for 2004-2008) ensured from the Global Fund to fight AIDS, TB and Malaria and for our country to address the most urgent needs of Georgia; the project supports the network development of VCT centers that will strengthen the psychological counseling capacity of healthcare institutions dealing with PLHIV.
- Budget for mental healthcare, financed by the government, regularly grows;
- Georgia has maintained provision of universal access to ART for all AIDS patients since December 2004, and as of September 1, 2007, a total of 290 patients were enrolled in the ART program countrywide;
- Georgia has universal access to HIV VCT for all pregnant women;
- Treatment standards and guidelines for MH care are developing.

[5] 1 USD = 1.54 GEL

Weakness of MH and HIV/AIDS Services

- Right now, there is no mental health policy or strategic plan.
- Psychiatric hospitals in the country need reforming because they are primarily outdated facilities; the condition of HIV/AIDS facilities also needs improvement, especially in Tbilisi. The GFATM project has included renovation of AIDS facilities in its budget- this will largely solve the problem.
- Most finances provided by the government are directed to inpatient care;
- Mechanisms to protect patients' human rights are only in the initial stage of development;
- Primary health care doctors receive insufficient training (only 3 days) on HIV/AIDS, mental health, and human rights issues;
- Nurses working in the mental health field have no special training in this area;
- The current system of psychosocial services does not involve the specific coping problems facing PLHIV;
- Access to psychological counseling is limited for patients from regions and for PLHIV who are in prisons.
- The knowledge and experience of specialists (physicians, social workers) involved in the psychosocial care of PLHIV are not adequate;
- The NGO sector working with people with mental disabilities in Georgia is not targeting PLHIV for service provision;
- The network of self support centers for PLHIV is limited in terms of geographic coverage (It is available only in Tbilisi, Samegrelo, Ajara and Imereti regions)
- Counselors have little knowledge and experience working with mentally disabled persons;
- Care and support services for PLHIV are still limited in Georgia. PLHIV have only access to peer counseling at the PLHIV support foundation's office in Tbilisi, Zugdidi and Batumi. They also have access to limited food assistance support through the Global Fund's project.
- A palliative care service is planned for the second Global Fund HIV project, from 2007 to 2009. However, both the current and planned activities do not meet PLHIV's demand for care and especially for social and psychological support.
- In Georgia, the HIV/AIDS service structure is more or less comprehensive but coverage and access to services is not adequate in all geographic locations.
- There are no national guidelines or standards for working on, treating, or preventing mental health problems among PLHIV.

V Mental Health Problems of PLHIV

Picture 2. Counselling session at the National AIDS Center

To identify the MH problems of PLHIV, a qualitative study (FGDs) was conducted in Tbilisi (the capital city) and Batumi in the Ajara region. These focus group discussions were organized with the HIV/AIDS Patients' Support Foundation's help and with three different groups: non IDU PLHIV (15 persons); drug user PLHIV[6] (16 persons); Family members and friends of PLHIV (16 persons). In addition, individual interviews were conducted with PLHIV in prisons (11 persons) and at the AIDS Center (14 persons). Medical personnel working with PLHIV were also involved in this research and presented professional opinions regarding the issue.

The study identified a number of mental health problems, common for PLHIV. The most frequently reported psychological complaints are those associated with depression, personality disorders, and sleeping disorders. The prevalence of each of them varies depending on which PLHIV group examined. Non-IDU PLHIV reported symptoms of depression frequently while IDU-PLHIV more often reported being explosive/irritable. Although, more serious mental health problems like personality disorders, cognitive disorders, paranoia, depression with suicidal intentions were observed in PLHIV who were interviewed in prisons

The problems can be grouped into two categories: Group I- depression and cognitive impairment (orientation, registration, attention, memory, language etc.). These problems, were in most cases preceded by HIV infection. Group 2- personality disorders, paranoia and auditory hallucinations (group II) usually exist separately from HIV infection or, as in case of personality disorders, often precede infection due to increased risk behavior associated with these disorders.

According to physicians at the AIDS Center, more severe mental disorders are diagnosed later during the AIDS phase after the disease manifests neurologically in about one fifth of patients. At the AIDS phase, without ART, cognitive impairment potentially resulting in dementia may require joint care from both a MH professional and an AIDS specialist.

[6] Some of them are in methadone program.

Factors influencing the Mental Health of PLHIV
Risk factors for development of MH problems among PLHIV

There are some negative factors, which increase the risk of MH problems for HIV positive people- lack of information on their disease and the potential implication of status on their lives and low awareness in the HIV in population.

In our research, PLHIV stressed the lack of information about HIV/AIDS in Georgia as a problem. People are not aware of this disease and have misconceptions regarding HIV/AIDS and PLHIV. On the other hand, PLHIV and their family members have little access to information regarding the disease and treatment and care options for them.
In addition, people's negative attitude towards them and the high rate of refusal to assist them at healthcare institutions along with the discrimination of experienced in society, the MH of PLHIV can be seriously harmed.

Stigma against PLHIV in Georgia influences PLHIV and their family members' attitudes. The discrimination observed by PLHIV restricts them from revealing their status to family members and the public- which in turn makes it more difficult for them to cope with their disease:

> *"Of course PLHIV are discriminated against in Georgia, but this issue is hidden, as very few of us inform others about our infection. People are not aggressive to us because they don't know our HIV status"*
>
> HIV positive man, 29 years old, Tbilisi

> *"Nobody other than you knows that I am HIV positive. I don't trust people. If not for God and the police, people would eat each other's meat and drink each others blood".*
>
> Female, 32 years old, Tbilisi.

PLHIV report many cases of discrimination at medical facilities where personnel refuse to provide assistance due to lack of information and stigma. IDU PLHIV also reported that some of their peers' attitudes have changed in such a bad way that they became aggressive and infected several people. That has a negative influence on public opinion regarding PLHIV. Family and friends indicate the negative role of mass media on the mental health of PLHIV. They reported being shocked and depressed by TV or radio programs, from which they receive little useful information and only a lot of stress.

Protective factors that help PLHIV include the following:
a) Family Support
The studied family members and friends of PLWHA report very positive and supportive attitude towards PLHIV. Generally, those studied reported that they did not fear infection through household contact because PLHIV and medical personnel have well informed them how to prevent transmission.

b) Peer support
PLHIV have indicated that peer support has a very positive impact. Self-support centers for PLHIV provide excellent opportunities for further expanding the peer network

through group counseling sessions, group events, home based peer support initiatives. Peer support seems to be the most valuable in prisons.

c) Specialized medical services
PLHIV indicated the extremely positive role of AIDS center personnel both during VCT and treatment follow up visits- although, there are very few other medical institutions where they receive adequate treatment in a non-discriminative manner.

d) Religion
Religion plays an important role in helping PLHIV cope with stress and isolation. It gives hope for the future and decreases the risk of depression among PLHIV.

