COUNTRY PROGRESS REPORT

MONTENEGRO

Reporting period: January 2010 - December 2011.

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I. Status at a glance

a) The inclusiveness of stakeholders in the report writing process

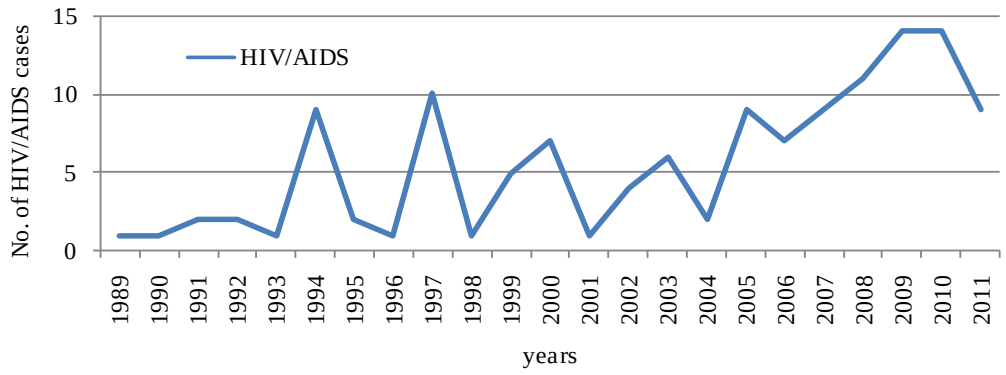
This report was prepared by the Institute of Public Health/Secretariat for HIV/AIDS in close collaboration with all members of National HIV/AIDS Commission/ especially with the members of NAC, which are part of civil sector and UN Theme Group/ UNICEF, WHO, UNDP and UNAIDS.

b) The status of epidemic

Montenegro is a low prevalence country with an estimated HIV prevalence of 0.01%. The first HIV infection was registered in 1989. According to data released by the Institute of Public Health (IPH), the cumulative number of people registered with HIV by the end of 2011 was 128, of whom 35 persons diagnosed with AIDS have died. However, the Institute of Public Health estimated that there were 463 (range 300 to 500) people living with HIV at the end of 2011 using the World Health Organisation (WHO) methodology for HIV estimations and regional trends suggest the potential for an increase in HIV transmission. According to this estimate, 20,4% of all infected are women.

If we look at the number of registered people infected with HIV in relation to the years when the infection was discovered, we can observe a discreete trend of increase (graph 1).

Graph 1. Distribution of HIV/AIDS cases registered in Montenegro, from 1989 to the end of 2011



c) The policy and programmatic response

The most recent official census data for Montenegro puts the population total at 620.029 (313.793 female and 306.236 male).[1] Capital and administrative center is the city of Podgorica, with 185.937 citizens.

In May 2006 Montenegro gained independency and in the same year Montenegro became a member of the United Nations. According to the Constitution, Montenegro is a civil state with the President, Assembly and Government.

Montenegro introduced HIV and AIDS programme in 1985, as part of the programme of the former Republic of Yugoslavia, four years before the first case of HIV infection was identified in Montenegro. Since 1987, special attention has been paid to ensure safe blood and blood products. The National AIDS Committee (NAC) was established in 2001 under the auspices of the then Ministry of Health, Labour and Social Welfare (MoHLSW) (now it is Ministry of Health – MoH) 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.

In June 2001 Montenegro, as a part of FRY, signed The Declaration of Commitment on HIV/AIDS adopted in New York at the UN General Assembly Special Session on HIV/AIDS

[1] MONSTAT, Statistical Yearbook of Montenegro 2011, p.43.

and established the National (Multi-sectoral) HIV/AIDS Commission (NAC). The NAC comprises 15 members and includes members from the Ministries (Health, Interior, Education, Labor and Social Welfare and Tourism), 4 NGOs and representatives of PLHIV. In order to develop project proposal for Global Fund for tuberculosis, malaria and AIDS competition, a wider body, Country Coordinating Mechanism (CCM) was established in August 2002, consisting of Republic Commission and the UN Theme Group on HIV/AIDS in Montenegro.

