



National AIDS Strategy for Montenegro 2010 to 2014

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PREFACE

To be added by Minister of Health, Labour and Social Welfare

Acronyms

AIDS	Acquired immuno-deficiency syndrome
ART	Anti-retroviral therapy
ARV	Anti-retroviral
BBS	Behavioural Bio-marker Surveillance
BCC	Behavioural change communication
BiH	Bosnia and Herzegovina
BTS	Blood Transfusion Service
CCM	Country Coordination Mechanism
CIDA	Canadian International Development Agency
CPHA	Canadian Public Health Association
DFID	Department for International Development, United Kingdom
EU	European Union
FSW	Female sex worker
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human immuno-deficiency virus
HPV	Human papilloma virus
HPVPI	HIV prevention among vulnerable populations initiative
IDC	Infectious Diseases Clinic
IDP	Internally displaced person
IDU	Injecting drug user
IPH	Institute of Public Health
KAPB	Knowledge, attitude, behaviour and practice
LSBE	Life skills based education
MARA	Most at-risk adolescents (for HIV)
MARPs	Most at-risk populations (for HIV)
M&E	Monitoring and evaluation
MMT	Methadone maintenance therapy
MoHLSW	Ministry of Health, Labour and Social Welfare
Mol	Ministry of Interior
MoJ	Ministry of Justice
MSM	Men who have sex with men
NAC	National AIDS Commission
NGO	Non governmental organisation
NHIF	National Health Insurance Fund
NHIS	National Health Information System
NSEP	Needle and syringe exchange programme
OI	Opportunistic infection

PEP	Post exposure prophylaxis (for HIV)
PHC	Primary health care
PMTCT	Prevention of mother to child transmission (of HIV)
PLHIV	People living with HIV
PRSP	Poverty Reduction Strategy Paper
RAE	Roma, Ashkali and Egyptian
RAR	Rapid assessment and response
SGBV	Sexual and gender based violence
SGS	Second generation surveillance
SIDA	Swedish International Development Agency
STI	Sexually transmitted infection
SW	Sex worker
TB	Tuberculosis
UN	United Nations
UNAIDS	United Nations joint programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session (on HIV)
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
UNTG	United Nations Theme Group (on AIDS)
VCT	Voluntary counselling and testing (for HIV)
WHO	World Health Organisation
YFHS	Youth Friendly Health Services

Summary

Montenegro introduced an AIDS programme in 1985 as part of the programme of the Former Republic of Yugoslavia, four years before the first HIV infection was identified in Montenegro. Since 1987, special attention has been paid to ensure safe blood and blood products. A National AIDS Committee (NAC) was established in 2001 under the auspices of the Ministry of Health, Labour and Social Welfare (MoHLSW) to provide overall coordination of a multi-sectoral response. There is political will to address AIDS comprehensively and in accordance with the United Nations Joint Programme on AIDS (UNAIDS) guidelines.

Although current infection rates appear to be low (Montenegro is a low prevalence country with an estimated HIV prevalence of 0.01%), regional trends suggest the very real potential for a rapid spread of HIV unless prevention efforts are scaled up amongst the key target groups. According to data released by the Institute for Public Health (IPH) the cumulative number of people registered with HIV or AIDS by the end of 2008 was 89, of whom 47 had developed AIDS and 29 died. This represents an increase of 65%: 35 persons registered with HIV over the five years since the development of the Montenegrin Strategy for HIV and AIDS (2005 to 2009). However, the IPH estimated that 388 (range 300 to 500) people were living with HIV at the end of 2008. The main mode of transmission is sexual (81%) - 49% heterosexual and 32% bi-homosexual transmission. Injecting drug use has contributed to 4% of HIV transmission amongst persons registered with HIV. In recent years, most of the newly registered people living with HIV have been men who have sex with men. Males are four times more likely than females to be registered with HIV (79%) and over three quarters of people living with HIV (77.5%) are under age 40 years. Only one injecting drug user has been registered with HIV since 2007, although significant numbers of them continue to engage in HIV risk behaviour.

The *National AIDS strategy for the period 2005 to 2009* provided a sound foundation for HIV prevention - with a specific focus on most-at risk populations and blood safety - and improved diagnosis, treatment and care for people living with HIV. The Ministry of Health and Social Welfare has been responsible for overall coordination of the response and implementation of activities within the health sector. Other key ministries have been Education, Interior, Justice and Tourism. Non-governmental organisations (NGOs) have been critical in reaching injecting drug users, sex workers and men who have sex with men and in providing young people with HIV information and condoms.

Support received from the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) in 2006 has accelerated the activities already undertaken by government and NGOs with support from international partners such as Canadian Public Health Association (CPHA), Canadian International Development Agency (CIDA), the United Kingdom Department for International Development (DFID), the Swedish International Development Agency (SIDA), the United Nations Development Programme (UNDP), the United Nations High Commission for Refugees (UNHCR) and the United Nations Children's Fund (UNICEF).

These efforts appear to be having an effect: numerous national HIV prevention and AIDS treatment guidelines and protocols have been developed, laws and policies have been revised or new ones introduced, key target groups have been reached by HIV prevention information, commodities and treatment services, capacity of health care providers, prison staff, peer educators, youth and NGOs has been built, and government capacity has been strengthened in monitoring and evaluation, including biological behavioural surveillance. The creation of the Country Coordinating Mechanism (CCM) has also contributed to a more coordinated response.

These successes must be sustained and the national response intensified to enable universal access to critical HIV prevention and treatment interventions. There is also need to address the factors influencing HIV transmission, especially the high levels of stigma and discrimination faced by people living with HIV (PLHIV) and those engaging in HIV risk behaviours (such as, selling sex, injecting drugs and men who have sex with men). Lack of, or low levels of knowledge, about HIV, vulnerability and social exclusion are also factors contributing to HIV risk behaviour. The absence of population size estimates for most at-risk groups and an inadequate evidence base makes monitoring the epidemic problematical. Finally, the capacity of government and NGOs to respond appropriately has to be strengthened with designated financial and human resources devoted to the implementation of the strategy.

Development of the national AIDS strategy

The *National AIDS strategy for 2010 to 2014* was developed in a participatory manner with key players from government and NGOs and the UN Theme Group on AIDS contributing to strategic planning meetings in early 2009. It combines the efforts of many stakeholders active within the National AIDS Commission/CCM with representatives from government ministries, institutions, NGOs and UN agencies. Due to the high level of stigma faced by most at-risk populations they did not directly participate in the development of the strategy, but organisation representing their interests did.

The strategy builds on the strengths and successes of the previous national strategy (2005 to 2009) and also addresses weakness identified during the implementation of the previous strategy. These have been identified in several documents: the Mid Term Review of the *National HIV/AIDS Strategy 2005 to 2009* and *Universal Access Plan*; results of biological behavioural surveillance (BBS) and other studies conducted during the five year period; review of GFATM funded activities in September 2008; and in the GFATM proposal prepared for submission to Round 9.

The main achievements of the *National AIDS Strategy for 2005 to 2009* include the development and dissemination of national HIV prevention and AIDS treatment guidelines and protocols in all required areas. Significant numbers of staff have been trained in priority areas such as the provision of safe blood and universal precautions. Further training is underway to scale up access to voluntary counselling and testing (VCT) services and to establish a national monitoring and evaluation unit under the auspices of the Institute of Public Health (IPH).

Slow progress has been made in delivering an essential package of interventions at sufficient scale and intensity to most at-risk populations of female sex workers (FSWs), injecting drug users (IDUs) and men who have sex with men (MSM). This is largely attributed to stigma and discrimination towards them and the lack of confidentiality within some health and related services. Within the essential package of targeted interventions for most at-risk populations, slowest progress has been made with scaling up access to services for sexually transmitted infections.

A five year work plan (2005 to 2009) was developed to accompany the *National AIDS Strategy* with a total budget of Euro 4,258,895. In 2005, Montenegro was awarded Euro 2,424,124 by the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) for the period August 2006 to August 2010. GFATM funds formed over half (57%) of the identified national resource requirements with 37.3% of the budget allocated to groups most at-risk of HIV. The budget for the *National AIDS Strategy for 2005 to 2009* is estimated to be Euro 16,340,000 with 38% of the budget allocated to groups most at-risk of HIV and about 16% to improved surveillance, monitoring and evaluation. A proposal for Euro 5,164,889 has been submitted to the GFATM Round 9.

