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**NATIONAL AIDS PROGRAM**

**UNGASS COUNTRY PROGRESS REPORT**

*Reporting period: January 2008-December 2010*

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## **Acronyms**

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MOH	Ministry of Health
CCM	Country Coordination Mechanism
NAP	National AIDS Program
M&E	Monitoring and Evaluation
GF	Global Fund
NGO	Non Governmental Organization
VCT	Voluntary Counseling and Testing
IDU	Injecting Drug User
MSM	Man having sex with man
ARV	Anti Retroviral Therapy
MMT	Methadone Maintenance Therapy
MTCT	Mother to Child Transmission
UHCT	University Hospital Center Tirana
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations Special Session on HIV/AIDS (June 2001)

## **II. Status at a glance**

### **(a) The inclusiveness of the stakeholders in the report writing process**

The UNGASS Report 2010 was prepared by the National AIDS Program at the Institute of Public Health. This report presents the progress made in the national response to HIV/AIDS during the period 2008-2009 in addressing the priorities defined within the national consultation process on Universal Access to prevention, treatment care and support.

National AIDS Program benefited from the active participation of all relevant national stakeholders and international partners through discussions on the report requirements and availability of national data. In the process of identification, provision and verification of the available epidemiological, clinical, programmatic and other data relevant for reporting to the proposed UNGASS indicators, representatives from the Ministry of Health, Institute of Public Health, and the Department of Infectious Diseases, University Hospital Center have been included.

The National Composite Policy Index (NCPI) form was sent to the governmental institutions and representatives of the civil society sector active in the area of HIV/AIDS. Contributions to the National Composite Policy Index have been completed at two separate meetings. The major partners gave their contribution to this report through the everyday work they have done during this reporting period and have helped the National AIDS Program when compiling the report through providing extensive consultations, promptly and expertly providing the information needed

During the whole process, technical support has been provided by UNAIDS and the Joint UN Team on HIV/AIDS.

### **(b) The status of the epidemic**

Albania remains a low HIV prevalence country. As of December 2009, 365 cases of HIV have been identified; 61 new cases were identified during 2009. More than 90 % of these infections occurred due to sexual contact (82% heterosexual and 10% homo-bisexual), and the most affected age group is people between the ages of 25 and 44 years. HIV transmission via infected blood has been confirmed in 3 percent of cases, and mother-to-child-transmission (MTCT) in 4

percent of the cases. However, country's specific socio-economic condition and the regional context of HIV/AIDS influence the vulnerability and the risk for rapid spread of HIV/AIDS epidemic, particularly among most-at-risk populations. Furthermore, the results from the repeated bio-behavioural surveillance studies in 2005 and 2008 indicate that high risk behaviours are still present among most-at-risk populations such Injecting Drug Users (IDU), Man who have Sex with Man (MSM).

### **(c) The policy and programmatic response**

The highlights of the country response in the period 2008- 2009 include the following:

Continuation of activities through the HIV program supported by the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), contributed to successful implementation of the key priorities and activities planned in line with the National Strategy and resulted in overall increase in coverage of clients reached and types of services provided.

The activities are strongly-focused on the sub-populations in Albania considered most vulnerable to HIV/AIDS, that is, injecting drug users (IDU), sex workers and men who have sex with men (MSM). These populations have been identified based both on evidence of epidemics in other countries, which have spread rapidly among one or more of these populations, and from in-country evidence of vulnerability factors such as unsafe sexual and injecting practices. The GFATM/HIV program has also contributed to improved collaboration and coordination between the governmental and non-governmental organizations, as essential precondition for implementation of services especially among hard to reach populations.

Based on the new development, reflecting monitoring and evaluation data, changes in the epidemiological situation, findings of research, and the meantime to strengthen the efforts and commitment of the Albanian Government and to achieve Millennium Development Goals a new National AIDS Strategy was developed in 2008.

Because of rapidly changing needs MOH and IPH developed and drafted a new Law on HIV/AIDS in Albania and this was approved by Parliament in July 2008. The law addresses the most critical legal aspects of HIV/AIDS including discrimination, the right to keeping one's job,

information consent, confidentiality, free access to information and treatment, the establishment of “safe places” where affected people have access to life saving treatment, and a complaints mechanism. The law provides for the right to treatment and care, and it also provides opportunities for new scientific research in HIV/AIDS.

The political support was crucial in formulation of the country future roadmap through identification of priorities within the national consultation process on Universal Access, development of the new National AIDS Strategy 2008-2014 and the approval of the new AIDS law.

### **UNGASS indicator data in an overview table**

Data reported for the UNGASS indicators (Table 1) are coming from the, surveillance studies on HIV prevalence and risk behaviours among most-at-risk-populations, conducted in 2006 and 2007, clinical records and DHS, Demographic Health Survey 2008-2009.