Late in 2003 the Government of Montenegro established Coordination Body for fight against human trafficking, appointed the Coordinator and opened the Centre for Accommodation of Victims of Trafficking.

It should be noticed that there is a political will to address the issue comprehensively and in accordance with UNAIDS guidelines.

The previous National HIV/AIDS Strategy for the Republic of Montenegro was developed for 2005 to 2009 period and was based on the results of several related activities: Situation Analysis and Response Analysis for HIV/AIDS completed in September 2004; proposal submitted to the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) in April 2004.

This strategy 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. Non-governmental organisations (NGOs) have been critical in reaching MSM, injecting drug users, sex workers and 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 the 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 have been built, and Government capacity has been strengthened in the area of monitoring and evaluation, including biological behavioural surveillance. The creation of the Country Coordination 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 a need to address the factors influencing HIV transmission. For example, 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 the Government and NGOs to respond appropriately has to be strengthened with designated financial and human resources devoted to the implementation of the strategy.

The strategy builds on the strengths and successes of the previous national strategy (2005 to 2009) and also addresses weaknesses 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 the *Universal Access Plan*; results of biological behavioural surveillance (BBS) and other studies conducted during the five years period; review of GFATM funded activities in September 2008; and in the GFATM proposal prepared for submission to Round 9.

The strategy is in accordance with international and regional commitments and strategies, namely:

- Millennium Development Goal (MDG) number 6 to combat HIV/AIDS, 2000
- United Nations General Assembly Special Session (UNGASS) on HIV/AIDS, 2001
- 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
- United Nations General Assembly Special Session (UNGASS) on HIV/AIDS, 2006
- Bremen Declaration on Responsibility and Partnership- Together Against HIV/AIDS, 2007
- WHO/Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector, 2008

The *National AIDS Strategy for the Republic of 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.

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.

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* have developed in 2009 and add as 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.

Total expenditures available for HIV cannot be precisely estimated under the current accounting system (since there is no separate budget line for HIV). Approximately, one third of

the funds allocated for HIV/AIDS are covered directly through National Budget, while two thirds are funded through Health Insurance Fund.

In the beginning of 2010, a project proposal to GFATM for R9 was adopted, valued at € 5.164.889 for a 5 year period. Montenegro will receive approximately 4.7 million Euros of non-repayable financial aid from GFATM during this 5 year period.

II. Overv

III. iew of the HIV/AIDS epidemic

HIV/AIDS epidemic in Montenegro started in 1989, when first case of AIDS was recorded. It is assumed that this really was the first case, because there were no other registered cases from Montenegro in the reports of the competent services from other republic of the former SFRY.

Information on the status of HIV infections in Montenegro can be obtained based on testing and prompt reporting. This includes:

- Voluntary blood tests for general population
- Testing blood and organ donors
- Testing health workers
- Testing pregnant women
- Testing people who work abroad
- Testing patients in healthcare institutions, based on doctors' request and for diagnostic purposes
- Testing high risk population groups.

There were 23 new cases of HIV/AIDS registered from January 2010 until December 2011. Incidence of the newly discovered infections during this period was 3.7/100.000 inhabitans. During this period, 5 death cases as a result of AIDS were recorded with motrality

rate 0.8/100.000 inhabitans. According to age disaggregation, 83% of the newly registered cases of HIV/AIDS are between 20 and 44 years of age.

Out of 23 newly registered with HIV during this period, 8 of them had already developed AIDS and 4 of them died.