Aim of National AIDS strategy

The aim of the *National AIDS Strategy for Montenegro (2010 to 2014)* is to maintain Montenegro as a low HIV prevalence country, ensure universal access to HIV prevention and treatment interventions, and to improve the quality of life of people living with HIV through a coordinated multi-sectoral response.

In order to achieve this aim, significant measures will need to be taken to reduce stigma and discrimination and to strengthen the health system to provide a sustainable health sector response.

Guiding principles

The involvement of other sectors and NGO partners working together in accordance with agreed principles is critical if Montenegro is to avoid the medical, social and economic consequences of HIV faced by other countries in the region. Thus the strategy is based on eight guiding principles in accordance with international and national human rights.

Guiding principles

1. Protection of human rights of all persons involved including the reduction of stigma and discrimination, and the creation of a supportive environment for HIV prevention, treatment, care and support.
2. Confidentiality and privacy of all data to be guaranteed at all levels in health and other sectors.
3. Equal access to sustainable health and protection services for all citizens (including persons with temporary residence) with special attention to people living with HIV, most at-risk and vulnerable groups (including displaced persons and refugees).
4. Most at-risk populations and people living with HIV have universal access to a package of essential cost-effective HIV interventions based on their needs.
5. Promotion of healthy life styles and interventions to prevent and empower individuals and groups to be able to protect themselves against HIV infection.
6. Participation of the target population to ensure their active involvement in the design, implementation and evaluation of all proposed activities.
7. Evidence-informed and results oriented programming, monitoring and evaluation.
8. A multi-sectoral age, gender and diversity approach to HIV, involving all partners at all levels within public, private and non-profit sectors, in accordance with other existing strategies and internationally adopted commitments.

International and regional commitments

The strategy is in accordance with international and regional commitments and strategies to address HIV and sexually transmitted infections and the rights of women and children, namely:

- Millennium Development Goal (MDG) number 6 to combat HIV/AIDS, 2000
- United Nations General Assembly Special Session (UNGASS) on HIV/AIDS, 2001
- United Nations General Assembly Special Session (UNGASS) on HIV/AIDS, 2006
- WHO *Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector*, 2008
-
- Convention of the Elimination of all forms of Discrimination Against Women (CEDAW), 1979
- Convention on the Rights of the Child, 1989

- WHO European Regional Strategy on Sexual and Reproductive health, 2001
- The Declaration of WHO European Ministerial Conference on Youth and Alcohol, 2001
- Declaration of Commitment on HIV/AIDS in South-Eastern Europe, Bucharest, 2002
- European Ministers Dublin Declaration on HIV/AIDS, 2004
- Vilnius Declaration on HIV/AIDS In Europe, 2004
- European Union Statement on HIV Prevention for an AIDS Free Generation, 2006
- Bremen Declaration on Responsibility and Partnership- Together Against HIV/AIDS, 2007

Strategic programme areas

The *National AIDS Strategy for Montenegro 2010 to 2014* has eight strategic programme areas that focus on the creation of a safe and supportive environment, prevention of HIV amongst well-defined target groups, treatment, care and support of people living with HIV, and an evidence-informed and coordinated response.

Strategic programme areas

Safe and supportive environment

1. Reduce stigma and discrimination of people living with HIV and people engaging in HIV risk behaviours and eliminate sexual and gender-based violence

Prevention of HIV amongst specific target groups and settings

2. Prevent HIV and sexually transmitted infections (STIs) and treat STIs amongst most at-risk groups - sex workers and their clients, injecting drug users and men who have sex with men
3. Prevent HIV and sexually transmitted infections (STIs) and treat STIs amongst people in settings where HIV risk behaviour may be more prevalent (prisons, hotels) and amongst groups such as, the military and uniformed services (including sailors) and socially excluded youth (such as some Roma and refugees)
4. Prevent HIV and STIs and treat STIs amongst young people and the general public
5. Prevent HIV transmission in health care and related settings

Treatment, care and support

6. Treat, care and support people infected and affected by HIV

Evidence-informed, coordinated and sustainable response

7. Strengthen the data base, including mapping, population size estimates, surveillance, monitoring and evaluation and evidence-informed planning
8. Build capacity and strengthen coordination and sustainability of the national response

The *AIDS Strategy 2010 to 2014* accords priority to changing the behaviours of males and females already engaging in HIV risk behaviours (such as unprotected anal, oral and vaginal sex, and injecting drugs with non-sterile equipment) and providing them with universal access to prevention and treatment interventions. Efforts to improve the quality of life of people living with HIV and to prevent HIV transmission to their sexual partners will also be intensified.

In order to implement these interventions, the intense stigma and discrimination faced by these groups will need to be addressed.

Attention is paid to groups (military, uniformed services and children and adolescents living without parental care, or working/living on the street) and settings (hotels, prisons, streets) where people may be more vulnerable to start engaging in HIV risk behaviour. In addition, a focus is maintained on primary prevention amongst youth and the general population.

The provision of safe blood and blood products will be continued according to the Law on *Provision of Sufficient Amount of Safe Blood Units, 2007* as will attention to universal precautions to prevent workplace based exposure to HIV - already in place for health care workers and to be extended to police and prison staff. A Strategy on the *Prevention of mother to child transmission of HIV* will be developed in 2009 and complement the national AIDS Strategy.

The strategy will be implemented through the coordinated efforts of different government departments, civil society (especially NGOs) and the private sector and with support from UN agencies, international, regional and national donors.

Country situation

Country profile

The last census was undertaken in Montenegro in 2003 and 620,145 citizens (314,920 female and 305,225 male) were recorded with 60% of them living in urban areas. According to the census, the majority of residents are Montenegrin (43.2%) and Serbs (32%), with smaller numbers of Bosniaks (7.8%), Albanians (5%), ethnic Muslims (4%), Croats (1.1%) Roma (0.42%), Yugoslavs (0.3%), and others (6.26%)¹. When Montenegro gained independence in May 2006 the population was estimated to be 673,000.

About 4% of the population are refugees or displaced persons. Of the displaced persons, the majority (7,876) originated from Kosovo, 5,005 from Bosnia and Herzegovina (BiH) and 1,921 from Croatia. The total number of internally displaced persons (IDPs) was 16,196 at the end of 2006. Almost one-fifth 4,500 (17%) of displaced persons are of Roma, Ashkali or Egyptian (RAE) ethnicity².

Gender

Women in Montenegro are *de jure* equal, although there are areas in which women are underprivileged in comparison with men. They are more exposed to poverty - a potential push factor for entering sex work - and are under-represented in positions of power: women hold only 11% of national parliament seats and 11.37% of seats in local parliament³. Gender-based violence is evident in Montenegrin society and traditional values about male and female roles prevail in many areas.

Gender equality in Montenegro is not only recognized as a human right, but is seen to be strongly interrelated with poverty reduction, law enforcement, and political and economical empowerment of women⁴. Two institutional mechanisms for gender equality exist in Montenegro: the Parliamentary Committee for Gender Equality (established in 2001) and the Governmental Office for Gender Equality (operational from 2003).

Also in 2003, a Coordination Body was established to fight against human trafficking and a Coordinator appointed. Along with this a Centre was opened to accommodate and rehabilitate victims of trafficking.

Poverty

The poverty rate in Montenegro was estimated at 11.3% in 2005/6⁵ and is concentrated especially amongst the Roma and internally displaced persons. An additional 30% of the population is regarded as being “economically vulnerable” and prone to poverty. There are sharp regional disparities in poverty with 45% of the poor living in the North of the country where the poverty rate is almost twice as high as the national average. Measured by the decile ratio and Gini coefficient, Montenegro is among the most unequal of countries in the West Balkans.

¹ Republic of Montenegro Statistical Office. *Census of Population, Households And Dwellings 2003: Population national or ethnic affiliation data by Settlements and Municipalities*, Podgorica, September 2004

² UNHCR *Montenegro Contribution to Country Operation Plan 2007, 2006*.

³ UNDP. *Montenegro Economic Brief*, 2008.