Need for Mental Health Services
Family members and friends indicate a high need for psychological assistance for PLHIV and his/her family members, especially when a patient first learns of his/her HIV status.

Only a limited number of specialized healthcare facilities and NGO/CBOs provide counseling and psychological support to PLHIV. These include:

- AIDS Treatment Centers (national and two regional centers);
- Self-support Centers of PLHIV (three centers);
- NGO Tanadgoma and Public Union Bemoni.

The Methadone Substitution Treatment centers have developed a relatively better capacity for psychosocial assistance, where drug using PLHIV have regular counseling sessions with trained psychologists (255 IDUs are enrolled in the program, including 19 HIV positive IDUs). According to most IDU PLHIV reports, the methadone substation program has had a positive influence on their psychological wellbeing.

Healthcare is extremely poor in prisons, especially for those inmates who are HIV positive. NAC physicians visit PLHIV in prison, but they cannot provide regular monitoring of their health. PLHIV have access to counseling in a few prisons, mostly in Tbilisi where NGO Tanadgoma provides counseling in penitentiary facilities.

PLHIV have emphasized the problem of access when seeking medical assistance outside the AIDS Center. Physicians refuse to assist PLHIV, and many HIV positive people choose to receive medical care without disclosing their HIV status:

> *"They [medical personnel at the maternity house] treated my pregnant wife very badly when my physician from the AIDS Centre informed them that we both have HIV and if I could have a choice I would definitely not have told them that we are HIV positive"*
>
> Male, 27 years old, Tbilisi.

Currently, medical personnel lack the supplies and skills needed to prevent HIV transmission in medical facilities- this lack of safe practice could lead to a high rate of nosocomial transmission of HIV infections in Georgia.

Stigma and Discrimination

HIV-related stigma and discrimination continues to manifest in every country and region of the world, creating major barriers to preventing the further spread of the infection, alleviating its impact, and providing appropriate care, support and treatment to sufferers (UNAIDS, HIV - Related Stigma, Discrimination and Human Rights Violations, case studies of successful programs, 2005). HIV-related stigma and discrimination is a problem for people living with HIV/AIDS in Georgia as well. Under the GIP MAIDS project, a qualitative and quantitative study was designed to further investigate the issue of HIV-related discrimination in Georgia. It will provide valuable background information not only to the project staff, but also to all key partner organizations working in the area of HIV/AIDS in the country, especially those who are responsible for policy development and those who provide HIV prevention, treatment, care and support services to target populations.

To measure HIV-related stigma and discrimination among youth and medical staff, the investigation used a combined methodology. Focus group discussions assessed the magnitude of the problem for PLHIV and medical personnel. A quantitative study was carried out among healthcare workers and young people to measure HIV-related stigma and attitudes towards PLHIV. The youth study applied the UNAIDS Knowledge, Attitude and Practice (KAP) survey tool (UNAIDS, 2006). The surveys were conducted in five cities in the country, which differ in HIV prevalence: Tbilisi, Kutaisi, Zugdidi (relatively high HIV prevalence areas), and Telavi and Akhaltsikhe (low HIV prevalence areas).

Survey results:

The study revealed a considerable asymmetry of awareness levels geographically. People in western Georgia have better knowledge and less fear regarding HIV/AIDS than those in eastern Georgia- HIV related stigma is stronger in the eastern parts of the country. It may be attributed to addressing western regions first with all HIV prevention and educational activities considering higher prevalence of HIV in these regions. In general, most PLHIV face discrimination when seeking medical assistance. Many of them prefer to hide their HIV-positive status in order to receive adequate treatment and care.

> *"I don't think that we should tell a doctor that we have HIV. He/She should treat us with equal precautions like everybody; anybody can be HIV positive. In my opinion, we don't need separate treatment centers like the AIDS Centre. Any hospital should be willing to assist us, we don't have the plague; we just have HIV"*
>
> Female FGD participant, 45 years old, Tbilisi.

Because of fear of stigma and discrimination, PLHIV disclose their status only to their closest circle of people (family members or closest friends), who's attitude towards them remains positive.

None of the PLHIV who participated in the study have ever been subjects of physical violence from family members or strangers, although, some of them, especially in regions, recall such cases happening to other HIV positive people.

Gynaecologists and paediatricians report never having heard anything about discrimination against PLHIV in Georgia and they could not explain the reasons for existing discrimination in the country. Only two participants stated that the reason behind the stigma and discrimination was fear.

FGD participants from the National AIDS Center think that the reasons for discrimination in the country is the lack of information about HIV/AIDS and the fear that PLHIV can transmit the virus through casual contact.

> *"The main reason for discrimination on the part of physicians is fear, especially in the regions. Most of them see an HIV-positive person for the first time in their lives. They are not familiar with universal precautions. Those, who know how to provide care in a safe manner, do not have adequate disposable instruments and equipment, or they do not feel comfortable working with gloves, masks, etc"*
>
> Female physician, 41 years old, from the National AIDS Centre

The quantitative study showed that a high percent of HCW have information on HIV/AIDS related issues. 78% (N=170) of healthcare providers correctly answered six questions related to awareness on HIV/AIDS (see annex 2, questions 1 to 6).The main reason for stigma and discrimination is the lack of skills and experience working with PLHIV. HCW have an unjustified fear for becoming infected when treating PLHIV. This further contributes to the stigma toward PLHIV among them. The high stigma results in resistance among HCWs to assist PLHIV. They would prefer to have a separate institution, like the AIDS Center that would be fully responsible for taking care of HIV/AIDS patients. They complain about the difficulty in following universal precautions at their institutions and worry that they might be at risk when treating HIV-positive people.

HIV/AIDS stigma is also high among young people. They report not being willing to go to a school where HIV positive students study or to a family that has an HIV-positive member. This can be attributed to the limited knowledge they have about this disease. Only one-fifth of them had correct answers to all six questions about on HIV/AIDS transmission routes. Most of them knew that HIV can be transmitted by unsafe sexual contact, and use of condom or faithfulness to one healthy sexual partner reduces the risk of transmission (questions 1 and 2). About 60% (N=350) of respondents were aware that an HIV-positive person may look healthy. 50% of our respondents thought that HIV can be transmitted by kissing; and 50% said that they could be infected if they shake hands with an HIV-positive person. Only 35% knew that sharing a meal with an HIV-positive person was safe. Further examination of the correlation between the HIV/AIDS-related knowledge and stigma and discrimination data revealed that those young people who answered incorrectly to all HIV awareness questions were 1.5 times more likely to discriminate against PLHIV than those who have correct knowledge regarding HIV transmission routes.

Like HIV positive patients, HCW FG participants believe that the public's awareness should be raised by spreading information about the disease. They suggest restoring trust between patients and physicians in the country. Over the last two years, the mass

media started reporting cases of physician misconduct; these mostly fatal cases fostered negative attitudes towards HCWs among the population.