**Table 1. Overview of UNGASS indicators data**

<b>National Commitment and Action</b>		
<b>Indicators</b>	<b>Status</b>	<b>Source of data</b>
1. Domestic and international AIDS spending by categories and financing sources	Not available	
2. National Composite Policy Index (Areas covered: gender, workplace programmes, stigma and discrimination, prevention, care and support, human rights, civil society involvement, and monitoring and] evaluation)	See ANNEX NCPI	
<b>National Programmes</b>		
3. Percentage of donated blood units screened for HIV in a quality assured manner	100%	National Blood Transfusion Center

4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	Numerator 114  Denominator: estimates not available	Clinical records from the Department of r Infectious Diseases, University Hospital Center
5. Percentage of HIV-positive pregnant women who receive antiretroviral to reduce the risk of mother-to-child transmission	No cases among pregnant women in 2008-2009	
6. Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV	Numerator 4 (2008-2009)  Denominator: estimates not available	Clinical records from the Department of r Infectious Diseases, University Hospital Center
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know the results	Female 0.2%  Male 0.6%	DHS (Demographic Health Survey) 2008-2009
8. Percentage of most-at-risk populations that have received a HIV test in the last 12 months and who know the results	IDU 16.5% (n.33)  MSM 44.9% (n.89)	Bio-BSS 2008. RDS was used as sampling methodology, samples allow us to make inferences about the characteristics of the larger networks of IDU(sample size 200)and MSM(sample size 198) in Tirana.
9. Percentage of most-at-risk populations reached with HIV prevention programmes	Data available only for question “Know where to receive HIV test” (MSM – 78.3%(n.123); IDUs – 79.1 % (n.131)	Bio-BSS 2008. RDS was use as sampling methodology, samples allow us to make inferences about the characteristics of the larger networks of IDU(sample size 200) and MSM(sample size 198) in Tirana.
10. Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child	Not relevant	
11. Percentage of schools that provided life skills-based HIV education within the last		

academic year		
<b>Knowledge and Behaviour</b>		
12. Current school attendance among orphans and among non-orphans aged 10–14	Not relevant	
13. Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Female 35.9% Male 22%	DHS (Demographic Health Survey) 2008-2009
14. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	MSM 18% IDU 15.2% (for IDU question Can e healthy – looking person have HIV missing)	Bio-BSS 2008. RDS was use as sampling methodology, samples allow us to make inferences about the characteristics of the larger networks of IDU (sample size 200) and MSM(sample size 198) in Tirana.
15. Percentage of young women and men who have had sexual intercourse before the age of 15	Female 0.5% Male 1.2%	DHS (Demographic Health Survey) 2008-2009
16. Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	Female 0.1% Male 5.4%	DHS (Demographic Health Survey) 2008-2009
17. Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse	Male 40.4% Female- not calculated because too few women having two or more partners in the past year	DHS (Demographic Health Survey) 2008-2009
18. Percentage of female and male sex workers reporting the use of a condom with their most	No data available	

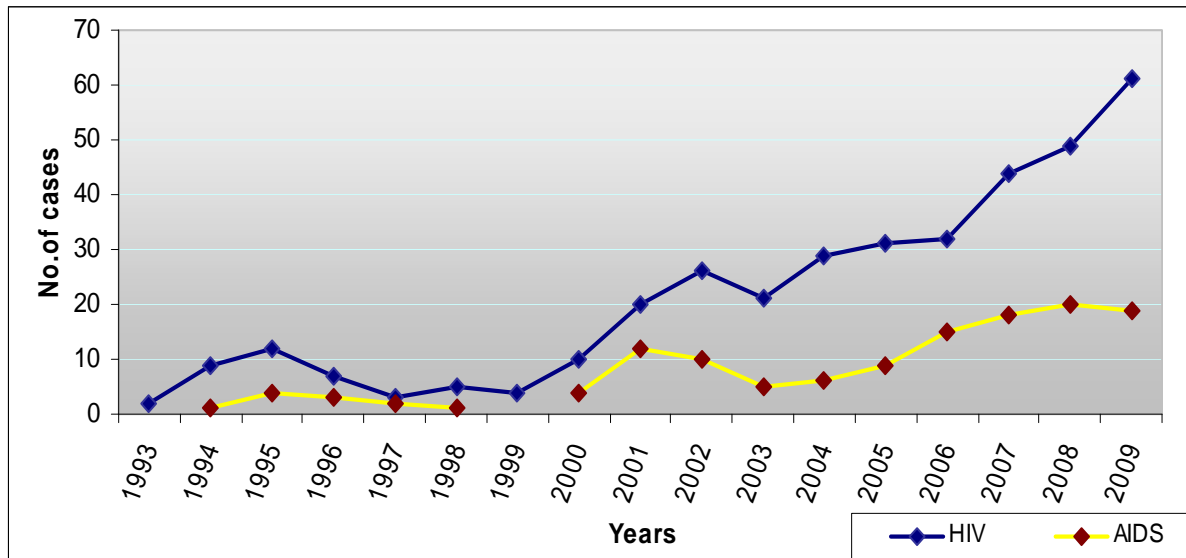


recent client		
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	With non-regular, non-commercial – 59.1%	Bio-BSS 2008. RDS was used as sampling methodology, samples allow us to make inferences about the characteristics of the larger networks of IDU(sample size 200) and MSM(sample size 198) in Tirana.
20. Percentage of injecting drug users who report the use of a condom at last sexual intercourse	With non-regular, non-commercial – 36%	Bio-BSS 2008. RDS was used as sampling methodology, samples allow us to make inferences about the characteristics of the larger networks of IDU(sample size 200) and MSM(sample size 198) in Tirana.
21. Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected	81.6%	Bio-BSS 2008. RDS was used as sampling methodology, samples allow us to make inferences about the characteristics of the larger networks of IDU(sample size 200)and MSM(sample size 198) in Tirana.
<b>Impact</b>		
22. Percentage of young women and men aged 15–24 who are HIV infected	Not relevant	
23. Percentage of most-at-risk populations who are HIV infected	MSM 1.8% No cases detected among IDU	Bio-BSS 2008. RDS was used as sampling methodology, samples allow us to make inferences about the characteristics of the larger networks of IDU(sample size 200)and MSM(sample size 198) in Tirana
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of ARV therapy	88.5% -2008	Clinical records from the Department of r Infectious Diseases, University Hospital Center