⁴ UNDP, 2008

⁵ June 2008 MONTSTAT and World Bank figures

The 2003 *Poverty Reduction Strategy Paper* (PRSP) was reviewed and a new strategy *Poverty Alleviation and Social Inclusion Strategy (2007-2011)* developed and adopted in 2007. It is multi-sectoral and includes: education, health, social welfare and employment.

Social exclusion

Several groups have been recognized as at risk of social exclusion⁶ and in need of specific attention. Some of these groups are of particular relevance to HIV transmission, although no studies to date have shown clear links between poverty and HIV (as a driver of the epidemic). Socially excluded youth are considered to be especially vulnerable to HIV risk behaviour.

Groups at risk of social exclusion
Economic exclusion: Poor, unemployed, homeless, housewives, minorities, displaced persons, and people with low levels of education
Family structure: Single-person households, single-parents, children without parental care, households with more than three children
Age: Youth aged 15-29, the elderly (65 and over) and pensioners
Criminal behaviour: Prisoners and ex-prisoners, juvenile delinquents, victims of crime and domestic violence
Health: People with mental or physical disabilities, people living with HIV, sex workers, sex workers, drug users, alcoholics and people undergoing rehabilitation for substance use
Sexual orientation: sexual minorities (transgender and transsexual)

Roma, Ashkali and Egyptian (RAE) displaced persons in Montenegro are considered to face extreme vulnerability and social exclusion. They are overrepresented among the most vulnerable groups (those living in extreme poverty, without secure housing and educational opportunities).

Epidemiological situation of HIV and AIDS

The first persons diagnosed with HIV in Montenegro were officially registered in 1989: an injecting drug user and a sailor. By the end of 2008, the total cumulative number of people registered with HIV was 89 (47 AIDS and 42 HIV). This represents an increase of 35 persons registered with HIV over the five years since the development of the Montenegrin Strategy for HIV and AIDS (2005 to 2009). However, the Institute for Public Health (IPH) estimated that there were 388 (range 300 to 500) people living with HIV at the end of 2008 using the World Health Organisation (WHO) methodology for HIV estimations and regional trends suggest the potential for an increase in HIV transmission.

From the total number of 47 persons diagnosed with AIDS, 29 have died. There are officially 18 persons living with AIDS and 41 living with HIV: 39 of them are under surveillance by the Infectious Diseases Clinic and 24 are receiving antiretroviral therapy (ART). Late diagnosis of HIV continues to be a problem with some people only seeking HIV testing when they have AIDS. For example, out of the nine people newly registered with HIV in 2008, four had already developed AIDS and two have subsequently died. This indicates the urgent need to encourage people who have engaged in HIV risk behaviour to seek HIV testing and counselling.

Most people living with HIV reside in the capital Podgorica and in the coastal areas.

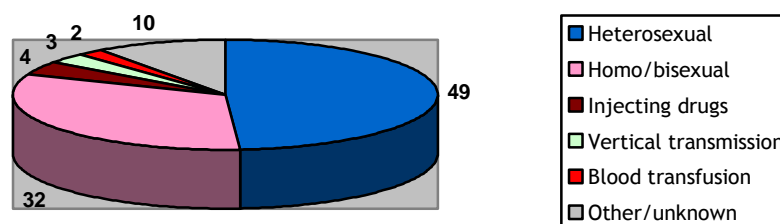
⁶ "Social exclusion is a process whereby certain individuals or social groups are pushed to the edge of society and prevented from participating fully by virtue of their poverty, or lack of basic competencies and lifelong learning opportunities, or as a result of discrimination", UNDP, Montenegro, 2008.

Since 2006 questions have been asked during pre-test counselling about where the person thought they acquired the infection. It is hoped that this data together with an analysis of HIV sub type will help inform how many people living with HIV acquired the infection domestically and how many outside of Montenegro (for example, with sex workers in other countries).

Mode of transmission

The main mode of transmission is sexual (81%) - 49% heterosexual transmission and bi-homo sexual, 32%. Other modes of transmission are injecting drug use 4%, mother-to-child transmission 3% and blood transfusion 2%. For 10% of persons registered with HIV the mode of transmission was unknown - see **Figure 1**. For two of children registered with HIV, information about their serological status was collected after their mother had been diagnosed HIV-positive. Two persons were infected via blood transfusion outside Montenegro before 2005.

Figure 1: Mode of transmission for all people registered with HIV and AIDS, 1989 to 2008, N= 89



Source: Montenegrin Institute of Public Health, IPH, 2009

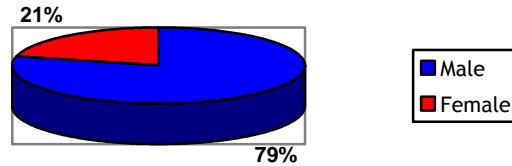
Nine people were newly registered with HIV in 2008 (six of them male). Out of the six HIV-positive males, four were men who have sex with men residing in Podgorica and the coastal areas. One injecting drug user was identified as HIV-positive during the biological behavioural surveillance study in 2007. The HIV prevalence rate for female sex workers is 0.75% and for injecting drug users 0.3%. A higher HIV prevalence rate of 1.54% was recorded for sailors in 2007, although the sample size was small and only 130 were tested for HIV.

Intense stigmatization of homosexual behaviour could be attributed to some men reporting heterosexual transmission or mode of transmission unknown, thereby leading to under-reporting of homosexual or bisexual transmission. However, improved counselling at the time of HIV testing may have contributed to more men who have sex with men coming forward for testing.

Gender

The male to female ratio of HIV infection in Montenegro is 4:1 - 79% of people registered with HIV are male. Most of the women infected were sexual partners of people living with HIV (many of whom were sailors), indicating the need to ensure that the national response addresses the HIV prevention needs of the sexual partners of people living with HIV. Out of the eight women who acquired HIV sexually and are currently under surveillance by the National Infectious Diseases Clinic, half (4) acquired the infection from their husband who was a sailor. Out of the other four no information is available about how they acquired the infection: whether their sexual partners was an injecting drug user or bisexual, or if they had themselves engaged in HIV risk behaviour such as selling sex.

Figure 2: Gender distribution of all persons diagnosed with HIV, 1989 to 2008

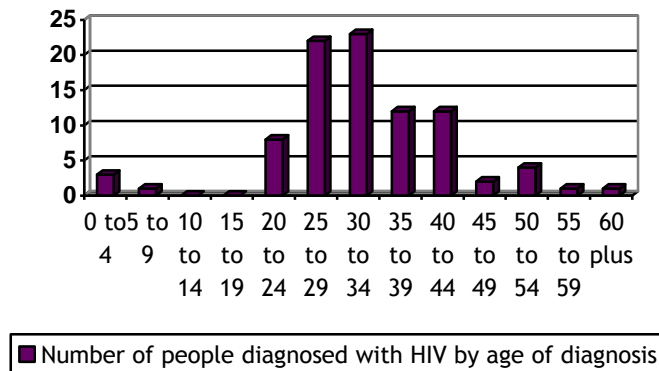


Source: Montenegrin Institute of Public Health, IPH, 2009

Age

The age group most affected by HIV is 30 to 34 years followed closely by the age group 25 to 29. These figures should be treated with caution as many people are diagnosed with HIV when they have already developed AIDS. The age at which they acquired the infection is thus likely to be much younger emphasising the need to focus on the specific needs of adolescents engaging in HIV risk behaviour.

Figure 3: Age at first diagnosis of HIV and AIDS for all persons diagnosed 1989 to 2008



Source: Montenegrin Institute of Public Health, IPH, 2008

Social characteristics of people living with HIV

In recent years it has become clear that men who have sex with other men and their sexual partners are most adversely affected by HIV in Montenegro due to unprotected anal sex. Other groups that feature amongst people living with HIV are male sailors who mainly acquired the infection abroad through unprotected sex with sex workers and HIV is beginning to be diagnosed amongst their sexual partners. A final occupational group is workers (primarily male) in the coastal tourism industry through unprotected sex. More qualitative data is needed on the sexual networks of people living with HIV.

HIV knowledge and risk behaviour

Studies of correct knowledge of HIV conducted in 2007 and 2008 show levels remain low: 22.1% amongst youth (2007) and sex workers (2008) and 46% amongst injecting drug users (2008).