PLHIV see raising public awareness as the most effective strategy for the reduction of HIV/AIDS related stigma and discrimination. Although, they would like to ensure that the messages spread by the media are professionally formulated and do not violate the deontology principle "do no harm". The media should be educated on how to sensitize the public regarding HIV without breeding additional fear. TV campaigns should be developed and broadcast to increase public awareness and reduce HIV-related stigma and discrimination.

VI. Voluntary Counseling and Testing services

National Preparedness in VCT Implementation
Individual interviews with the Department of Public Health Focal Point and the Manager of the National AIDS Prevention Program (NAPP) showed that VCT services are seen by decision makers as a priority for the National AIDS Program. This is stated in the main policy document on HIV in the country – the National Strategic Plan of Action on HIV/AIDS, however, there is very limited funding available through the state budget for strengthening and expanding the VCT services. The interviewed officials assess the VCT service of Georgia as limited, because it is delivered only in Tbilisi, the capital city and in some major districts of Georgia.

The National Strategic Plan of Action on HIV/AIDS revision was completed in 2007. Based on WHO VCT guidelines, a draft VCT National guideline is being developed and will be approved by the end of 2008.

National HIV/AIDS Prevention Program
The National AIDS Prevention Program was established in 1994 and along with other activities, it included testing of MARPs on HIV infection. Since 2000, the National AIDS Center and program implementing partner organizations have been advocating for development of VCT capacity in all regions of the country. These facilities would be directly linked to the existing HIV/AIDS diagnostic labs operating throughout Georgia. Due to very limited funding provided for the NAPP, operation of VCT units through the governmental program has not been thought possible. The only institution providing VCT through NAPP is the National AIDS Center in Tbilisi.

International Support
The issue was considered during development of the country proposal for Global Fund to fight AIDS, TB and Malaria in 2003 that received 12 million from the fund. Establishment of up to 15 VCT units for MARP groups is envisaged through GFATM support by 2009.

USAID's project SHIP provided considerable support for the development of an effective VCT network for IDUs, FSWs and MSM in Tbilisi, Batumi and Kutaisi through offices of local NGOs Tanadgoma and Bemoni. Four VCT units are functioning because of the project.

However, many VCT units established through external support are not adequate and their geographic distribution is uneven. In addition, sustainability of those services is not guaranteed, due to limited funds available from local sources.

Access and use
VCT services are important as an entry point for prevention and care intervention for people with HIV/AIDS.

At the outset, VCT was primarily used for diagnosing infection in symptomatic people and to help medical management; testing was often accompanied by minimal counseling. Development of antiretroviral (ARV) treatment for people with HIV, less costly interventions to reduce the incidence of HIV-associated infections (such as tuberculosis preventive therapy, and cotrimoxazole prophylaxis), and relatively cheap

and feasible methods of preventing MTCT, have made the need to promote VCT for people with an asymptomatic form of the disease more compelling. VCT services for young people are also being developed, and services linked with family planning are becoming more widely available. Worldwide, VCT services have also been set up for vulnerable groups such as sex workers, prison populations, intravenous drug users, and refugees. These services need particularly careful monitoring to ensure that such groups are not further marginalized, and that services are truly voluntary and confidential (*WHO Guidelines for implementing HIV/AIDS counseling).*

As of 2007, there are a limited number of voluntary counseling and testing units/centers in Georgia (10) and their geographic distribution is uneven. More than 45 HIV testing sites do not have any counseling capacity. Relatively full standard VCT services are available in Tbilisi, Batumi, Zugdidi and Kutaisi. In addition, HIV VCT and HIV counseling without testing for youth is being provided at 4 sites.

As was mentioned above, there are few VCT units in the country and little information is available for the population, including MARP groups. Therefore, access remains an issue, especially considering the geographic asymmetry of service delivery. Counseling and testing of MARP groups (FSWs, IDUs, MSM, prisoners, TB patients, patients with viral hepatitis B and C, and IDPs) is provided within the National AIDS Prevention Program free of charge. Testing without counseling is also provided to pregnant women at Women's Health Centers supported by the State Agency of Health and Social Programs and the Rostrapovich Foundation (private donor organization). All other people must pay out-of-pocket, and the cost is about US$7 per VCT. This is approximately 70% of the average daily salary in Georgia.

Picture 3. VCT Center at the NAC in Tbilisi

Quality

Service delivery and quality differ considerably across service providers. Only five sites out of ten provide VCT meeting WHO guidelines (ensuring pre and post-test counseling for clients). The following VCT sites received the highest scores during their evaluation: VCT Center at the Tanadgoma office in Tbilisi and Batumi; and the VCT unit at the Public Union Bemoni in Tbilisi.

The research group observed that privacy issues were being addressed in most VCT units. All VCT units investigated, are for MARP groups only, with the exception of the National AIDS Centre, which provides counseling for the general population as well. All of them had a separate room where counselors on duty provided counseling services on an individual basis, but only three of the eight VCT sites had a convenient waiting area for clients. All sites ensured confidentiality, but not all of them informed clients that no personal information would be revealed to third parties.

Referrals and Linkage

Some strong links between counseling centers and HIV testing sites (HIV diagnostic labs) and STI sites exist. In particular, voluntary counseling centers and units collect blood samples and send them for testing to HIV diagnostic labs. The labs provide test results back to the centers. Links with other service providers (IDU clinics, reproductive health centers, self-support centers of PLHA, etc) are all in an infantile stage of development. VCT units receive referrals from STI and IDU clinics, harm-reduction programs and medical facilities. In addition, Tanadgoma and the AIDS Center do outreach counseling for MARP groups (FSWs, MSM, Prisoners, IDUs). However, there are no links between VCT centers and MH services. HIV positive people identified at the VCT centers, contact support foundations and none of them addressed MH services for psychological support.

Testing

HIV blood tests are done by rapid simple or ELISA tests. In regions, AIDS tests are mostly performed by rapid tests. Quality control is provided by the National AIDS Centre through the National AIDS Prevention and National Safe Blood program in the form of period site visits and evaluation of lab performance. The results of testing are available within one week if the lab performs ELISA testing and the same day or day after in case of rapid testing.

Those operating VCT units observed which target Most at Risk Population groups, including IDUs, FSWs and MSM, require additional qualification and skills for counselors. The majority of staff working at those centers meets these criteria.

Client satisfaction

To evaluate client satisfaction, 23 clients completed the questionnaire (Batumi, Zugdidi, Tbilisi; June-July, 2006). The study assessed the following issues:

- Duration of pre- and post-test counseling sessions;
- Reasons for attending the VCT units;
- High-risk behavior and assessment of client's personal risk for HIV infection;
- Confidentiality issues;
- Support available for HIV-positive people;
- Adopting safer behavior;
- Discussion of routes of HIV transmission
- Information regarding the testing methodology and possible results;
- Counselor's responses to client's questions and attitude towards the client;
- Would he/she like to get counseling support from the same counselor again?
- Would he/she recommend the counselor to friends or relatives or promote the VCT unit among his/her peers?