### III. Overview of the AIDS epidemic

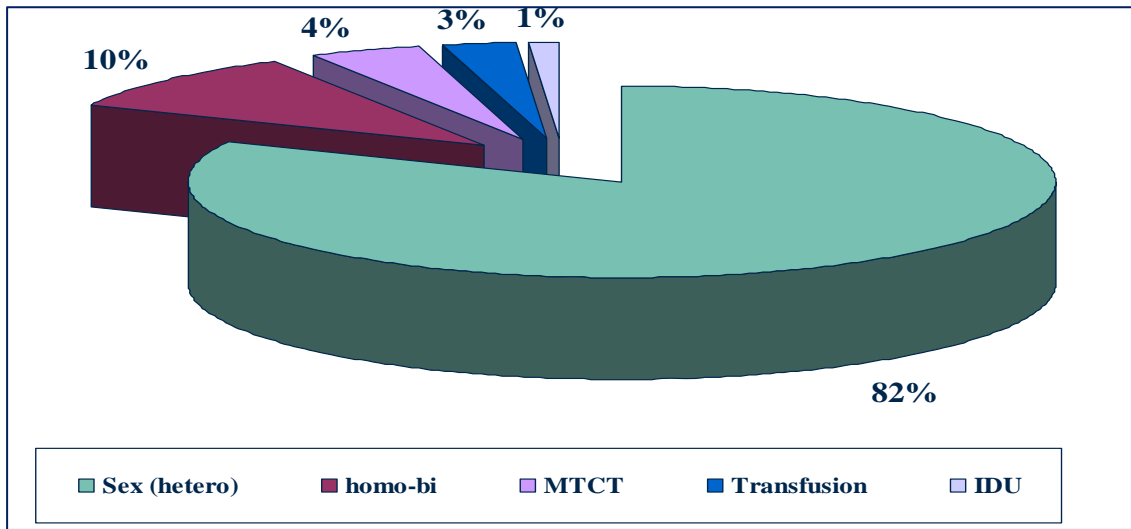
Albania remains a low HIV prevalence country. Nevertheless the trend of HIV infection is going up and the estimates show a high number of undiagnosed cases. This fact emphasizes that is very important to strengthen continually the Surveillance System and to promote the Voluntary and Counseling Centers (VCT) especially for vulnerable groups. As of December 2009, 365 cases of HIV have been identified; 61 new cases were identified during 2009.

*Figure 1. Distribution of HIV and AIDS cases in years (1993-2009)*



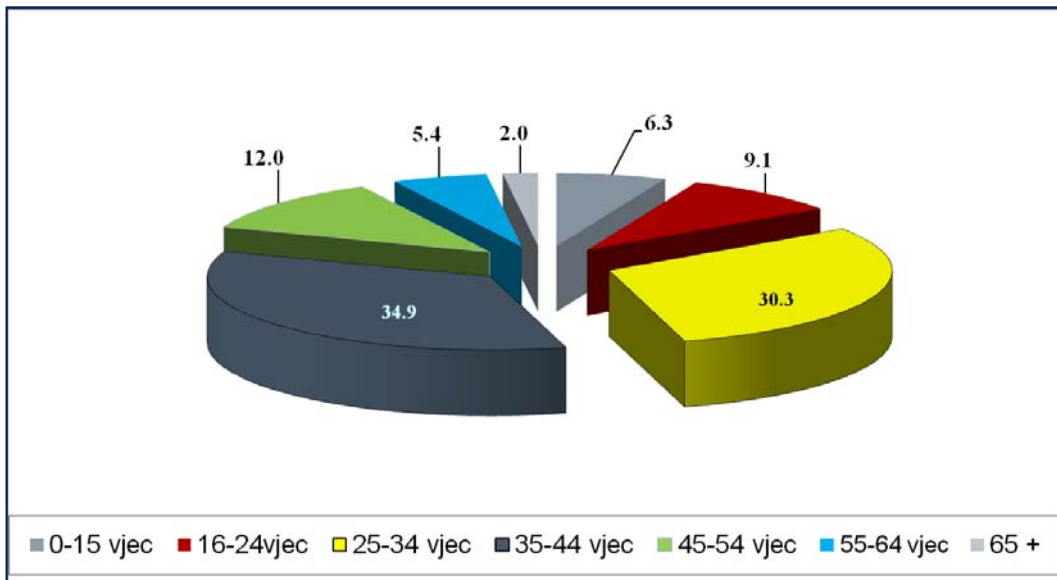
More than 90 % of these infections occurred due to sexual contact (82% heterosexual and 10% homo-bisexual). HIV transmission via infected blood has been confirmed in 3 percent of cases, and mother-to-child-transmission (MTCT) in 4 percent of the cases.