Data on HIV risk behaviour have been collected from a range of behavioural studies conducted since 2002 and more recently through biological behavioural surveillance studies conducted with most at-risk and vulnerable populations. Rapid assessment and response (RAR) studies conducted in 2002 showed high rates of HIV risk behaviour amongst injecting drug users (IDUs), sailors and youth with 67% of IDUs having shared drug injection equipment, over 40% of all groups had had more than 2 to 5 sexual partners in the past year and condom use was not consistent. For example, only 12.5% of IDUs always used condoms, 37% of sailors and 50% of youth. A worrying third of the IDUs had ever had sex in return for money.

Further small scale rapid assessment and response studies of HIV risk behaviour amongst 39 female sex workers (25 in Bar and 14 in Podgorica) and 57 men who have sex with men (19 in Bar and 28 in Podgorica) conducted in 2005 found that “always use condom” rates were 71.4% amongst FSW and 63% amongst MSM, but were significantly lower in Bar where 92% of the sex workers interviewed said they “sometimes” used condoms and 7.7% said they never used condoms.

Behavioural biological surveillance research undertaken in 2008 showed encouraging trends. Condom use at last sex amongst IDUs increased to 41.1%, and was 73.1% amongst female and male sex workers. An encouraging 89.2% of IDUs reported using sterile drug injecting equipment the last time they injected, and 75.8% during the past month. The overlap between sex work and drug use was demonstrated with 16% of IDUs have sold sex for money or drugs, and 14% of sex workers having used drugs.

Condom use amongst other groups found an increase in condom use amongst youth (aged 18 to 24) from 51% in 2002 to 66.7% in 2008; and amongst sailors, 37% in 2002 to 79.5% in 2008. Condom use at last sex with a non-regular partner amongst workers in the tourism industry was reported at 60.1%.

Other groups known to engage in HIV risk behaviour or to be vulnerable are displaced Roma, Ashkali and Egyptian (RAE) youth and prisoners. Displaced RAE youth are especially vulnerable because they are largely socially excluded with low levels of education, higher rates of poverty than the general population, live in camps situations, and a substantial number of them do not have birth registration which makes it difficult for them to access education and health services. A 2008 behavioural study of 288 RAE youth aged 15 to 24 years (101 girls and 187 boys) living in refugee camps in Niksic and Podgorica found that they had low levels of knowledge of HIV, early sexual experience (average age of first sex 16 years), low condom use and 6% reported selling sex, 19% of male youth said they had paid for sex and 13.4% of them had anal sex with other men.

HIV risk behaviour has also been reported in penitentiary institutions: injecting drugs with used injection equipment and unsafe sex amongst inmates⁷. No systematic studies of HIV risk behaviour in prisons have yet been conducted.

Sexually transmitted infections (STIs)

The official number of registered cases of sexually transmitted infections (STIs) is extremely low due to weak registration (for both private and governmental institutions) and reporting of STI cases. A total of 23 cases were reported in the IPH Annual Report on Communicable Diseases in 2008: two cases of Syphilis, three of Gonorrhoea and 18 cases of Hepatitis B. However, anecdotal data from doctors suggest that the number of cases is far greater and increasing.

⁷ Data from Juventas 2004 to 2009.

It is mandatory to report Syphilis and Gonorrhoea cases with detailed information about the patient. Medical institutions are obliged to report Chlamydia, genital herpes and other STIs, but this does not routinely happen. Given the stigma attached to STIs and a lack of confidentiality regarding the diagnosis, some people with STIs will self-treat with drugs bought over the counter at a pharmacy. Others may request their doctor not to record their name on the reporting form.

Organization of health care

The health and social welfare system in Montenegro is undergoing intensive reform to be in accordance with European Union (EU) standards and in the best interest of the beneficiaries. Primary health care (PHC) is organized under the *Dom zdravlja* (PHC centre) and based on two key pillars: teams of chosen doctors; and Support Centres in each *Dom zdravlja*. One of the Support Centres is dedicated to Prevention and general Counselling Centres have been established to promote healthy life styles and prevent ill-health in every *Dom zdravlja* (there are 18 PHC centres through out Montenegro). According to the Health Programme for 2009 onwards the focus of these centres will be on three priority groups of health conditions: diabetes, non-communicable diseases (such as smoking cessation) and HIV.

One of the key underlying principles of the PHC reform model is that chosen doctors are responsible for referring patients to other services i.e. an insured person can enter the health system only through the chosen doctor. However, it is possible for an insured person to access services at the Counselling Centre either with referral from their chosen doctor or directly (without being referred by their doctor).

Since 2002, some *Dom zdravlja* in Bar, Berane, Bijelo Polje, Herceg Novi and Podgorica have been providing sexual and reproductive health information and services to young people as part of an initiative on Youth Friendly Health Services (YFHS). It is envisaged that these services will be integrated in the Population Counselling Centres in all 18 *Dom zdravlja* to provide anonymous and free of charge counselling services for young people, including for HIV. Standards for the Youth Friendly Health Services are being developed by the Ministry of Health, Labour and Social Welfare, paying particular attention to socially excluded youth and minors.

HIV Testing and counselling

Considerable stigma related to HIV remains in Montenegro. This coupled with concerns regarding the confidentiality of the testing process, provides little incentive for an individual to be tested for HIV. As a result, many people were reluctant to be tested for HIV until they had developed symptoms of HIV-related illnesses. Up until 2005 most people diagnosed with HIV were only tested late in the course of HIV disease and some individuals took advantage of out-of-country testing to maintain confidentiality of the results.

Considerable efforts have been made since 2005 to improve the quality of pre- and post-test counselling for HIV testing. Eight Voluntary Counselling and Testing (VCT) Centres have been established within Population Counselling Centres: two in the Central Region (Niksic and Podgorica), three in the Southern coastal region (Bar, Herceg Novi and Kotor) and three in the Northern Region (Berane, Bijelo Polje and Pljevlja). About 50 staff have been trained and it is planned to train additional staff and open two additional VCT Centres in Podgorica. Activities in the existing eight HIV counselling centres are implemented in accordance with the Institute for Public Health (IPH) protocols for HIV testing and counselling. A network of VCT Centres has been established and undertakes regular monitoring of the services provided. It is envisaged

that voluntary HIV testing and counselling and prevention services for STIs will be integrated into their work in accordance with World Health Organisation recommendations⁸.

HIV testing is anonymous and free of charge for the patient - the cost is covered by the National Health Insurance Fund.

Blood Safety

Since 1974, blood donation in Montenegro has been voluntary, anonymous and free and blood donors do not receive material compensation. All donated blood and blood products are tested for Hepatitis B (1972), HIV (1987), Hepatitis C (1997), and Syphilis. Approximately 20,000 blood units are tested each year. Since the beginning of HIV testing, nine HIV-positive donors have been detected (and none since 2005).

Routine testing of blood for HIV is done by fourth generation ELISA tests. In suspected positive results, new blood samples are tested again by ELISA and if positive or inconclusive, the blood is sent for confirmatory test by Western Blot or polymerase chain reaction (PCR).

The Republican Commission for Blood Transfusion was established in 2003 and a project on Safe Blood initiated in 2004. In 2006, the *Strategy for Safe Blood* was adopted and this was followed by the 2007 adoption of the *Law on the provision of blood* in compliance with European Union Directives.

Over four fifths (83%) of blood donors are family members and 17% are voluntary blood donors (17%). The Montenegrin Red Cross and the Blood Transfusion Service in cooperation with the Ministry of Health, Labour and Social Welfare educate the public about the importance of voluntary blood donation and the need for sufficient blood donors. Efforts to increase the percentage of voluntary blood donations and has been achieved in some municipalities (up to 35%). In 2008, the *National Programme of Voluntary Blood Donations* was drafted together with an Action Plan and budget.

⁸ The Fifty-ninth World Health Assembly (2006) urged Member States to include prevention and control of sexually transmitted infections as an integral part of HIV prevention.

Review of national AIDS response

The *National AIDS Strategy for Montenegro (2010 to 2014)* builds on the strengths and successes of the previous national strategy (2005 to 2009) and also addresses weakness identified during the implementation of the previous strategy. These have been identified in several documents: the Mid Term Review of the *National HIV/AIDS Strategy 2005 to 2009* and *Universal Access Plan*; results of biological behavioural surveillance (BBS) and other studies conducted during the five year period; review of GFATM funded activities in September 2008; and in the GFATM proposal prepared for submission to Round 9.