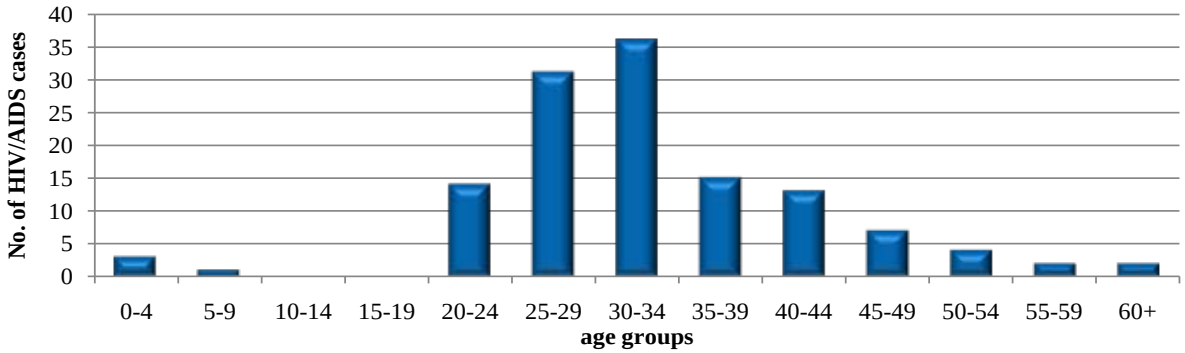
From the total number of 93 persons still living at the end of 2011, there are officially registered 30 persons diagnosed with AIDS and 63 persons with HIV.

During 2011, according to the data that health institutions submitted to the Institute, the total number of people tested for HIV is 22.106, which is 6.6% more compared to the previous year. Out of this number, 19.279 people were tested within transfusiological units. There were 14.849 voluntary blood donors tested, out of which 4.728 were first time donors. There was 1 HIV positive case among first time donors. Number of citizens tested on other diverse grounds (voluntary, anonymous, based on doctor's recommendation) was 7.257.

Testing in Montenegro has been significantly improved by opening Counselling Centres for confidential counselling and testing/VCT, and now there is a network consisting of seven regional counselling centres in health care centres and one in the Institute for Public Health. 1.306 persons in risk of being infected with HIV were tested within these counselling centres during 2011, which is a 48% increase compared to the previous year. Out of the total number, 3.4% were MSM and 4.9% were IDU. During 2011, HIV tests were reactive for 7 persons tested in the counselling centres.

Detection of HIV infections in the age group under 15 is rare (3%), as well as in the 15-24 age group (11%). The largest number of infections was detected within the working and reproductive age group, 15-49 years of age (90%), graph 2. Over 50% of people with AIDS were between 25 and 34 years of age.

Graph 2. Age disaggregation of HIV infected persons at the moment of detection, for the period 1989-2011