**Figure 2. Distribution of HIV cases by mode of transmission**



The most affected age group is people between the ages of 25 and 44 years

**Figure 3. Distribution of HIV cases by age group**



Regarding geographical distribution of HIV cases, the majority of HIV cases is located in capital city Tirana (54 %). Based on epidemiological investigations 54 % are infected during the period of their emigration or their visit in other countries and 46% inside the country.

## Bio-Behavioral Studies

After the first national Bio-Behavioral Surveillance study carried out in 2005, which results have been already reported, the same study with among IDU, MSM and Roma population have been conducted 2008 under the GFATM funded HIV program. Respondent-driven sampling (RDS) was used to recruit IDU and MSM respondents, while The Roma population were sampled using standard household cluster sampling techniques

**Sample Size Projected and Achieved, by Study Population**

<b>Group</b>	<b>Sample Size Calculated</b>	<b>Sample Size Achieved</b>
<b>IDU</b>	200	200
<b>MSM</b>	200	198
<b>Roma</b>	1260	1265
<b>Total</b>	1,660	1,663

## Biological Data

Overall, the prevalence of biological infections among the Bio-BSS target populations was low. HIV was not detected among the IDU and Roma; estimated prevalence among MSM 1.8% (95% CI: 0.5%–3.3%).

Syphilis rates were low among IDU and Roma (0.5% and 0.3%), while among MSM was 2.6% Hepatitis C among IDU was 7.6%. Behavioral data related to HIV for each study population are presented below.

## Behavioral Data

### Injecting Drug User

The estimates regarding the IDU population in Tirana reveal that the majority of IDU are male, that about 35% of IDU are less than 25 years old and that the majority are married, almost 58% and 40 % do not live with a sexual partner. In terms of education, an estimated proportion of 26.6 % are illiterate and 33.1 % of the IDU have completed at least 8 classes. 18.4 % have also completed high school (12 classes).

IDU did report high levels of alcohol use. Population estimates show that almost 29 % consume alcohol daily, and that almost 25 % consume alcohol at least once a week.

The vast majority of IDU (81.2 %) have injected for 5 years or less, with almost 20% having injected for less than 12 months. The median age at first injection is 24 years, with about 30% of IDU estimated to have injected before the age of 19. 20.1 % of the population injected drugs multiple times daily. This figure differs significantly from the one in the first Bio\_BSS (81.7%), but in the first study, because of an error in the questionnaire, the percentage that came out was a result of adding up two indicators. The most commonly used injectable and non-injectable drugs in the past month were heroin (85.2%), diazepam (37.4%), marijuana (55.8%), and cocaine (39.1%).

The overwhelming majority (97.5%) of IDU are estimated to have ever engaged in sexual intercourse and almost the same (87.3%) had sexual intercourse in the past 12 months. The median age at first sexual encounter was 16 years.

80.5 % of the sample size refer first sex before the age of 18. An estimated proportion of 87.3% had sex in the last 12 months Population estimates reveal that 45 % of IDU have had two or more sex partners in the previous 12 months.

Among those who have had sex in the past 12 months, population estimates show that almost 82% (65.7% in the first Bio BSS study) had sex with a regular partner. 38.5% of those who are sexually active have had sex with non-regular partners in the last 12 months. An estimated proportion of 13.3% reported having sex with commercial sex partners in the past 12 months(4% in the first Bio BSS ).

Condom use varies greatly by the type of sex partner, but it was not common to use condoms with either regular or non-regular sex partners. It is estimated that 16.5% (27.8% in the first Bio BSS) of the IDU population used a condom with their regular partner during their last sex and 36% (38.9% in the first Bio BSS) with non-regular partners. Even fewer IDU use condoms consistently: only 7.3% (similar to the first Bio BSS) with regular sex partners and 36.8% (17% in the first study) with non-regular sex partners.

An estimated more than two-thirds of IDU (almost 80%) are aware that confidential HIV testing is available, with almost 35% having had an HIV blood test (30% in the first Bio BSS).

### **Men Who Have Sex with Men**

The median age of MSM participants was 26.5 years, and less than half of MSM in Tirana are estimated to be younger than 24 years of age (44%). Population estimates indicate that 26.1% of MSM never received any formal education, 35% of MSM completed the compulsory education of 8 classes, and almost 17 % completed 12 classes.

In terms of drug use, an estimated 64.8% of MSM have tried drugs (injected or non-injected), Population estimates indicate that more than half of MSM inject drugs (59.2%), with heroin being the most frequently injected drug among MSM in Albania

The MSM population is sexually active, with almost 90% estimated to have had sex in the past 6 months. An estimated 15% of MSM were forced to have sex when they did not want it. In the 6 months preceding the survey, population estimates indicate that 84% (about 60% in the first Bio BSS) of MSM had oral sex with a man, and almost 73% either ejaculated into his partner's mouth or his partner ejaculated into his mouth

Surprisingly a big difference in comparison with the first Bio BSS, was that the majority of MSM (80.2%) had more than four sexual partner during this period; the median number of partners was twenty.