Legal and policy environment

HIV prevention and AIDS treatment care and support in Montenegro are provided in accordance with international and regional commitments. In addition, national legislation and strategies provide the context in which HIV activities with specific population groups are undertaken within the health and related sectors (see later).

As part of the AIDS response to 2009, national HIV prevention and AIDS treatment guidelines and protocols have been developed with donor support and disseminated on:

- Antiretroviral therapy treatment protocol (Government and GFATM)
- Prevention of mother to child transmission of HIV (Government and UNICEF)
- Safe blood (Government and GFATM)
- Sexually transmitted infections (Government and GFATM)
- Universal Precaution Measures in Health Care Settings (Government and GFATM)
- Voluntary counselling and testing (Government and GFATM)

Whilst an impressive array of legislation has been approved, implementation has not always been optimal and the draft Law on Discrimination has not yet been adopted. With specific reference to HIV, high levels of stigma and discrimination persist towards people living with HIV, female sex workers, injecting drug users and particularly amongst men who have sex with men. Stigmatising attitudes held by health care providers, law enforcement officers and the general public have resulted in low uptake of HIV testing and counselling services and in difficulties in reaching men who have sex with men. This coupled with perceived lack of confidentiality of services was identified as the main barrier to implementing the previous AIDS strategy.

Criminalisation of HIV risk behaviour also makes access to the population difficult and deters most-at risk groups from accessing HIV information and services.

HIV Prevention interventions

HIV prevention amongst most at-risk populations

During the past five years government and NGOs with GFATM and UN and bilateral donor support have intensified efforts to provide HIV interventions to most at-risk populations, namely female and male sex workers and injecting drug users, and men who have sex with men and notable reductions have been observed amongst IDUs and sex workers. However, despite these efforts, by the end of 2008 only a small number of sex workers (280) and MSM (142) had been identified and it was not possible to conduct a behavioural survey amongst MSM. Larger numbers of injecting drug users (863) had been reached. As there are no national population

size estimates for each of these groups in Montenegro⁹, it is not known what percentage of the total population at risk had been reached.

A range of HIV, STI and harm reduction information (including on hepatitis and methadone therapy) and educational materials have been developed and disseminated for injecting drug users, men who have sex with men and sex workers. Involvement of members of the target population (or ex-members) has facilitated access to most at-risk populations, especially amongst IDUs. However, insufficient knowledge of HIV remains amongst these populations and whilst HIV risk behaviour appears to have decreased in some towns this remains short of the universal access targets. This indicates the need to intensify behaviour change communication activities amongst the most at-risk populations.

Needle exchange programmes are functioning in four towns and condoms have been distributed to IDUs, sex workers and MSM as well as amongst sailors, workers in the tourism industry, Roma, Ashkali and Egyptian youth and youth in school. A methadone maintenance therapy programme is operational in the *Dom zdravlja* in Podgorica.

Almost one third of IDUs (31.3%) and 39.5% of sex workers surveyed in 2008 had ever had a HIV test. However, the absence of, or poor, confidentiality in HIV testing and STI services is still considered a major barrier to uptake of this service. The introduction of rapid HIV tests is proposed to facilitate access to HIV testing services.

Greater focus now needs to be placed on delivering an essential package of HIV interventions (behaviour change communication, condoms, harm reduction, HIV testing and counselling and referral to treatment care and support) at sufficient scale and intensity to female sex workers (FSWs) and their clients, IDUs and MSM. The main barrier to accessing comprehensive HIV prevention interventions is stigma and discrimination towards most at-risk populations (especially MSM) and a lack of confidentiality within some health and related services. A lack of understanding of HIV prevention programmes, such as harm reduction, by key government staff continues to hinder progress. It has been reported that there is resistance amongst health workers to treat people with STIs and HIV.

Other barriers include poor counselling services for sex workers who also inject drugs and the absence of Drop-in Centres for people engaging in HIV risk behaviour. Actions to address these barriers are included in the strategy.

Although 85% of people registered with HIV acquired the infection sexually, the prompt diagnosis and treatment of STIs for men¹⁰ is not yet included as part of the basic package of health care agreed under the reform of primary health care services. Nor was this intervention integrated into the previous national AIDS response. As a consequence, minimal progress has been made with scaling-up access to services for STIs and in building capacity of health professionals in the diagnosis, treatment and reporting of STIs. It is expected that the situation will improve with the development of the National Health Information System (NHIS) which should be functional by 2010. "Chosen" or family doctors are also expected to diagnose, treat and refer STIs, although the lack of confidentiality and anonymity in the current system may be a deterrent to people consulting them. The integration of counselling for STIs into HIV testing and counselling services should improve access to confidential services.

Prevention amongst vulnerable populations

A range of HIV and STI information has been developed and disseminated amongst sailors, prisoners and persons of Roma, Ashkali and Egyptian origin. Interventions in prisons are in place

⁹ In 2005 Imperial College in London estimated that there were 650 injecting drug users in Podgorica.

¹⁰ The basic benefit package for pregnant women includes tests for Hepatitis B, HIV and Syphilis.

and prison staff and inmates have received information on HIV and prisoners have started to receive counselling on HIV, Hepatitis A, B and C, condom use, safe drug injection and drug rehabilitation. Condoms and sterile injection equipment have not yet been provided within prison settings, nor has testing for HIV.

Diversion programmes for juveniles in conflict with the law need to be introduced to avoid incarceration. Health, law enforcement and NGO staff also should be trained in the *Optional Protocol* relating to sexual exploitation of children.

No studies of HIV risk behaviour have yet been conducted amongst the military and uniformed services personnel, or amongst prisoners. However, evidence from other countries shows that they often engage in HIV risk behaviour, especially when posted away from home. As Montenegro plans to join the North Atlantic Treaty Organization (NATO), it is timely to include the military and peacekeepers in HIV prevention and treatment efforts. Police and prison staff should also be included to improve their knowledge of HIV, reduce stigma towards affected persons and ensure that they know how to protect themselves personally and professionally from HIV.

Prevention amongst general population and youth

Information and educational materials have been developed for teachers, pedagogues, psychologists, peer educators, students, youth and the general public on HIV, Hepatitis, homophobia and STIs. A healthy lifestyles manual for eighth and ninth grade primary school children has been developed and piloted amongst 2,688 students who received lessons in healthy lifestyles (including HIV and STIs). A manual has also been developed for primary school teachers and peer educators working in schools and NGOs trained as trainers of peer educators. As a result over 20,000 school children in 12 cities have reached by HIV/STI peer education activities. A SOS phone counselling service on HIV and STIs is operational for young people.

Building on the success of the pilot, it is proposed to expand the course to secondary school students from 2010 onwards. A potential barrier to scaling up the schools-based programme is insufficient teachers with skills in participatory methods. The ideal would be for the healthy lifestyles course to be compulsory for all pupils.

HIV transmission in health care and related settings

Blood Safety - A *Law on Provision of Sufficient Amount of Safe Blood Units* was adopted in November 2007 and foresees the establishment of a national network of Centres for Blood Transfusion (CBT) with quality control systems in place. The Law also recommends a shift away from family donations to voluntary blood donation as a primary source of ensuring blood and blood components. This will be achieved by further education and motivation to promote voluntary blood donation amongst the general public.

The main focus in the coming five years will be to maintain the quality standards defined in the *Guide for Safe blood* developed by Government with GFATM support. Staff shortages will be addressed, equipment supplied and monitoring of blood safety improved. In addition, increased emphasis will be placed on increasing voluntary blood donations, especially amongst students and youth and the establishment of a data base of voluntary blood donors.

Universal precautions are in place, although there is need to further build capacity of health professionals and to extend training to dentists, police and prison staff and to institute measures to prevent occupational transmission of HIV.

AIDS treatment, care and support

Considerable improvements have been noted in HIV diagnosis and treatment and access to care for PLHIV and there is no longer need for HIV-positive persons to travel outside Montenegro for treatment. Antiretroviral therapy is provided free of charge under the National Health Insurance Fund.