The study revealed that the quality of counseling delivered in general is not considered adequate; in particular, the sessions are seen as too short and lacking in correct usage of medical terminology. Pre-test counseling delivered at most VCT sites is somewhat satisfactory, but there remain VCT units where no counseling was offered.

Implementation of post-test counseling is especially weak. In many cases, patients observed or interviewed received inadequate post-test counseling (63%, N=23) or did not receive post-test counseling at all (25%, N=23).

The interviews identified two groups of clients regarding the level of satisfaction with VCT. One group (6 out of 23), consisted of clients who gave negative evaluations of counselors; they cited the counselors' lack of devotion, knowledge and skills as reasons for such negative feedback.

The second group (17 out of 23) gave it a score of at least 8 out of 10. This group was happy with the pre- and post-test counseling sessions, and in majority of cases (2/3), the pre- and post-test counseling was provided by the same counselors. In most cases (2/3), counselors discussed the confidentiality issues with clients. Most (83%) clients received complete information about HIV transmission routes and a personal risk assessment.

More than two thirds of the 23 clients surveyed would recommend the center for counseling to their friends and relatives, although 5% did not answer the question. 12% said that would not promote the center among their peers.

Guidelines and Protocols

Two VCT guidelines are available in Georgian language. The Save the Children Federation prepared one manual; the National AIDS Centre prepared the other. Both manuals are adapted versions of the WHO VCT guideline. The guidelines are very useful in addressing all potential issues of HIV VCT.

NGO Tanadgoma, National AIDS Centre, and Public Union Bemoni, all developed training courses on VCT and provide in-service training for newly recruited counselors. The VCT trainers would be the best professionals for supervision of the VCT counselors at the centers throughout the country.

Staff Training and Corresponding Needs

To evaluate HIV VCT counselor satisfaction and needs, the research team interviewed 15 consultants from different VCT centers.

The average career as a counselor in Georgia is 5.7 years. Nobody participating in the study exceeded 21 years on the job and everyone stayed for at least one year. On average, the counselors worked 2.8 hours per day (full and part time position together) for counseling with a maximum of 7 hours per day, depending on whether their job was part-time or full-time. Because counseling is not limited to HIV/AIDS, they spend 20 to 45 percent of their daily working hours on HIV VCT, 20 to 40 percent on other STIs, and 35 to 80 percent on other tasks.

The counselors interviewed had all completed at least one training on VCT organized by Save the Children International Federation within the SHIP project supported by USAID or organized by the World Health Organization (WHO).

The trainings were interactive, involving role-playing games, practical tasks, a video recording of role-playing games, and discussions. *Some weaknesses in the training reported were* trainers' inadequate communication skills and their poor responses to questions and no opportunity to provide feedback. Others indicated that the training session was too short to cover all materials needed.

The VCT counselors identified areas they need additional training in: counseling patients with co-morbid diagnoses (HIV/AIDS and mental health); stigma and discrimination; patient interviewing; counseling family members; diseases associated with HIV infection.

Support and Supervision:
Seven counselors reported that they attended voluntary support meetings organized by themselves on an irregular basis. These professionals feel it is beneficial to share their experiences, knowledge, and VCT recommendations. Eight counselors said they would gladly take part in these support meetings and that sharing experiences would improve the quality of their counseling sessions. Additionally, those interviewed felt that by having the chance to discuss their jobs amongst peers, career burnout is less likely to occur..

Only six our of fifteen counselors have a supervisor—an experienced colleague who provides technical support and supervision on a regular basis. The nine others work without any supervision. The majority of counselors reported that they were satisfied with their job, and considered it very interesting and important. Three counselors reported feeling "frequently" emotionally drained, seven said they felt this way "occasionally" and five claimed that they "never" feel emotionally drained. Nine people evaluated their job as frequently stressful, four called it is stressful sometimes, and two reported never feeling stressed at work.

Sharing experiences for VCT staff is useful for adopting best practices. Development of an effective burnout-prevention strategy for counselors by administrators is critical. In addition, there is a need for regular supervision, monitoring and evaluation of counselors and VCTs, for implementation of WHO guidelines.

VII. Mental Health Problems of PLHIV in Prisons

The study focused on identification of co-morbid mental illness among people living with HIV as well as on the examination of legal, policy and organizational structure of the services available for them in the country.

Healthcare for PLHIV is extremely poor in Georgian prisons. NAC physicians visit PLHIV in prisons but they cannot provide regular monitoring of their health. PLHIV have access to counseling in a few prisons- mostly those in Tbilisi where NGO Tanadgoma provides counseling. Severe MH problems like suicidal thought never receive appropriate attention from healthcare professionals. Families are usually responsible for providing most psychological support to prisoners. According to HIV positive individuals interviewed, PLHIV in prisons of Georgia do not feel discriminated against by their peers. For many of them, their primary way to cope with the disease is revealing their status to others. Those interviewed stressed that PLHIV in the prisons of Georgia do not have access to adequate medical services and this must change.

According to data from the National AIDS Center done on March 20, 2008, 61 HIV infected prisoners have served sentences in Georgian prisons.

Compared to worldwide statistics of HIV infected prisoners the numbers in Georgia do not seem significant, but the study revealed factors facilitating HIV transmission and high-risk behavior among prisoners in Georgia. Based on this, HIV infection could be expected to spread quickly within the penitentiary institutions, unless effective preventive measures are undertaken.
Diagram I demonstrates the breakdown of prisoners according to risk groups in penitentiary system of Georgia.