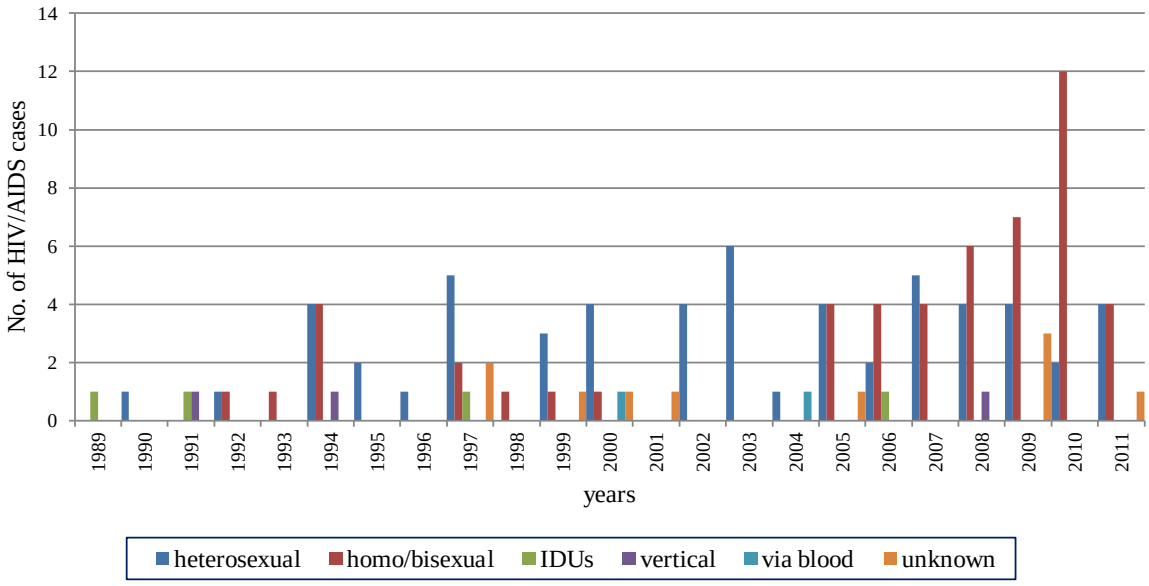


The male to female ratio of HIV infection is almost 5:1 (83% of people registered with HIV are male).

Geographic disaggregation of people with HIV/AIDS in Montenegro is correlated with life style and location of risk groups. Most of them are situated in the coastal region (42%) and Podgorica (37%).

The leading form of HIV transmission in Montenegro is through sexual intercourse (85%). Without taking into account the kind of sexual intercourse, epidemiological surveys of the people infected through sexual intercourse demonstrate their habit of practicing sexual intercourse without protection (heterosexuals 44% and bi and homosexuals 41%). This form of transmission is the most frequent and retains a steady increase rate since the start of the epidemic (graph 3). As opposed to sexual intercourse, HIV infections through blood, whether it is among injecting drug users or people that received infected blood during transfusion in health care institutions, still remain quite uncommon.

Graph 3 Disaggregation of people with HIV/AIDS through time and form of transmission, for the period 1989-2011



Since the start of epidemic until the end of 2011, there were registered 35 people that died from AIDS (27 men and 8 women). Most of the deceased is in correlation with the number of the infected people and their geographical disaggregation.

Impact indicators

• *Reduction in HIV prevalence*

Indicator is not relevant to our country.

•*HIV treatment: survival after 12 months on antiretroviral therapy*

In 2010, 7 persons started with ARV and out of them 4 persons are still alive.

• *Reduction in mother-to-child transmission*

No mandatory testing on HIV for pregnant women was introduced in the country. The health personnel need additional skills and knowledge to provide safer delivery practices, infant-feeding counselling and support. In 2009 the PMTCT Strategy was prepared in collaboration

with UNICEF and IPH. New National Strategy is adopted and it incorporates PMTST Strategy as its integral part. During 2010 and 2011 no pregnant women were diagnosed with HIV.

•*Most-at-risk populations: reduction in HIV prevalence*

Despite some encouraging trends in behaviour detected in recent surveys implemented from 2006 to 2011 among MSM, IDU, and SW, overall surveillance results indicate a very strong need to intensify preventive interventions in all vulnerable groups. Activities planned through National Strategy focus on MSM, IDU, SW, poor RAE youth, merchant marines and prisoners. They include outreach work (NEP, condom and lubricant distribution, rapid tests, counselling, distribution of IEC materials, etc.), drop in and counselling centres and peer education programmes. Sensitisation trainings are planned for key health and law enforcement professionals, police officers, prison staff and social workers with the aim of creating a more supportive environment for HIV prevention among vulnerable populations. Operation of the 8 existing Montenegrin VCT centres is planned to be improved through additional training, strengthened supervision and improved coordination. [2]

1. Coverage of most-at-risk populations by preventive activities

There has been a significant increase in the number of most at-risk groups reached with HIV prevention interventions, mainly information (verbal and written), condoms and lubricants, and for IDUs with needles and syringes. This was attributed to an increased number of outreach workers, opened drop-in/counselling centres for the key most-at-risk populations (IDUs, SW and MSM) and greater trust between the most at-risk population groups and the respective NGOs.