The main constraints remain: stigma and discrimination towards HIV-positive persons which contributes to delays in seeking a HIV test, late diagnosis and access to care; insufficient facilities in the Infectious Diseases Clinic; and an undeveloped system for psychosocial support, palliative and home-based care.

Capacity of service providers

Capacity has been built amongst a significant number of health staff in HIV/STI prevention, treatment and care. However, there is a shortage of government staff dedicated to work in these areas and problems have been encountered in the retention of health trained staff, insufficient experienced field workers (community-based and outreach) and poor training and quality control amongst private doctors.

The NGO response has proved critical, but variable capacity exists between NGOs which requires further strengthening and there are insufficient NGOs working in the field.

Coordination, participation and partnerships

Improved coordination between government and NGOs has been noted and there is now broad recognition of the strong role community service organisations play in the AIDS response. Support from the Prosecutor's Office of Montenegro and written consent/support of the police for field work with IDUs has facilitated access to the IDU community. The inclusion of a representative of the National Health Insurance Fund (NHIF) on the CCM has led to improved understanding of the cost saving implications of HIV prevention activities.

The absence of formal organizations representing IDUs, MSM and sex workers makes it difficult to involve them in planning and implementing interventions that are appropriate to their needs. There is no coordination mechanism for NGOs to avoid duplication of activities and facilitate a coherent and consistent response.

It is assumed that private doctors play an important role in providing confidential HIV/STI services to those who can afford to pay for them. Yet the private sector is not yet formally recognised as a full participant in health care.

Sustainable financing

Support from GFATM and other donors, such as UNICEF has been invaluable to the implementation of 2005 to 2009 AIDS strategy. In 2005 to 2009 GFATM funds formed over half (57%) of the identified national resource requirements with 37.3% of the budget allocated to groups most at-risk of HIV.

Concerns over future financing remain:

1. Government AIDS and STI Programme does not have approved separate budget.
2. Insufficient national funds allocated to the national AIDS response.
3. National Health Insurance Fund does not cover national AIDS and STI Work Plan.
4. Lack of technical expertise in costing HIV/STI prevention and treatment interventions.

Monitoring and evaluation

Responsibility for national monitoring and evaluation of the AIDS response is under the guidance of the Institute of Public Health (IPH) and supported by GFATM PIU. IPH has, with support from NGOs, DFID (under the HIV prevention among vulnerable populations initiative, HPVPI), the GFATM, Irish Aid and UNICEF conducted a range of behavioural studies amongst youth aged 18 to 24 years, displaced youth in refugee camps, and workers in the tourism industry (conducted by the NGO *Protection*).

A Second Generation HIV Surveillance system has been established and biological behavioural surveillance (BBS) surveys of male and female injecting drug users and sex workers conducted by the Institute of Public Health. The planned 2007 BBS with MSM was not realised due to an insufficient sample. The NGO *Protection* conducted a BBS amongst sailors in 2008. These surveys were conducted using representative sampling methods wherever possible (youth and tourist workers - multi stage cluster sampling), injecting drug users (respondent driven sampling), sex workers (snowball sampling), and sailors (convenience sampling). The results have provided baseline values for impact (HIV prevalence) and outcome indicators (as defined in the National AIDS Strategy and GFATM Round 5 Proposal).

Good collaboration between NGOs and the IPH in undertaking surveys in 2008 led to NGOs being recognized as an important player in conducting behavioural surveys and in providing access to the target population. Revised field reporting forms for NGOs working with IDUs have been developed and are being used to monitor the services provided and numbers reached. However, problems in data reporting remain in terms of possible duplication of clients reached.

Weaknesses exist due to the absence of population size estimates, lack of baseline and HIV prevalence data for MSM, and inadequate reporting of sexually transmitted infections. The lack of skills to conduct bio-behavioural research and inadequate skills in project monitoring and evaluation amongst government and NGO staff has also hampered progress and resulted in the inadequate use of surveillance data for decision making, planning and programming purposes. Initial monitoring has tended to focus on the activity level rather than on programmatic issues. There is now more emphasis on the number of at-risk groups receiving a package of interventions, rather than counting the number of condoms or needles distributed.

More research is needed on most-at risk adolescents¹¹ and HIV interventions targeted to them, especially to children living or working on the streets. The ethical considerations of conducting research and providing services to minors will be addressed in the revised strategy.

In the forthcoming five year period it is proposed to conduct biological behavioural and behavioural surveys among most at-risk populations: MSM and IDU in Years 1 and 4; sailors in Year 3; Prisoners in Year 2; Youth in Years 2 and 5, and amongst Roma, Ashkali and Egyptian in Year 3. In addition, ten professional staff will be trained in second generation HIV surveillance, monitoring and evaluation. Greater efforts will be made to monitor the number of new and repeat clients accessing the essential package through an improved data base.

Non health sector response

Sexual and gender based violence is emerging as an issue to be addressed in the future together with an analysis of poverty as a driver of HIV risk behaviour (especially selling sex).

¹¹ The 2008 study of sex workers only included adults although started selling sex under age 18 years.

Strategic programme areas

The seven strategic priority areas defined in the National HIV and AIDS Strategy for 2005 to 2009 have provided a sound basis and focus for HIV prevention and treatment in Montenegro. Considerable progress has been made in some of them so that they are no longer areas for priority action in 2010 and beyond. For example, the policy on HIV testing has been developed and is being implemented. The promotion of access to HIV testing and counselling services (including rapid HIV tests) should be continued and be part of the essential package of health sector interventions targeted to people engaging in HIV risk behaviour.

During the development of the *National AIDS Strategy for Montenegro (2010 to 2014)* it was proposed to re-order and slightly revise the strategic priority areas to: address stigma and discrimination; to make the clear distinction between different interventions required for most at-risk populations and vulnerable groups; integrate STI and HIV testing and counselling services into primary health care; pay attention to primary prevention efforts amongst youth in and out of school and the general public; continue to focus on the quality of life of people living with HIV and their need for palliative care; maintain a safe blood supply; and strengthen management, coordination, monitoring and evaluation of the AIDS response.

Strategic programme areas

Safe and supportive environment

1. Reduce stigma and discrimination of people living with HIV and people engaging in HIV risk behaviours and eliminate sexual and gender-based violence

Prevention of HIV amongst specific target groups and settings

2. Prevent HIV and sexually transmitted infections (STIs) and treat STIs amongst most at-risk groups - sex workers and their clients, injecting drug users and men who have sex with men
3. Prevent HIV and sexually transmitted infections (STIs) and treat STIs amongst people in settings where HIV risk behaviour may be more prevalent (prisons, hotels) and amongst groups such as, the military and uniformed services (including sailors) and socially excluded youth (such as some Roma and refugees)
4. Prevent HIV and STIs and treat STIs amongst young people and the general public

5. Prevent HIV transmission in health care and related settings

Treatment, care and support

6. Treat, care and support people infected and affected by HIV

Evidence-informed, coordinated and sustainable response

7. Strengthen the data base, including mapping, population size estimates, surveillance, monitoring and evaluation and evidence-informed planning
8. Build capacity and strengthen coordination and sustainability of the national response

These strategic priorities all require that age, gender and diversity are factored into the response, paying specific attention to HIV risk behaviour amongst adolescents and young people who are living juvenile detention, in institutional care, or living/working on the streets. Capacity building and on-going skills development of key service personnel and organizations are critical to the success of the strategy.

A strategy on the prevention of mother to child transmission of HIV is being developed and once approved will complement the national AIDS strategy 2010 to 2014.