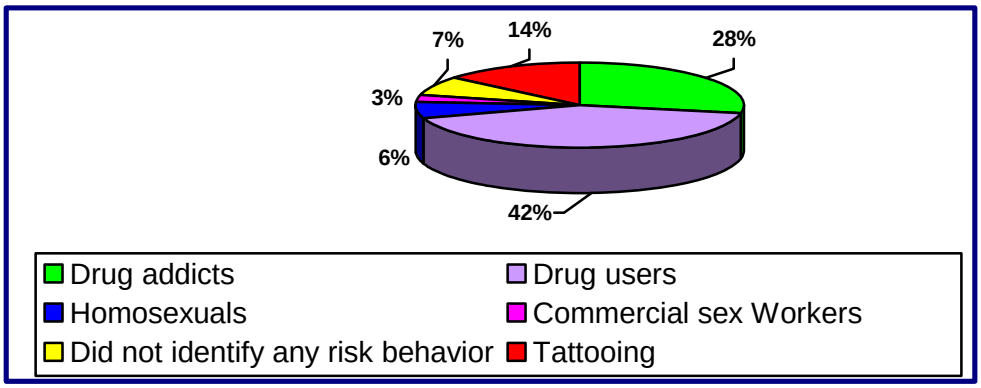


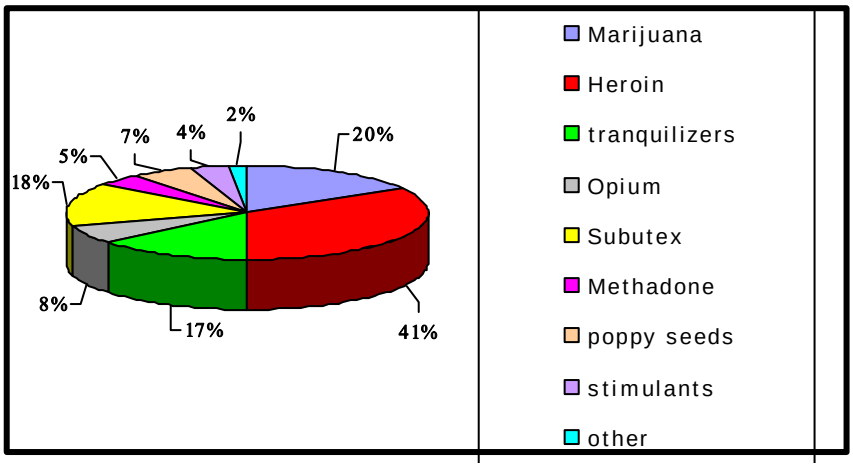
Diagram 1. Prevalence of risky Behavior in prisoners, National AIDS Centre, 2005

Intravenous drug use is especially remarkable among high-risk behavior in the penitentiary system. The number of prisoners in penal institutions sentenced for sale, possession, distribution or drug use is not very high – 7-9%.

23% of the respondents did not report drug use in prisons, while a majority of prisoners admitted that small amounts of drugs are available in prisons; they also confessed that they occasionally used drug. Simultaneously they mentioned that they used drugs

before detention and about 40% of IDU prisoners continued their drug use in prisons. About 25% of prisoners admitted that they started to use drugs after going to prison[7]. According to those interviewed, the main narcotics used are opioids (Diagram 2) and the leading method of use is injection.

Diagram 2. Drugs used by sentenced individuals and prisoners, National AIDS Center, 2005



Since sterile and/or disposable injection devices are not readily available in prisons, prisoners usually use non-sterile, shared syringes and containers for preparation of drugs.

Mental health problems and coping strategies for PLHIV in Prisons of Georgia
Mental health problems for PLHIV in prisons were investigated through in-depth interviews. All 11 PLHIV found in 16 prisons were interviewed. Some food and means of personal hygiene was provided to PLHIV in prisons as an incentive to partake in the research.

This study revealed that the spectrum of problems present for prisoners with HIV is much more diverse. The majority of prisoners who participated in this research have personality disorders. Some of them have cognitive disorders as well, especially those who had AIDS before entering prison. All PLHIV in prisons reported depression. One of the prisoners interviewed was paranoiac; he believed that his infection was a result of an act of personal revenge (male, 34 years old, Batumi prison). All HIV positive prisoners reported mood changes. They became explosive and unpredictable. Although, one of the prisoners thinks that after learning about his HIV infection, he became quieter and more stable, this in fact could be a manifestation of mild depression. Almost all interviewed reported having sleeping disorders and anxiety. Three out of eleven reported loosing hope and a fear of death:

> *"I will not be able to leave this prison alive"*
> – Male, 37 years old, Batumi prison.

[7] M. Tsintsadze,"Study of HIV/AIDS Prevalence and high risk behavior in penitentiary system of Georgia, 2006;

Physicians of the AIDS center confirmed that PLHIV in prisons have greater need for psychological assistance:

> "*Depression is followed by anxiety among PLHIV in prisons, then again depression… and the problems never ends"*
>
> Female physician , 35 years old, Tbilisi

Co-infections with hepatitis B and C are common among PLHIV in prisons, some of them have TB also, therefore, they have complaints related to liver inflammation, weight loss, high temperatures, etc. Physical health problems farther complicate their mental health problems.

Their first reaction to HIV positive diagnoses seems to be sharper among those PLHIV who learned about the disease in prisons. This is attributed to other coexisting negative factors, like loss of freedom, poor health and hygienic conditions in prison cells, worrying about families, worrying about the future, etc.

For some of them, learning about their HIV infection was so shocking that they could not listen to the counselor. Two of them reported psychomotor anxiety also:

> *"I was yelling and screaming, but I don't remember what"*
>
> Male PLHIV, 42 years old, Prison in Tbilisi

Two PLHIV interviewed attempted suicide- although, it is difficult to say if this manifested only because of their HIV status. Both of these prisoners had borderline personality disorder that presumably existed before HIV diagnosis. We can suppose that their preexisting problematic mental health status could cause specific high-risk behaviors. Hence, in time, psychological treatment/consultations could decrease the possibility of risky behavior.

There is no professional mental health assistance available in prisons for inmates, including PLHIV. In such an environment, PLHIV seek alternative options for psychosocial support. For many of them, their major disease coping strategy was informing others of their status. Seven out of eleven people decided to inform their family members and had support from them. Two prisoners informed everybody they knew and would like to tell others also:

> *"I have nothing to hide; I want everybody to know that I am HIV positive."*
>
> Male, 42 years old, Tbilisi prison.

According to the interviewed PLHIV, there is more security when other prisoners know about their HIV positive status than if they tried to hide it and somebody accidentally learned that they have HIV. Other prisoners appreciate being informed and show very friendly attitudes towards them:

> *"Other prisoners often share food with me."*
>
> Male PLHIV , 47 years old, Tbilisi Prison

"When my cell-mates do something or play something they always ask me to participate."

Male, 37 years old, Batumi Prison

However, PLHIV would prefer to share cells with other HIV positive prisoners and have peer support. Staying in one cell together would provide them with the opportunity to take care of each other better:

"If HIV infected people could be placed together in prisons, it will be good. We know each others' problems better and will be able to help each other without any fear of being infected."

Male, 42 years old, Tbilisi prison

Support received from families is particularly important for PLHIV in prisons because not only their mental health but, in many cases, their lives depend on the assistance they received from families:

"If not for my family I would be dead already. They support me in every way, financially and mentally".

Male PLHIV, 37 years old, Batumi prison

Physicians of the AIDS Center provide another key support group for PLHIV in prisons. Many of these doctors are the only ones prisoners see for several months. Although, HIV positive prisoners in Tbilisi have regular contact and access to counseling by physicians from the National AIDS Center, HIV positive inmates in other prisons have very limited access to such valuable assistance. PLHIV in prisons report feeling worried about their health status. They believe they are in urgent need of consultation, lab and clinical diagnostic and treatment services that must be available for PLHIV in the penitentiary system.