In 2011 new 127 sex workers, 525 injecting drug users and 265 men who have sex with men have been covered by preventive services (outreach, drop-in centres, VCT). A range of HIV preventive activities have been implemented amongst IDU, MSM, SW, merchant marines, Roma, Ashkali and Egyptian. However, services require scaling up (geographically and in terms of reach) and diversifying in order to reach more ambitious targets and provide more effective protection from HIV. Interventions in prisons are in place and prison staff and inmates have

[2] Montenegro_GFATM Round 9_HIV_Project Proposal

received information on HIV and prisoners have started to receive counselling on HIV. Condoms and sterile injection equipment have so far not been provided within prison settings.

In 2010 and 2011, bio-behavioral surveys (RDS and snowball sampling surveys) were conducted among SWs, MSM and IDUs (within the GF Project "Support to implementation of Montenegrin HIV/AIDS Strategy"):

1. In Aprile 2010 bio-behavioral (snowball sampling survey) among SWs had been started, and data were gathered during 3 months period. The study included 190 respondents who met criteria to be classified as sex workers (18 years of age and above who had sex with clients in the last 12 months, and with place of abode in Montenegro at least three months before the survey started). Valid data were obtained from 181 respondents. Due to low number (only 5 persons), male respondents were excluded from analyzing. 176 female respondents were processed and analyzed. Anonymous HIV tests with informed consent were performed during the survey. Out of 181 women that were tested, positive HIV test result was found in two female respondents, which amounts to 1.1% prevalence among this population. Knowledge of HIV transmission and prevention is not satisfactory – complete information on the most important prevention methods (correct answers to all questions) had 9.1% of female respondents. 56% of female respondents do not know that it is possible to prevent HIV infection by proper and regular condom use during sexual intercourse and 38.4% of respondents have a wrong belief or do not know that HIV can be transmitted using the already used drug unjecting equipment (needle/syringe). The prevalence of risky sexual behaviour is significant, considering that a high percentage of SWs do not use condoms regularly during sexual intercourse with clients (during the last month 58% of female respondents used condom each time having sex with client). The prevalence of drug use, as well as injecting drug use, among SWs is significant (30.7% of respondents are using or have used drugs; 13.5% of respondents who injected drugs shared drug-injecting equipment). 38% of female respondents have been tested for HIV once or more times.
2. Bio-behavioral survey among MSM (snowball sampling survey) was conducted in 2011. Data were collected in the three month period, from March till May 2011. Survey included 111 participants who met criteria to be classified as MSM. This BBS among MSM, regardless of using the non-representative sample (wich does not allow the

generalisation of the result to entire MSM population), has provided certain basic information related to this population as well as very precious data related to many important aspects of the problems this population is being faced with in Montenegro. Acording to findings from this survey, HIV epidemics in the MSM population is close to the limit of concentrated epidemic taking into account the determined HIV prevalence of 4.5%. Analysis of the survey data revealed that knowledge related to HIV transmission and prevention was insufficient – only 31.5% of the respondent gave correct answers to all of the questions. Findings confirmed that prevalence of the risk behaviours is significantly high, because: half of the participants, in the last 6 months, had 3 or more partners; half of the participants had not used condom at last anal intercourse; almost one third had been selling sexual services; in the last six months, half of the participants had sexual intercourse with women, while only 17.1% regulary used condoms; and high prevalence of STIs. Only one third participants ever been tested for HIV (34.2%) and visited VCT (29.7%)