Safe and supportive environment

1. Stigma and discrimination

Objective 1

By 2015, create a safe and supportive environment through advocacy, policy dialogue, legal frameworks and service delivery to fight against stigma and discrimination of people living with HIV and people engaging in HIV risk behaviours

National indicators

Percent of people surveyed having an accepting attitude towards people living with HIV
Number of people living with HIV, injecting drug users, men who have sex with men and sex workers who report having experienced stigma and discrimination

Activities

- 1.1 Review legislation contributing to the fight against stigma and discrimination amongst people engaging in HIV risk behaviours
- 1.2 Review curricula for health professionals to assess adequacy of content on ethical, legal and patient communication issues related to HIV
- 1.3 Assess media representation of HIV and AIDS issues in Montenegro to gauge correct information, terminology, appropriate attitudes, and identify examples of discrimination
- 1.4 Conduct surveys on stigma and discrimination:
 - 1.4.1 among service providers (including private dentists and pharmacists) to establish baseline information
 - 1.4.2 experienced by PLHIV
 - 1.4.3 experienced by people engaging in HIV risk behaviours
- 1.5 Based on the survey findings and reviews, build capacity of :
 - 1.5.1 health professionals (including private dentists and pharmacists) on ethical issues (especially confidentiality and working with minors), stigma and discrimination, communication with patients and relevant national and international regulations and legislation related to HIV
 - 1.5.2 judges, lawyers, police officers, prison staff, public prosecutors and other public servants
 - 1.5.3 students of medicine, dentistry and nursing on gender, sexuality and HIV-related discrimination
 - 1.5.4 journalists, students of journalism and young politicians on gender, sexuality and HIV-related discrimination
- 1.6 Establish a consultative process with politicians on issues of HIV-related stigma and discrimination within the context of the respective international conventions
- 1.7. Conduct annual national anti-stigma and discrimination campaigns to address issues of gender, sexuality, violence and HIV

Prevention of HIV amongst specific target groups and settings

2. Most at-risk populations

Objective 2:

By 2015, provide an essential package of HIV and STI prevention interventions to sex workers and their clients, injecting drug users and men who have sex with men

Indicators (UNGASS and for most at-risk populations):

- Number and percent of key intervention sites with HIV prevention programmes in place
- Number and percent of most at-risk populations (FSWs, IDUs and MSM) reached by prevention programmes
- Number and percent of most at-risk populations (FSWs, IDUs and MSM) who received an HIV test in the last 12 months and who know the results
- Number and percent of most-at-risk populations (FSWs, IDUs and MSM) who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission
- Number and percent of female and male sex workers reporting the use of a condom with their most recent client
- Number and percent of men reporting the use of a condom the last time they had anal sex with a male partner
- Number and percent of female and male injecting drug users reporting the use of a condom the last time they had sexual intercourse
- Number and percent of female and male injecting drug users reporting the use of sterile injecting equipment the last time they injected

Activities

- 2.1 Agree an essential package of HIV prevention interventions for most at-risk populations (FSWs, IDU, MSM) and clients of sex workers.
- 2.2 Develop sub-regional outreach manual and curriculum, building on existing outreach training programmes (local NGOs) and train appropriate staff.
- 2.3 Build capacity of staff (government, private and NGO) working with FSWs (and their clients), IDUs, MSM on:
 - 2.3.1 sexuality, sexual and reproductive health
 - 2.3.2 adolescents engaging in HIV risk behaviour
- 2.4 Build capacity of FSWs, IDU, MSM and PLHIV and assist them to develop their own organisations

Injecting drug users

- 2.5 Scale up outreach activities with IDUs
- 2.6 Establish two drop in centres for IDUs
- 2.7 Scale up methadone maintenance therapy (MMT) activities in PHC system
- 2.8 Sensitize key stakeholders on harm reduction principles

Men who have sex with men

- 2.9 Scale up outreach activities with MSMs
- 2.10 Establish counselling centre for MSMs run by NGOs

Sex workers

- 2.11 Scale up outreach activities for SWs
- 2.12 Establish drop in centre in Podgorica for SWs
- 2.12 Sensitize police officers, psychologists and social workers to issues of sex work and HIV (link with Activity 1.5.2)

Most at-risk adolescents (MARA)

- 2.13 Conduct behaviour change communication (BCC) training for MARA peer educators
- 2.14 Establish outreach programme and peer education for MARA
- 2.15 Adapt STI, VCT and YFHS to the needs of MARA boys and girls

3. Vulnerable populations

Objective 3:

By 2015, provide an essential package of HIV and STI prevention interventions to people in settings where HIV risk behaviour may be more prevalent (prisons, hotels) and amongst the military and uniformed services (including sailors) and amongst socially excluded youth

Indicators (national for vulnerable populations):

Percent of female and male sailors, prisoners, RAE youth, workers in the tourism industry who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

Percent of female and male sailors, prisoners, RAE youth, workers in the tourism industry reporting the use of a condom the last time they had sexual intercourse with a non- regular partner

Activities

- 3.1 Agree an essential package of HIV prevention interventions for:
 - 3.1.1 prisoners and juveniles in detention facilities
 - 3.1.2 sailors and their sexual partners
 - 3.1.3 people working in the tourism industry
 - 3.1.4 RAE and socially excluded youth
- 3.2 Build capacity of staff (government, private and NGO) working with:
 - 3.2.1 male and female prisoners and juveniles in detention facilities
 - 3.2.2 sailors
 - 3.2.3 male and female staff working the tourism industry
 - 3.2.4 RAE and socially excluded youth
- 3.3 Scale up outreach activities for:
 - 3.3.1 sailors
 - 3.3.2 male and female staff working in the tourism industry
 - 3.3.3 RAE and socially excluded youth through peer educators and the establishment of RAE health mediators
 - 3.3.4 prisoners including for HIV testing, through trained medical staff
- 3.4 Provide training on HIV and STI prevention for:
 - 3.4.1 prisoners
 - 3.4.2 juveniles in detention facilities
 - 3.4.3 the military
 - 3.4.4 police
- 3.5 Establish two additional counselling centres for sailors and their sexual partners
- 3.6 Review the policy on categorisation of tourist facilities to enable installation of condom machines

4. Primary prevention amongst young people and the general public

Objective 4:

By 2015, provide primary prevention information on HIV and sexually transmitted infections (STI) amongst young people and the general public

Indicators (UNGASS):

Percent of female and male youth (15-24) who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*

Percent of female and male youth (15-24) who have had sexual intercourse before the age of 15

Percent of primary and secondary schools that provided life skills-based HIV education within the last academic year

Activities

- 4.1 Introduce healthy life styles (including on HIV and STIs) curriculum in secondary schools
- 4.2 Conduct training on peer education, debates and life-skills based HIV and STI prevention (young adolescents and other young people) in schools and other places where young people gather (youth clubs, volunteer groups and student unions)
- 4.3 Establish standards for Youth Friendly Health Services as part of counselling services integrated with VCT and STI services within *Dom zdravlja*
- 4.4 Monitor implementation of the national standards for YFHS paying particular attention to access of socially excluded youth
- 4.5 Integrate VCT, STIs and YFHS within primary health care system
- 4.6 Conduct public campaigns and media events (e.g. concerts) on prevention of HIV and STIs and condom promotion amongst young people
- 4.7 Conduct annual national anti-stigma and discrimination campaigns to address issues of gender, sexuality, violence and HIV (link with Activity 1.7)

5. Prevent HIV transmission in health care and other occupational settings

Objective 5:

By 2015, prevent HIV transmission in all health care settings through the provision of safe blood and blood products, and through the application of universal (standard precautions) and use of post exposure prophylaxis when needed in health care settings (including private dentists), prisons and amongst police.

Indicator (UNGASS):

Percent of donated blood units screened for HIV in a quality assured manner

National indicators:

Percent of donated blood received by voluntary blood donations

Activities

- 5.1 Maintain and monitor quality of blood and blood products before transfusion and ensure regular supply of all reagents
- 5.2 Maintain and ensure universal precautions are followed in health care settings
- 5.3 Educate other professionals in universal precautions and how to prevent HIV transmission
 - 5.3.1 Private dentists
 - 5.3.2 Prison staff
 - 5.3.3 Police officers
- 5.4 Review the feasibility of providing immunization for Hepatitis A and B for staff in contact with blood and blood products.

- 5.5 Ensure post exposure prophylaxis is available for persons exposed to HIV during the course of their work
- 5.6 Motivate the general population and young people about voluntary blood donation through public campaigns on blood safety and school/university based educational events in cooperation with MoHLSW, Red Cross and the media
- 5.7 Establish data base and registry of all voluntary blood donors
- 5.8 Introduce questionnaire for all blood donors to facilitate self-exclusion if already engaged in HIV risk behaviour

Treatment, care and support

6. Treat, care and support people infected and affected by HIV

Objective 6:

By 2015, provide affordable and equitable treatment, care and support for all people infected and affected by HIV.