Picture 4. Prison in Batumi

VIII. Conclusions

- Officials in the current healthcare system of Georgia do not recognize the need for psychosocial services for PLHIV. There are no governmental policies, documents, or programs, which address the link between HIV and MH issues. Georgian legislation addresses both issues separately, but no guidelines exist which would regulate referrals between the two (MH and HIV) spheres.

- PLHIV have a number of common mental health problems, even though they manifest in different ways and to different extents in the three groups analyzed (non IDU PLHIV, IDU PLHIV, and PLHIV in prisons). The mental health problems reported most frequently are depression, personality disorders, and sleeping disorders. The prevalence of each varies according to PLHIV groups. Non IDU PLHIV reported being depressed more frequently, while IDU PLHIV reported explosiveness/irritability as the most common manifestation of their mental health troubles.

- Mental health issues are more frequently reported among PLHIV in the penitentiary system. At the same time, they have less access to MH and HIV/AIDS diagnostic and treatment services than PLHIV outside of prisons. Some serious mental health problems were observed in PLHIV in prisons, like personality and/or cognitive disorders, paranoia, depression with suicidal intentions, but these problems cannot only be attributed to only their HIV positive status.

- Family members and friends indicated a need for psychological assistance among PLHIV and the family members, especially when they first learn about an HIV positive status.

- The main burden for psychological support is taken on by the physicians of the National AIDS Center and consultants from self supported centers of HIV Patients' Support Foundation, who are not trained in psychological counseling;

- Mental health specialists have little knowledge about the problems specific to patients with HIV/AIDS. NGOs operating in MH field are not involved in service provision for PLHIV, although, leaders of those organizations express readiness to work on MH issues of AIDS patients and to cooperate with HIV/AIDS healthcare services;

- International organizations that are actively involved in other areas of HIV/AIDS are not participating in the provision of mental healthcare services to PLHIV or in the development of capacity at the local institutions in Georgia, except for GIP;

- There are no official institutional training courses developed and delivered to mental healthcare or HIV/AIDS specialists on psychiatric and mental health issues and management of HIV/AIDS patients.

- The number of VCT units in the country is limited (9) and geographical coverage is uneven.

- Service delivery and quality differs considerably across service providers and has to be improved. Only five sites provide VCT according to WHO guidelines (ensuring pre- and post-test counseling for clients).

- The National Policy on HIV/AIDS and a corresponding strategic plan was approved at the end of 2007. Although the plan does not have a separate chapter on VCT, VCT is included in all strategy papers for HIV-prevention that targets various high-risk behavior groups.

- The counselors reported experiencing symptoms of burnout, but had no coping mechanism in place. They are interested in having regular meetings to share experiences and gain knowledge and counseling skills.

- According to the clients' reports—especially those from marginalized groups (MSM, CSW, etc.)—the most important issue is the friendly and respectful manner of the VCT service they receive. Some clients were not satisfied with the counseling, and they pointed to the lack of knowledge and skills (especially communication skills) of their counselors.

- All of the counselors have been trained in VCT, and some of them completed additional training. Although, it was a 3-4 day training course and some counselors were not happy with the trainers who delivered the VCT training. Two VCT guidelines are available in Georgian language.

- There is need for regular monitoring of the VCTs, with emphasis on assessment of the implementation of WHO guidelines by counselors.

- The lack of knowledge among HCW and young people results in negative attitudes towards PLHIV. PLHIV have emphasized the problem of HIV related stigma and discrimination in the country. Access to medical services is very poor if seeking assistance outside the AIDS Center. Some physicians refuse to assist PLHIV. Because of fear of discrimination, PLHIV disclose their status only to their family members or closest friends, because their attitudes towards them remain positive. The most prevalent feelings expressed by young people and HCWs towards PLHIV was fear and pity. However, about one fifth of them have anger towards PLHIV.

- The educational activities conducted since 1994 by the AIDS Centre and the few HIV/AIDS-related NGOs have not been sufficient to bring adequate HIV/AIDS knowledge to Georgian young people and healthcare workers.

- None of the PLHIV who participated in the study report ever being subjected to physical violence. However, some of them, especially in the regions, recall such cases happening to other HIV positive people.

- PLHIV feel support through contact with each other through the HIV/AIDS Patients Support Foundation Offices. They highly value joint meetings and discussions regarding their emotional status and common needs (social and legal protection); meetings empower them to overcome their fear of discrimination and disclose their status.

- PLHIV see raising public awareness as the most effective strategy for the reduction of HIV/AIDS related stigma and discrimination. Although, they would like to ensure that the messages spread by the media are professionally formulated and do not violate the principle to "do no harm".

- HCWs are aware of basic facts regarding HIV/AIDS but lack the skills and experience working with PLHIV. Universal precautions seem are not always applied. HCWs therefore unnecessarily fear becoming infected when treating PLHIV. This further contributes to the stigma towards PLHIV.

IX. Recommendations to enhance mental health well being of PLHA

For Policymakers

- Needs of PLHIV for psychosocial assistance should be considered during the elaboration of all HIV/AIDS related policy and strategy documents;
- The national health and social policies should ensure that PLHIV have guaranteed access to healthcare services, including counseling at the central and regional levels;
- The national legislation and policies should guarantee that PLHIV's rights and freedoms will not be violated;
- Healthcare policies should address the issue of MH and HIV/AIDS services in the penitentiary system of Georgia to ensure that the PLHIV have access to adequate medical services in prisons

For Government

- A special plan of action should be created to guarantee that PLHIV have access to quality counseling and psychiatric healthcare in the country through structural and referral service organization changes. Funding for the action plan should be identified and regional asymmetry in the service delivery should be considered;

- The government must ensure access to services and address the uneven geographic distribution of counseling and treatment facilities;

- Mental healthcare guidelines and standards for PLHIV should be elaborated;

- Medical schools and continuous medical education programmes should develop training manuals and provide training to increase knowledge of those working with PLHIV on mental healthcare;

- All medical personnel involved in the care and treatment of PLHIV should be trained in mental healthcare;

For National AIDS programme managers

- National AIDS programme managers should advocate for recognition of the importance of psychosocial assistance needs for PLHIV. Programs should include all supported services at every service point.

- The program managers should ensure that psychosocial assistance is provided by trained personnel with good understanding of mental health and HIV/AIDS using MAIDS training center's resources;

- Through advocacy activities with officials of the MoLHSA, the National AIDS Program managers should take steps to ensure that PLHIV have adequate access to quality services .

- HIV counseling capacity should be developed in prisons to provide access to correct information and promote healthy behavior among prisoners.