3. Persons older than 18, who have been injecting drugs during the last month and have been living in Montenegro for more than 3 months during the last 12 months, have been included in the RDS bio-behavioral survey. Data were collected during the three month period (from the end of February till the end of May 2011. Survey covered 355 respondents (83.2% males and 16.8% females). Currently, sterile drug injecting equipment (new sterile needles and syringes) is available to 99.6% of IDUs. Majority of respondents buy sterile needles and syringes in public pharmacies (58.9%), 27.5% IDUs get them, free of charge, in Drop-in center for IDUs while 16.1% get them through needle exchange programs within Primary Health Care Centre and 3.8% through outreach needle exchange program. During the last month, 13.3% of the surveyed IDUs shared the injecting equipment. If the entire “injecting drug use” experience was taken into consideration, percentage of those who had ever shared injecting equipment increased to 63.4%. At last sexual intercourse, condom was used by 41.8% of participants. Laboratory testing revealed that the actual HIV prevalence among IDUs is very low (0.3%), as well as the prevalence of HbsAg (0%), as opposed to very high HCV prevalence (55%).

III. National Response to the AIDS epidemic

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.

The **aim** of the *National AIDS Strategy for the Republic of 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. In 2010 Parlament of Montenegro adopted antidiscrimination Law wich forbids discrimination on the grounds of various characteristics, including sexual orientation and gender indentity. The national AIDS programme has identified the role of the mass media in transmitting images and messages that are stigmatising and could lead to discrimination, and therefore posters, brochures, billboards to address issues of stigma and discrimination have been developed. Stakeholders have participated in television shows, radio programmes and organised meetings with journalist to promote non stigmatising messages about HIV in the media.

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.

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. Multisectoral approach to HIV based on age, gender and diversities, including all partners at all levels within public, private and non-profit sector, in accordance with existing strategies and international obligations.

The National AIDS Strategy for the Republic of Montenegro 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.

Efforts undertaken so far 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. Government capacity has been

strengthened in monitoring and evaluation, including biological behavioral surveillance. 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. Surveys undertaken in 2010 and 2011 detected low prevalence among SWs and IDUs and showed some encouraging trends with detected improvements in behaviour among IDUs and SWs. Survey undertaken in 2011 among MSM is the first BBS among MSM in Montenegro and it was conducted after one unsuccessful attempt of RDS survey in 2008 and successful formative survey in 2010. Study was designed as bio-behavioral cross sectional survey based on the snowball sampling methodology. This survey provides solid informational basis for having the initial insight into the situation related to HIV infection among MSM population and serves as the basis for preparing and conducting of surveys that will follow in this population. Nevertheless, despite the substantial progresses made, programmes targeting at-risk populations have to keep momentum and substantially expand coverage to be able to provide significant effect in the national response to HIV.

The improved HIV outcomes are expected to be reflected in the decrease of HIV-related risk behaviours among at-risk groups, increased utilisation of VCT services and other services, improved care and support to PLHIV and lower stigmatization and discrimination of PLHIV and those most vulnerable to HIV. The progress towards achieving the aims of the Strategy are measured by the monitoring and evaluation system which has been set up within the framework of the GFATM 5th Round grant.

Most-at-risk populations: HIV testing

The first VCT service has been established in mid July 2005 within the Institute of Public Health in Podgorica. Voluntary testing and counselling is currently available in 8 VCT centres geographically distributed throughout Montenegro. VCT centres have become an integral part of preventive services targeted at populations at risk. While the centres were started grace to funding available from the round 5 grant GFATM, the government has ensured the long term sustainability of Montenegrin VCT through taking over their funding as of year 2009.

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 80 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 recommendations[3].

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

In 2011, 1306 people received VCT services and out of this number 44 persons were MSM, 64 were IDUs and 1 was SW. During late 2009, counselling centres started doing analyses by using rapid tests, which simplified the procedure and decreased the waiting time and anxiety of the clients.

Most-at-risk populations: prevention programmes

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. As there are no national population size estimates for each of these groups in Montenegro, 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.

[3] 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.

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 Health Center in Podgorica and from 2010 and 2011 in Berane and Kotor.

58.1% of IDUs and 34.2% MSM surveyed in 2011 had ever had a HIV test (in 2008 31.3% of IDUs 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 in other towns of Montenegro. 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 men[4] 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). “Chosen” or family doctors are also expected to diagnose, treat and refer STIs, although the lack

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

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.