Indicators (UNGASS):

Number of adults and children with advanced HIV infection receiving antiretroviral therapy
Number of adults and children with HIV still alive and known to be on treatment 12 months after initiation of antiretroviral therapy

Activities

- 6.1 Improve planning between MoHLSW and NHIF to maintain sustainable supplies of:
 - 6.1.1 antiretroviral therapy
 - 6.1.2 diagnostic tests and CD4 tests
 - 6.1.3 drugs for the treatment of opportunistic infections
 - 6.1.4 tests for drug resistance
- 6.2 Monitor PLHIV access to ARV
- 6.3 Construct and equip new Infectious Diseases Clinic
- 6.4 Conduct survey on stigma and discrimination experienced by PLHIV (see Activity 1.4.2)
- 6.5 Build capacity of:
 - 6.5.1 pharmacists on stigma (see Activity 1.5.1) to facilitate PLHIV access to ARV
 - 6.5.2 health and related staff, NGOs and faith based organisations in psycho-social support for PLHIV
 - 6.5.3 health and related staff, NGOs and faith based organisations in palliative care

Evidence-informed and coordinated response

7. Surveillance, monitoring and evaluation an evidence informed planning

Objective 7:

By 2015, improve surveillance, monitoring and evaluation of activities related to HIV and AIDS and base planning on the evidence obtained

Indicators (UNGASS):

HIV prevalence among most at-risk populations

Activities

- 7.1 Strengthen national capacity in monitoring and evaluation and second generation surveillance system with BBS data disaggregated by age, sex and diversity.
- 7.2 Revise HIV/STI data collection form to collect data on displacement, language, sexuality
- 7.3 Obtain population size estimates for people who: inject drugs and sell/ exchange sex, and men who have sex with men
- 7.4 Develop agreed common national protocol for data collection with most at-risk populations
- 7.5 Conduct biannual BBS surveys among IDUs, SWs and MSM (biological samples to be tested for HIV, Hepatitis B and C, Syphilis, Gonorrhoea)
- 7.6 Conduct BBS surveys among prisoners and sailors
- 7.7 Conduct behavioural surveys amongst
 - 7.7.1 Socially excluded youth (RAE, children living working on the streets and in institutional care - juvenile detention, orphanages)
 - 7.7.2 Youth (15 to 24)
- 7.8 Build capacity in research methodology, monitoring and evaluation amongst:
 - 7.8.1 Government and NGO staff (research methodology)
 - 7.8.2 Government and NGO staff (monitoring and evaluation)
- 7.9 Conduct annual six monthly planning and review meetings involving all partners
- 7.10 Evaluate GFATM 5th round project implementation
- 7.11 Conduct Mid Term Review of national strategic plan in 2012
- 7.12 Conduct final evaluation of national AIDS Strategy
- 7.13 Procure equipment (computers, printers, digital projectors)

8. Coordination, capacity and financing of national response

Objective 8:

By 2015, strengthen capacity, coordination and sustainability of the national response to AIDS

Indicator (UNGASS):

AIDS spending by categories and financing source

Activities

Sustainable financing

- 8.1 Develop and gain government approval for National AIDS budget
- 8.2 Lobby and advocate year by year increase in State Budget allocations for AIDS and STIs
- 8.3 Include AIDS and STI Work plan within the NHIF annual plan
- 8.4 Develop national resource mobilization plan and update annually

Human resources and management

- 8.5 Establish an efficient management structure within the Ministry of Health, Labour and Social Welfare with designated responsible officers
- 8.6 Produce comprehensive training plan showing numbers of staff trained (by topic, government/private sector, NGO and geographical location) and identify those to be trained by topic

Coordination and partnerships

- 8.7 Convene quarterly meetings of National AIDS Commission and establish Working Groups on specific topics reporting to NAC

- 8.8 Accredite private doctors so they become full partners in AIDS/STI response, maintain quality of services provided and contribute to government reporting mechanisms
- 8.9 Coordinate and report in a timely manner on work plan, budgets and on activities of partners
- 8.10 Establish coordination mechanism for NGOs

National coordination and management of the strategy

Coordination, participation and partnerships

The government of Montenegro is overall responsible for the implementation of the national AIDS response. To this end the National AIDS Commission (NAC) was established with a legal mandate to coordinate all AIDS activities within Montenegro. It has 15 members and including representatives of key Ministries, four NGOs and people living with HIV and is convened by the Ministry of Health, Labour and Social Welfare (the responsible executive body). Within this ministry the Institute of Public Health has been designated as the responsible technical department.

The Country Coordinating Mechanism (CCM) has broader representation than the NAC with about 25 voluntary members from five different ministries (Education, Interior, Justice, and Tourism, in addition to Health, Labour and Social Welfare) and also includes representatives of PLHIV, NGOs, the National Health Insurance Fund and members of the UN Theme Group on AIDS.

It is proposed to strengthen the National AIDS Commission through the establishment of working groups on particular thematic areas (for example, blood safety, prevention, treatment, World AIDS Day campaigns) who would report to the Ministry of Health, Labour and Social Welfare through the Institute of Public Health. This would facilitate greater participation of civil society and community involvement within the national response and complement the work of the CCM in implementing the GFATM grant. The selection of a NGO (CAZAS) as one of the two principle recipients for GFATM Round 9 should also enhance NGO participation in HIV prevention efforts.

The UN Theme Group on AIDS will continue to be pivotal in providing technical and financial support to the national AIDS response.

All stakeholders involved in the development of the Strategy are committed to ensuring that measures are implemented for the benefit of individuals, communities and the general public. The strategy builds on initiatives to extend AIDS activities beyond the health sector. This requires sustained coordination and cooperation with other organizations to ensure the multi-sectoral response takes into account national legislation and strategies (including those listed chronologically below):

- Cooperation Agreement to Prevent and Combat Trans-border Crime with SECI (South Eastern Cooperative Initiative), 1999
- Action Plan of the Government of Montenegro for Drug Abuse Prevention in Children and Youth, 2001
- National Programme for the Prevention of Violence and Human Trafficking, 2003
- Poverty Reduction Strategy Paper, 2003
- Law on Health Care, 2004
- Law on Health Insurance, 2004
- Law on Protection against Infectious Diseases, 2005
- Law on Rights of Mentally Ill Patients, 2005
- National Action Plan for Roma Inclusion Decade in Montenegro 2005 to 2015, 2005
- National Strategy for Permanent Solution of the Problem of Refugees and Internally Displaced Persons, 2005
- Strategy for Preserving and the Improvement of Reproductive Health, 2005

- Strategy on Mental Health, 2006
- National Plan of Action for Children in Montenegro, 2006
- Strategy for Social and Child Protection Development, 2007
- Strategy on Poverty Alleviation and Social Inclusion (2007 -2011), 2007
- Law on Provision of Sufficient Amount of Safe Blood Units, 2007
- Strategy for improvement of the position of the Roma, Ashkali and Egyptian population in Montenegro for 2008 to 2012, 2008
- Strategy on Health Care Development and Bill on Health Care Data Collection, 2008
- National Strategic response to Drugs (2008 to 2012), 2008
- National Action Plan on the achievement of Gender Equality (2008 to 2010) and reporting in accordance with the Convention of the Elimination of all forms of Discrimination Against Women (CEDAW), 2008
- Law on Anti-Discrimination, 2008 (under adoption)
- Law on Gender Equality, 2008 (under adoption)

All activities of the national AIDS response will be in accordance with Montenegrin health and social welfare reform and be consistent with EU accession requirements.

Budget

The budget for the *National AIDS Strategy for 2005 to 2009* is estimated to be Euro 16,340,000 with 38% of the budget allocated to groups most at-risk of HIV and about 16% to improved surveillance, monitoring and evaluation. A proposal for Euro 5,164,889 has been submitted to the GFATM Round 9. The precise government contribution is not yet known as the annual budget figures will not be available until July 2009. Support is being requested from the World Bank AIDS Strategy and Action Plan (ASAP) to assist the government of Montenegro develop precise costings. UNAIDS, UNDP, UNHCR and UNICEF have agreed to continue supporting the national AIDS programme 2010 onwards and the precise figures will be available once the Resource Mobilisation Plan is finalised.