For MAIDS Project Staff

- The MAIDS program personnel should consider the problems of PLHIV indicated in the study and target HIV/AIDS policy makers and program managers as well as potential treatment and caregivers of PLHIV with awareness raising, advocacy and training interventions;

- MAIDS trainers should promote trainings of all people who provide and should provide counseling to PLHIV on HIV/AIDS mental health issues;

- MAIDS should expand its interest targets to family members and friends of PLHIV as the most common care and support givers of HIV positive persons;

- MAIDS should intensify their advocacy of psychosocial assistance to PLHIV at every service point through meetings with key decision makers and empowering PLHIV to demand such services.

- GIP should advocate for the expansion of methadone substitution treatment programs for IDUs in general and guaranteed access to it for HIV positive IDUs, as well as for VCT service provision for prisoners.

- MAIDS should work with physicians to minimize the fear of serving PLHIV by increasing their HIV and the universal precautions knowledge and help them to acquire the needed skills

- MAIDS should establish links with religious organizations to ensure adequate understanding by church of mental health problems of PLHIV; MAIDS trainers could organize training seminars for priests to increase awareness regarding the problem;

- MAIDS should target the mass media to promote accurate and non discriminatory information dissemination regarding HIV/AIDS and PLHIV in the country; it should work closely with journalists providing relevant training and advocating the running of a PLHIV support information campaign in the mass media

- MAIDS should apply the findings of their research project to conduct further investigations into gaps in government and nongovernmental organizations' capacity in the HIV and mental healthcare fields and tailor project training modules to the population's actual needs.

For Service Providers

The main burden for psychological support should be redistributed to other institutions: healthcare providers, primary healthcare physicians, VCT counselors, physicians working at MH care facilities after relevant education and skills building.

- Institutions providing care and treatment services to PLHIV should provide psychological services as well;

- MH and AIDS treatment facilities should ensure continuous training of personnel involved in the care and treatment of PLHIV, in providing mental healthcare to HIV positive patients;

- Staff that provides counseling to PLHIV should take into account the specifics of the health, mental, and social problems they face and take extra precautions regarding the psychosocial conditions of PLHIV and confidentiality issues;

For local NGOs and CBOs

- Psychosocial assistance must be a component for any services targeting PLHIV;

- The network of self-support centers for PLHIV should be expanded and their psychological counseling capacity should be strengthened through relevant training;

- The centers should work on enhancing peer support for PLHIV.

- Advocacy should be enhanced to increase interest among NGOs and CBOs in delivering mental health assistance to PLHIV;

- NGOs and CBOs should improve their networking and identify capacity gaps to address mental health issues in PLHIV;

- Effective anti-stigma campaigns should be implemented to improve the public's attitude towards patients with HIV/AIDS and mental disorders.

- Family members of PLHIV should have access to psychological assistance also. The possibilities for the operation of an AIDS psychological assistance hot line should also be considered.

For International organizations

- International organizations active in the field of HIV/AIDS and mental health should consider PLHIV's needs for psychosocial assistance during the planning, implementing and monitoring of their programs;

- They should collaborate with national and local organizations, working with PLHIV through participation in existing official and non-official coordination mechanisms (CCM, PTF, etc.)

- International organizations should provide technical assistance and capacity building support to ensure that personnel working with PLHIV are knowledgeable, skilled, and motivated to work with HIV positive people.

- HIV/AIDS related stigma is very strong in Georgia. Physicians and psychologists working with PLHIV must avoid further harming PLHIV and their families.

- Medical personnel working with PLHIV should continue advocating and raising awareness to reduce stigma associated with HIV/AIDS.

- Recommendations for additional study:
- Comparison study of mental health problems of PLHIV at early and advanced stages of infection;
- Influence of HAART on mental health of PLHIV;
- Mental health problems in HIV positive children and their parents;

- Possible approaches for programs or for further research

This research revealed a need for psychosocial counseling for PLHIV and their family members. Access to such services is poor in Georgia, therefore, the research team has advocated opening a hot line and providing face-to-face psychological counseling services for PLHIV. Two leading NGOs in the field of HIV/AIDS – Bemoni and Tanadgoma - have applied and received a grant from the Euro Commission to provide psychosocial assistance to PLHIV. This pilot project will lay the base to expand psychosocial services for PLHIV.

Coordination and integration of psychosocial assistance programmes into other services for PLHIV are needed in the country.

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XI Appendices

Appendix 1.

Matrix for HIV/AIDS and MH Stakeholders' Analysis

Prioritization of Stakeholders
For the purpose of identifying potential partners and supporting organizations among stakeholders, the MAIDS research team prioritized them based on the following criteria:[8]

Criteria of 'power' have been defined as following:

- ✓ Influence or authority arising from elevated position
- ✓ Quality of performance and experience
- ✓ Large financial, logistical, and human resources
- ✓ Positive image and high reputation at national and/or international levels
- ✓ Acknowledged ascendancy in the country
- ✓ Possibility to affect political decisions in HIV/AIDS and/or mental health

Criteria of 'interest' have been defined as the following:

- ✓ The project relevancy to the mission and objectives of stakeholder
- ✓ Acknowledgement of importance of mental health aspects of HIV/AIDS
- ✓ Awareness of benefits of the project implementation
- ✓ Demonstrated interest in special activities within the project
- ✓ Declared wish to establish mutual cooperation with MAIDS Expert Center

According to the power and interest revealed in the stakeholders, they have been categorized in the following groups:

High powered, interested stakeholders:
These organizations should be fully engaged in project development as potential partners

High powered, less interested stakeholders:
These organizations should be satisfied with the project development.

Low powered, interested stakeholders:
The organizations that should be adequately informed to be engaged in the project as beneficiaries.

Low powered, less interested stakeholders:
These organizations can be regarded as potential partners as well.

[8] The criteria have been developed and shared by the colleagues from MAIDS Project in Azerbaijan

Appendix 2
Questionnaires used

Tool 1. HIV/AIDS Knowledge, Attitude and Practice Survey Questionnaire

Adapted from the UNAIDS HIV/AIDS Knowledge, Attitude and Practice Survey Tool 2006

1. Knowledge about HIV/AIDS

- Having one healthy sexual partner prevents HIV infection;
- Condom use during every sexual encounter reduces the risk of getting HIV;
- An HIV-positive person may look healthy;
- HIV can be transmitted through kissing an HIV-positive person;
- HIV can be transmitted through shaking a hand with an HIV-positive person;
- A person can get HIV by sharing a meal with an HIV-positive person

2. Stigma and discrimination issues

- I will take care a family member if he/she contracts HIV;
- I would buy fruit and vegetables from an HIV-positive salesperson.
- An HIV-positive person can work as a teacher at a school
- If one of my family members were HIV-positive, I would keep it a secret.
- I would feel comfortable if my children had HIV-positive classmates at school.
- I wouldn't mind having an HIV-positive co-worker.
- I wouldn't mind putting on a nice sweater that belonged to an HIV positive person after washing it.
- I would feel comfortable eating at the house of a person who is HIV positive.
- People with AIDS should be isolated
- The names of people living with HIV/AIDS should be stated openly so that others can avoid contact with them
- Women who are pregnant should be required to be tested on HIV in order to protect the health of their unborn baby.
- Most people with AIDS don't care if they infect other people with HIV.
- People who got HIV through sex or drug use are being punished for their bad behaviour.
- All high risk populations (IDUs, MSM, FSWs and others) should be periodically tested for HIV

3. Feelings toward HIV positives

I feel the following towards people who have AIDS are:

- Anger
- Fear
- Sadness
- Disgust
- Sympathy

Appendix 3

Interview guide

Tool for individual interviews with medical personnel treating PLHIV

Introduction
Aim of the study
Confidentiality

PLHIV diagnostic and treatment:
How long have you managed HIV/AIDS patients?
How many do you manage now?