Harm reduction programmes

***Institutional setting*:** From 2005 Health Centre Podgorica has been included in a needle and syringes exchange programme, which is conducted through 13 injection points in the capital.

NGOs: Juventas and CAZAS outreach work, drop-in centre for IDUs in Podgorica

Pharmacies: still do not distribute free syringes and needles.

Table 2. Number of distributed syringes and needles during 2011

2011		
Place	Syringes	Needles
NVO Juventas	5194	9239
NVO Cazas	19628	19348

In 2010 and 2011 two more methadone centres were opened – one in Kotor (southern region of Montenegro) and one in Berane (northern pregion of Montenegro).

HIV treatment: antiretroviral combination therapy

It is estimated that all PLHIV who are eligible to receive highly active antiretroviral therapy (HAART) are now doing so. Since 2009 HAART has been made available through the Health Insurance Fund and by the end of December 2011, 42 people living with HIV or AIDS were receiving HAART. During 2010, 7 persons started with ARV and out of them 4 persons are still alive. Eligibility criteria and treatment regime adopted in Montenegro are in accordance with the European AIDS Clinic Society Guidelines: Clinical Management and Treatment of HIV Infected Adults in Europe.

The significant progress was made in access to diagnostics and treatment. IPH procured PCR and CD4 counter. Continuous supply and availability of HAART is provided by Clinic for Infectious Diseases in Montenegro.

Blood safety

Since 1987 all donated blood products have passed through mandatory testing for HIV. Routine testing is done by ELISA tests of fourth generation in all seven hospitals that operate in Montenegro and in Clinical Center of Montenegro (transfusion services), which are used for detection of HIV antibodies. If the results are found to be suspicious, testing of the suspicious and a new blood sample is done by ELISA tests of different manufacturers. In the case of inconclusive results, the blood is sent for confirmation with Western Blot tests. All blood samples taken for treatment are mandatory to be tested for Hepatitis B, Hepatitis C and syphilis. Testing of clinical and ward patients is performed at doctor's request, and for testing of interested citizens without the doctor's refferal there is the possibility to pay for the test. A questionnaire for voluntary blood donors is in the final stage of introduction.

EQAS are not set up and SOP standard operating procedures are currently ongoing. There was one new case of HIV infection among blood donors during 2011.

Knowledge and attitudes

The aim of the study *" HIV/AIDS related knowledge, attitudes and sexual behavior in young adults, aged 18-24 years in Montenegro in 2009"* was to collect and analyze data on: knowledge on HIV transmission and prevention, attitudes towards people living with HIV/AIDS, attitudes towards sexuality, sexual behavior, frequency of the symptoms of sexually transmitted infections as well as the frequency of testing for HIV on the representative sample of the population of yout aged 15-24 years at the entire territory of Montenegro. This study, designed as cross-sectional study, was conducted during December 2009 on a sample of 1.200 households.

Survey covered 1.164 respondents aged 15-24, out of wich 620 (53.3%) males and 544 (46.7%) females. The average age of the respondents was 19.28 years.

Table 3. *Knowledge of HIV transmission and prevention*

Is it possible to prevent HIV transmission during the sexual intercourse by:	Correct answer
1. Proper condom use?	86.0%
2. Having sexual intercourse with only one, uninfected and faithful person?	73.4%
Is there a possibility to get HIV infected:	
3. Through mosquito bites?	68.4%
4. Using public toilette?	62.1%
5. Using a glass already used by the HIV infected person?	56.5%
6. Sharing meals (food) with HIV infected person?	62.0%
7. Having sex with a healthy-looking person?	79.7%

Research has shown that very low number of young people answered correctly to all 5 questions (no questions. 1, 2, 3, 6, 7 in the table 3) – only 27.2%. This result indicates the overall poor knowledge of the surveyed population and it is a direct argument in support to all the prevention activities that, in any way, affect the increase in the level of knowledge on HIV/AIDS.