The overwhelming MSM respondents (89.7%) had anal sex in the past 6 months

It is estimated that 74.2 % of MSM had anal sex with a commercial partner in the 6 months preceding the survey. Out of MSM who have had a commercial sex partner, the majority (77.1%) used a condom with that partner during the last anal sex,. On the other hand, almost 58% (only 16% for the first Bio BSS) used a condom consistently during every anal sex act with a commercial sex

Almost 50% in the Tirana MSM network have had sex with a female. It is estimated that 84% of those had sex with a female in the past 6 months, and the majority 71.3% having 1-3 female partners. Condom use with females is at 56.5 % and 42.3% reporting consistent condom use with all female partners in the past 6 months.

The majority of MSM are estimated to know that confidential HIV testing is available in Tirana with 78.3%. All those who know about the test have had and HIV test. The sample characteristics indicate that of those MSM who had been tested, two in three had taken the HIV test voluntarily, and that the majority of those tested had received their test results. Most of the MSM tested have taken the test in the last 12 months (71.2%)

## **Roma**

The weighted Roma study sample was young, with almost one-third (31%) of participants being less than 24 years of age (median age = 31). About 41% had married before the age of 16 (official legal age for marriage in Albania is 18), and the majority who had married before the age of 16 were female (53.3 %). Almost 20% report to be not married, but living with sexual partner. In terms of education, 28 % had received no education and one-fourth had completed only 4 years of education.

92.2% of the Roma reported having had sexual intercourse ever (defined as vaginal or anal intercourse). The median age at first sex was 16 years for the Roma. The majority of Roma (about 77%) had sex before the age of 18, with 21.6 % having first engaged in sex between the ages of 10 and 14 years. This early age of sexual initiation is almost equal among Roma males and females. Regarding condom use, 23.2% of Roma reported having used a condom (ever), while 65 % of those who had sex in the last 12 months, have not used condoms.

Only 7.9 % of the Roma population females reported that a sexual partner had forced her to have sex when she did not want to in the past 12 months.

Despite a general awareness of HIV prevention methods, there are many misconceptions about HIV among the Roma Population. For example, only about 26% of Roma believed that HIV is not transmitted through mosquito bites and almost 29% believed that HIV is not transmitted by sharing a meal with someone who is living with HIV. Of particular importance is the fact that 66.3% of the Roma believed that a healthy-looking person could be infected with HIV. Correct and incorrect response rates to knowledge questions were almost similar for males and females.

Despite this reality, only almost one in three of respondents reported being aware that a confidential HIV test is available in their location. The fact is that these centers are newly

opened. Actual HIV testing was infrequent and very low with only 3.5 % that responded ever had an HIV test.

### **MARA (Most at Risk Adolescents)**

Recognizing the fact that while the population of Albania is the youngest in Europe and adolescents are among all sub-populations most at risk of HIV, there is inadequate information available regarding Most at Risk Adolescents (MARA), and their age-specific risks and vulnerabilities. Accordingly, the Institute of Public Health in partnership with UNICEF Albania and relevant NGOs in 2008 conducted the first-ever Most at Risk Adolescents (MARA) Behavioral Surveillance Study (BSS) in Tirana. What emerges from this survey is that all the risk populations reached are at high risk of HIV infection from a variety of factors, including; the vast majority of respondents started their HIV risk behavior in adolescence, all risk populations have substantial overlapping risks, condom use is significantly less than 100% with commercial and casual partners across sub-populations and needle sharing is common. In addition, few respondents sought medical attention for their STI.

## **IV. National response to the AIDS epidemic**

The Albanian response to HIV/AIDS had been focused on prevention, and includes measures of primary, secondary and tertiary prevention. A large proportion of measures for HIV/AIDS prevention are based on health education in the general sense, especially focusing on populations with high risk behaviour, with the goal of changing such behaviour. Due to the low level of HIV/AIDS risk in Albania these measures are predominantly focused on promotion of protective behaviour in general population and adolescent population and on prevention of determined risk behaviour within certain most-at-risk groups. A part of these measures refers to risk reduction among populations such as MSM, IDUs, SWs, promiscuous persons, sexual partners of HIV positive persons and others. Protection measures against nosocomial infections as well as blood control and control of immunobiologic preparations are continually conducted in Albania and these measures should be conducted further on. Respecting and promoting human rights of HIV infected persons is also of exceptional importance. HIV infected people have a right to privacy, normal education, health care, housing and nondiscriminating relations in all aspects of their life.



Some highlights in the development of Albania's national program include:

- The recruitment of a multidisciplinary team of physicians, epidemiologists, psychologists and social workers at IPH with the responsibility for coordinating HIV/AIDS prevention activities and monitoring Albania's epidemiological situation.
- In 2003 the establishment of a network of strategic partners to strengthen the multidisciplinary approach to HIV/AIDS prevention and care.
- An Inter-ministerial HIV/AIDS committee was established in 2003 which aimed to strengthen political efforts for fighting HIV/AIDS.
- Albania's Country Coordinating Mechanism, which meet regularly, was established with government, NGO, and PLWHA participation.
- successful application for a Global Fund grant in round 5, which made possible to further improve existing services and develop new interventions such as: providing services to the most vulnerable groups, strengthening laboratory capacities at IPH and TUHC, improving diagnosis and the prevention and treatment of opportunistic infections, providing treatment with ARV drugs, expanding voluntary counselling and testing (VCT) centres, strengthening the second generation surveillance, increasing advocacy for respecting the rights of, and fighting discrimination against, persons living with HIV/AIDS.