MH problems:
How would you evaluate the MH of your patients?
What kind of MH problems have you observed in PLHIV?
What was your reaction/follow up to these problems?
How can you describe the dynamics of MH problems in PLHIV?
How can you describe the current needs of PLHIV?

Services:
What kind of services do you provide to PLHIV?
What kind of services do PLHIV receive regarding MH problems?
What kind of referral system is in place at your institution regarding the MH problems of PLHIV?
Do you think that the current service is effective?
What you would improve/change in the current system of management for PLHIV?
Do you think that PLHIV are satisfied with the services they receive?
What other health services do you think PLHIV need?

Tool for individual interviews with PLHIV in prisons

Introduction
Aim of the study
Confidentiality

HIV testing and counseling:
How long have you known about your HIV positive status?
What was the route of your infection, if you know?
Did you receive counseling (pre and post counseling) for your HIV infection?
If yes, was counseling effective?
Who, and which institution provided counseling to you?

MH problems:
Have you had any psychological problems?
Do you think you have this kind of problem now? If yes, what kind of problem do you have?
What was your reaction to your HIV diagnosis?
How did you cope with the diagnosis?
Has your perception of being a PLHIV changed over time? If yes, in what ways?

Services
Do you have access to health services? If yes, please tell us what kind of services you receive.
Do you have access to counseling in prison?
Do you have access to treatment in prison?

How often do you see a doctor in prison?
How would you evaluate healthcare in prisons?
What you would improve/change in the current system of management of PLHIV in prisons?
What other support do you need?

Factors influencing MH of PLHIV
What/who supports you in prison?
What disturbs you as an HIV infected person?
Have you ever been discriminated against due to having HIV in prison?
How would you describe the attitudes of other prisoners towards you?

Appendix 4
Tools for Focus Group Discussions

Tool for FGD with PLHIV on HIV/AIDS related stigma and discrimination

The questionnaire developed by the Georgian team of researchers of MAIDS project includes an introduction, warm-up questions and questions related to HIV stigma and discrimination.

Introduction
Aim of the FGD
Assurance of Confidentiality

Warm-up question
Questions related to stigma and discrimination:

- Could you tell us what stigma and discrimination mean to you?
- Does anybody know about your HIV-positive status? If yes, to who have you disclosed your status?
- Have you ever felt discriminated against because you have HIV?
- How often do you hear people say that HIV is a disease of commercial sex workers, intravenous drug users or MSM?
- In your opinion, who can get HIV?
- What was the route of your infection?
- Do you think that the route of your infection may influence the stigma and discrimination you face?
- What in your opinion is the reason for HIV-related stigma?
- How do people react when they learn about your positive status?
- Do people around you, such as your colleagues at work, know about your infection? If yes, what was their reaction?
- What prevents you from disclosing your status?
- Does your sexual partner know about your HIV-positive status?
- (If the respondent is an IDU) Do your fellow IDUs (with whom you may share needles) know about your HIV status?
- Can you recall any case of abuse that you or your family have experienced because of your HIV?
- Do you have contact with other PLHIV? Why or why not?
- What can be done to combat HIV/AIDS-related stigma and discrimination against PLHIV?

Tool for Focus Group Discussion with Medical Personnel

A warming up/introductory question

1. What is the risk of getting an HIV infection?
2. Do you think that medical personnel can become infected with HIV? If yes, in what way?
3. Could you define the terms stigma and discrimination?
4. What do you know about discrimination against HIV positive people? What do you think is a reason behind such attitudes/actions?
5. How did you react when you were approached for treatment by an HIV positive patient?
6. Suppose you had a patient you didn't know was HIV-positive. What could be the cause of you being unaware of the patient's HIV status?
7. To whom do you think medical personnel have the right to disclose information about a patient's HIV status?
8. In your opinion, where should HIV-positive patients receive medical care?
    a. at any medical institution
    b. at specialized medical institutions;
    c. at nowhere
9. When providing medical care, what would you define as discrimination against an HIV-positive individual?
10. What are the minimal safety conditions you would like to have at your medical institution to provide care for HIV positive patients so that you would not fear being infected?
11. What governmental- or donor-supported programs do you know that cover treatment and care for people living with HIV/AIDS in Georgia?
12. Please, comment on the law on HIV/AIDS prevention. How does it protect the rights of medical personnel treating PLHIV?
13. What recommendations would you give to HIV-positive medical personnel given the nature of their job?
14. In your opinion, what should be done to reduce HIV associated stigma and discrimination?

Tool for Focus Group Discussion with PLHIV (non IDU and IDU PLHIV)

Introduction
Aim of the FGD
Confidentiality
Introduction of participants

Warm-up questions:
What do you know about the HIV situation in the country?

MH problems:
How did you feel when you learned you are HIV positive?
How do you feel now?
- feelings/emotion
- thoughts (suicide thoughts)
- actions (suicide attempt)

What changes did you notice in your personality since you learned about your status?
How can you describe you current needs?

Outcomes:
Spectrum of MH problems common for PLHIV

Dynamics/phases of MH problems of PLHIV
Personal reactions of PLHIV to HIV/AIDS diagnosis and disease progression

Factors influencing MH of PLHIV:
What / who supported you?
What / who supports you now?
What / who could have been supportive for you?
What / who can be supportive for you? (Physically, socially)
What / who disturbed you, what kind of negative factors can you remember?
What / who disturbs you now?

Service
What kind of services/support have you received as PLHIV?
What did you like and what did you not like in services received?
How can you describe the service/support you would like to have?
What kind of other help/support do you have or would you like to have?

Appendix 5

Distribution of Participants in different Cities of Georgia to determine Stigma and Discrimination Level

Table No 1

Numbers of respondents (18-25 years old) interviewed	
Cities	# of Participants
Tbilisi	150
Zugdidi	70
Kutaisi	70
Akhaltsikhe	30
Telavi	30
Total	350

Table No 2

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Number of healthcare workers interviewed by cities

City	# participants
Tbilisi	60
Zugdidi	40
Kutaisi	40
Akhaltsikhe	15
Telavi	15
Total	170