Level of stigma is, still, high regardless the efforts invested in the previous four year period. Almost half of the respondents would not share a meal with PLHIV, while one third of the respondents would not hang out with the PLHIV. Survey results indicate high level of stigma not only towards person living with HIV, but also towards members of populations associated with HIV, which is indicative in the result that more than three fourths of the interviewed young people think that all the members of the most-at-risk groups (IDUs, homosexuals, persons selling sex, hemophiliacs) should be tested for HIV, while almost one third think that all PLHIV should be registered in the police records.

Comparasion in regard to the type of settlement revealed statistically significant difference, where respondents from rural settlements expressed, in regard to all of the questions, significantly lower level of PLHIV acceptance.

IV. The best practices

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

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

V. Major challenges faced and actions needed to achieve the goals/targets

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 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.

In the area of 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).

Although all eligible HIV-positive persons can access treatment, access to care and support services is lacking. The provision of training to psychologists and social workers is included in the National AIDS Workplan so these shortcomings should be addressed in the future.

Actions that are planned to ensure achievement of the targets:

- To establish more accurate population size estimates which would make more precise estimation of coverage possible.
- To scale up interventions 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 behaviors (such as, selling sex, injecting drugs and unprotected anal sex amongst men).
- To conduct surveys of stigma and discrimination amongst health professionals, journalists/media representatives and law enforcement officers with follow-up training to address stigma and discrimination as appropriate.
- To develop guidelines for journalists on HIV related reporting with special focus on stigma free articles and reports.
- To develop a comprehensive programme of psycho-social care and support for people living with HIV.
- To undertake qualitative studies of sexual networks of people living with HIV and most at-risk populations, especially MSM, to ensure that the response is appropriate to their needs.
- To support and develop the skills of people living with HIV and most at-risk populations to become more involved in the national HIV response.

VI. Support required from country's development partners

The following UN agencies have supported, or proposed to support the following national HIV/AIDS and STI prevention and treatment efforts:

- ***UNAIDS***: Programme Acceleration Funds (PAF) supported the development of the Universal Access plan and Medium Term Review of the National Strategy 2005-2009, awareness rising on human rights of PLHIV, improvement of 2nd generation surveillance and skills of health professionals treating PLHIV, drafting the National Strategy 2010-2014 and development of the Project Proposal for R9 of the GFATM.

- ***UNHCR*:** Addressing HIV among displaced populations (refugees and IDPs) with special attention to HIV prevention and access to services amongst Roma youth.
- ***UNICEF:*** HIV prevention in most at-risk adolescents, support to strengthening the evidence base and monitoring and evaluation, PMTCT.
- ***WHO:*** HIV/STI surveillance, health policy and systems, pharmaceutical policy and blood safety.
- **UNDP** is providing support to the implementation of the GFATM programme and also has the following areas as part of its mandate: HIV/AIDS development, governance and mainstreaming, PRSPs, and enabling legislation, human rights and gender.
- **UNFPA** does not have an office in Montenegro, but is responsible for providing technical support to HIV prevention interventions for FSWs and MSM.

VII. Monitoring and evaluation environment

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.

A Second Generation HIV Surveillance system has been established and biological behavioural surveillance (BBS) surveys of male and female injecting drug users, MSM and sex workers conducted by the Institute of Public Health. These surveys were conducted using representative sampling methods wherever possible (youth - multi stage cluster sampling), injecting drug users (respondent driven sampling), sex workers (snowball sampling), MSM (snowball sampling). The results have provided baseline values for impact (HIV prevalence).

Good collaboration between NGOs and the IPH in undertaking surveys 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 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 adolescents 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.

Greater efforts will be made to monitor the number of new and repeat clients accessing the essential package through an improved data base.

The NCPI was filled in based on desk review of the existing documents as well as on interviews with the key informants in relevant institutions dealing with HIV/AIDS.