The National HIV/AIDS Strategic Plan 2008–2014 states that the National HIV/AIDS/STI Programme is responsible for coordinating the efforts of government agencies, NGOs and international organisations to achieve programme objectives, and for ensuring adherence to national policies. The National HIV/AIDS Programme is located within the Institute of Public Health (IPH). It coordinates all reference laboratories and departments within IPH, relevant clinics and other strategic partners in regard to HIV/AIDS/STI. Despite its successes, the established strategic partnership needs to be strengthened further in order to increase the effort for implementing effective interventions, better planning, and strengthening civil society and government, public, and private partnerships.

In view of the need to create standards and monitor achievements, the following Reference Centres have been established as part of the national strategic plan 2008 - 2014:

The Clinical Reference Centre (at TUHC “Mother Theresa” Infectious Diseases Department and the referent laboratory attached to this department); The PMTCT Reference Centre (at Obstetric Gynaecologic University Hospital “ Koco Glozheni” in Tirana with the referent laboratory); A national reference laboratory at IPH.

### **Confidential and voluntary counselling and testing**

HIV transmission can be reduced by promoting behaviour change and providing psychosocial support to people with HIV/AIDS. Research has shown that VCT programs are; effective in promoting behaviour change, cost-effective, and practical as one of the most effective strategies for HIV infection prevention in countries with limited resources. HIV/AIDS counselling and testing plays two major roles in preventing and controlling HIV/AIDS: first, prevention through behaviour change, using risk assessments and reduction planning; and second, care through psychosocial support to help patients plan their future. People who receive negative test results have a chance to change their behaviour in order to keep their HIV test results negative and those who are HIV-positive can protect themselves against reinfection and opportunistic infections, can seek medical care for early symptoms and, perhaps most importantly protect other people who they could infect.

VCT centres have been established in ten prefectures using GFTAM funds and they are located in Tirana, Durrës, Vlora, Lezha, Shkodra, Korca, Gjirokastra, Berat and Fier, and Elbasan. These centres provide counseling and voluntary testing for HIV/AIDS and other STIs. Since the establishment of these center the number of people tested has been increased more than ten times, from 250 in 2005, this number is more than 3000 in 2009.

### **Diagnostic and Treatment capacity**

ARVs have been provided to people living with HIV/AIDS in Albania since mid-2004, and is carried out in inpatient and outpatient settings at TUHC and Infectious Disease Service. An Outpatient Clinic for persons with HIV/AIDS was opened with Global Fund support at the end of 2007. The clinic provides services in the areas of ART, its monitoring, psychosocial support, voluntary HIV/STI counselling and testing, TB diagnosis test (skin test), and preventive

medication service. Diagnostic capacities of IPH have increased and viral load measurement techniques were introduced.

ARV therapy is started, applied and monitored on the basis of a guideline approved by the Infective Disease Department and Service and the Albanian Infective Diseases Association. The therapy and its side effects are monitored through routine check-ups and various laboratory tests including the measurement of CD4 levels, which helps monitor the therapy progress more accurately. In addition, IPH has started to apply the measurement of viral load for the HIV infection. Problems remain relative to service coverage throughout the year and better cooperation among institutions is required.

### **Legal acts ensuring health and human rights**

Laws and regulations in Albania have been developed and implemented in line with the HIV/AIDS epidemiological situation and the country's economic and social development. The Law on Preventing the Spreading of HIV/AIDS in the Republic of Albania was adopted by the Albanian Parliament in 2000. Its implementation and the resulting domestic and international experience showed that the law needed revising, as the fight against HIV/AIDS and identification and prevention of HIV/AIDS changed rapidly.

In the light of rapidly changing needs MOH and IPH developed and drafted a new Law on HIV/AIDS in Albania and this was approved by Parliament in July 2008. The law addresses the most critical legal aspects of HIV/AIDS including discrimination, the right to keeping one's job, information consent, confidentiality, free access to information and treatment, the establishment of "safe places" where affected people have access to life saving treatment, and a complaints mechanism. The law provides for the right to treatment and care, and it also provides opportunities for new scientific research in HIV/AIDS.

### **Blood Safety**

Blood screening for HIV and other infective agents is now regulated by law whereby all donated blood units are screened for infective agents that can be transmitted through blood such as HIV, Hepatitis B and C, CMV and syphilis. The number of paid blood donors fell from 18,000 in 1991 to 4,000 in 2004; voluntary blood donation became established in mid-1990s, but only 5% of

blood donation is voluntary in Albania. Donation from family member to the other family increased to 2,000 donations in 2004. While there is a policy for reducing the number of blood transfusions, the need for blood is clearly still present and a significant number of paid blood donors are from vulnerable groups who have low awareness of self-exclusion

## **Surveillance**

The HIV-surveillance system in Albania has been developing gradually since the early 1990s, with important achievements to date. Since the mid-1990s, the responsibility for HIV surveillance in Albania has been with the Institute of Public Health (IPH). The IPH is the central level institution under the MoH that is responsible for prevention and control of infectious diseases. The IPH operates through the District Primary Health Directorates, and collects infectious disease surveillance information from disease-based and syndrome-based systems.

Until 2005, sentinel clinic surveillance was the most common method of monitoring prevalence of HIV infection in Albania. Sentinel groups were established in Tirana to measure the trends of the epidemic among injecting drug users (IDUs), pregnant women, and new military recruits.

In 2005, a *second-generation HIV-surveillance (SGS) system* was initiated in accordance with UNAIDS/WHO guidelines. SGS is a surveillance system, capable of monitoring HIV-related biological and behavioural trends on a regular basis (every three years). It allows monitoring the impact of HIV/AIDS prevention, care and treatment programmes, and provides the basis for planning and programming decisions. The first Bio-BSS study in 2005 (IDU, MSM, and Roma population) provided a solid base for ongoing surveillance of high-risk behaviour as an integral part of the Albanian National AIDS Programme's Monitoring and Evaluation Plan. The second round of Bio-BSS was conducted in 2008, and for the first time allowed establishing trends in HIV rates and related risk behaviours among key most-at-risk populations (MARP), which provided an indication of the combined effects of different interventions.

*Syndromic surveillance* was established in 2007 for STIs: this system comprises reporting on six syndromes through gynaecologists, infectious disease specialists, dermatologist and urologists; as well as with support from general practitioners. To date, seven districts are participating and reporting. In addition, a case-based laboratory surveillance system will be established this year (2009).

## **Information, education, communication and training**

The Department of Health Education and Promotion at the IPH serves as a reference centre on IEC problems related to the prevention of HIV/AIDS under National Program technical and scientific leadership. School HIV and sex education programs have been assisted with the preparation of literature and manuals and while teachers have been trained, there are considerable gaps in the implementation of the curricula. Training programs for nurses, physicians, and social workers, and in the areas of behavioural surveillance and sex education have been organized in cooperation with IPH, University Medical School, University Social Sciences School and UN agencies. In 2008, the National HIV/AIDS/STI Program established the “Let Us Talk about HIV/AIDS” program, which aims at establishing a broader HIV/AIDS communication program focusing on youth.

## **V. Best Practices**

Albania has received a GFTAM grant for the period 2007 – 2012, which seeks to provide essential services to the most vulnerable sub-populations to fill these critical gaps. The overall goal of the proposed program is *to maintain low HIV prevalence among all vulnerable groups in Albania and to provide care, support and treatment for PLWHA*. This will be achieved through focus on three objectives which are targeted HIV prevention; care, support and treatment for PLWHA; and building a coordinated, evidence-based response.

Highlights of the intervention under the GFTAM include:

- *Expanding existing harm reduction programs and establishing new ones* – currently 4 harm reduction programs are functioning, offering a range of services to IDU
- *Establishing and expanding drug substitution therapy with Methadone* - from one center offering this services in capital city, now 4 other centers are established in other districts.
- *Expanding of VCT services by establishing new VCT centers* - prior to the Global Fund project there were only two voluntary counselling and testing (VCT). Under the Global Fund 12 VCT centers are established (in capital city and in ten prefectures). Starting from this year all the VCT centers are taken over by the Ministry of health, assuring the continuity and sustainability of this service

- *Establishment of Outpatient Clinic for HIV/AIDS-* the services provided at the Department of Infectious Diseases were strongly focused on in-patient services, it was a necessity the establishment of an outpatient clinic. For this purpose a ward within the building of the hospital was renovated and fully equipped. The staff of the clinic consists on 5 nurses (1 full time and 4 part time), 1 psychologist, 1 lab technician, and 1 data base manager, offering the necessary services to PLWHA.
- *Establishing and expanding preventive programs with Roma community* - aimed at increasing awareness of Roma community on the HIV/AIDS prevention issues through promoting preventive approaches regarding STI/HIV/AIDS, and encourage voluntary testing among Roma People and through strengthening the capacities among medical staff and peer educator in areas where Roma are located. During the project implementation Roma NGOs have been actively involved. The NGOs that implemented the preventive activities have closely worked with Roma NGOs, establishing good communication with these organizations such as: the Roma Active Albania, Romani Bact, Amarodrom dhe Qendra e Gruas per Zhvillim, Romet per Integrim, Shprese per te Vaferit.
- *Multisectoral cooperation has significantly improved* thanks to the Global fund project, notably resulting in involvement of civil society in the policymaking process through civil society representatives' active role in the CCM.

## **VI. Major challenges and remedial actions**

### **Obstacles to expanding the national response**

The obstacles to expanding the national response are:

- Inadequate data on the scale and location of the HIV and STI problem makes planning for and providing strategic and adequate services to tackle the problem extremely difficult.
- Estimations of the population sizes in general (size of most-at-risk populations, estimated number of HIV positive people and people in need of ARV treatment, etc) are not available yet, besides the fact that, significant amount of prevention, treatment and other services have been provided and bio-behavioural studies have been conducted

- Inadequate and under-funded national prevention, treatment and care programs, and lack of integration of existing health programs results in ineffective services and awareness, especially for vulnerable groups.
- Difficulties in the coordination of supply chain activities actions and the lack of appropriate management systems
- Legal status of SWs means that it is very difficult to provide meaningful outreach, social, and health services to this large at risk group.
- Health systems which discourage many at risk groups from attending primary health care services and obtaining appropriate treatment and very poor referral systems to HIV and STI diagnostic services.
- Inability to track and monitor migrants means that many people who could be affected go undetected.

### **Opportunities for expanding the national response**

The opportunities for expanding the national response are:

- Albania is a country of low prevalence and this means that there is far greater opportunity to contain the spread of HIV.
- There is a health framework in place which can be built upon to provide services to the most at risk members of the population.
- The population is largely literate so they should be responsive to effective HIV and STI campaigns.
- The new law on prevention and control of HIV AIDS in Albania provides a more favorable environment for prevention and treatment.

## **VII. Support from the country`s development partners**

Many of the United Nations agencies present in Albania have been actively involved in the area of prevention and control of HIV/AIDS. The UN Theme Group on HIV/AIDS in Albania was established in 1997. The assets of the UN Theme Group in Albania are shared responsibility, advocacy, and a consensus policy.

The contribution of to the national response consisted:

- Support to Government in development of relevant national policies, such as the new HIV/AIDS strategy (2008-2014)
- Support in strengthening of national HIV/AIDS and STIs surveillance system through capacity building trainings in research study design, data analysis and data use and review of the current surveillance system with specific recommendations for its adjustments and improvements;
- Support research programs (Behavioral Surveillance among Most at Risk Adolescents ), IEC programs, preparation of life skills manual, health education in schools, project on youth friendly services, trainings of health personnel, representatives of NGOs, vulnerable groups, programs of reproductive health and facilitated the implementation of social marketing of condoms.

Future actions need to be taken and planned to be supported by the UN partners in order to scale up national response to HIV/AIDS and ensure achievement of the UNGASS targets, include:

- Support to planning, budgeting and coordination for a sustainable AIDS response, to ensure coherence with the new National AIDS Strategy Action Plan and increase capacities for its decentralized implementation, at regional and local level;
- Support to strengthen evidence based and accountability of the AIDS response, through improved evaluation of the current programmes, their cost effectiveness and coverage in reaching different populations groups; estimation of the sizes among most at-risk population, scale up and include different components of the surveillance system into an integrated national Health Information System, leading to more accurate and sustainable reporting for both national and international commitments and obligations



The establishment of the CCM paved the way for Albania's successful application for a Global Fund grant of approximately US\$5 million to be monitored by IPH and to be implemented in two phases over five years beginning in early 2007. The grant provided funds for:

- providing services to the most vulnerable groups,
- strengthening laboratory capacities at IPH and TUHC,
- improving diagnosis and the prevention and treatment of opportunistic infections,
- providing treatment with ARV drugs,
- expanding voluntary counselling and testing (VCT) centres,
- strengthening the second generation surveillance,
- increasing advocacy for respecting the rights of, and fighting discrimination against, persons living with HIV/AIDS.

## **VIII. Monitoring and evaluation environment**

In 2005 the Monitoring and Evaluation System and Plan for the national response to HIV/AIDS was designed and formally approved by all stakeholders. The plan is structured according to the national strategy. Two types of key indicators have been identified, the first type are focused on the strategy as a whole, particularly the effects it is having. They include:

- Impact indicators (1) – measures of HIV prevalence among the most vulnerable groups
- Outcome indicators [prevention] (3) – measures of knowledge and behavior among young people, and measures of behavior among vulnerable groups
- Outcome indicators [care and support] (1) – survival of PLWHAs on ARV treatment
- Indicators of National Commitment and Action (2) – these are UNGASS indicators and are focused on government financing to HIV/AIDS activities and presence of relevant policies in four key areas

The second type measures services provided under the strategy. They have mostly been selected from a multi-agency toolkit on HIV/AIDS M&E (GFATM et al, 2004).

There are several specific elements within this plan. These include:

- **Measuring Coverage** – One of the key aims of HIV/AIDS M&E is to ensure that services are reaching all the people who need them. In order to measure this, it is necessary to know the number of people receiving a service and the total number who require that service.
- **Tracking Quality** – It is important that services are provided of the required quality. M&E systems can be extremely useful in ensuring the quality of activities carried out.
- **Program Adaptation** – It is not enough simply to track program progress. Rather, data should be used by program management to adapt activities, for example increasing focus in areas with slow progress.
- **Lesson Learning** – M&E data is a potentially rich source of lessons learned from the experience of the national program. This requires space being created to reflect on practice and generation/ documentation of key lessons learned.
- **Financial Accountability** – Although financial accountability is an important element of program monitoring, it is often seen as the main reason for M&E. As such, it can dominate the national M&E system. This should not be the case, particularly within the national response, as a whole, which receives funds from a diversity of different sources.
- **Impact Assessment** – Part of the purpose of a monitoring and evaluation system is to assess the effect that program activities are having or contributing to. These effects are sometimes called outcomes or impact. In the case of this program, the intended effects are changes in behavior, rates of HIV infection and survival rates of PLWHAs.

*Programme M&E approaches are strongly focused on reporting quantitative data on targets and coverage to satisfy donor requirements, with insufficient attention for quality of services. The lack of common standards for services hampers quality assurance and monitoring of services, including client satisfaction and impact of programmes & services on behaviours.*

## Data Flows within the National HIV/AIDS Response in Albania

