

# UNGASS COUNTRY PROGRESS REPORT MONTENEGRO

*Reporting period: January 2008-December 2009*

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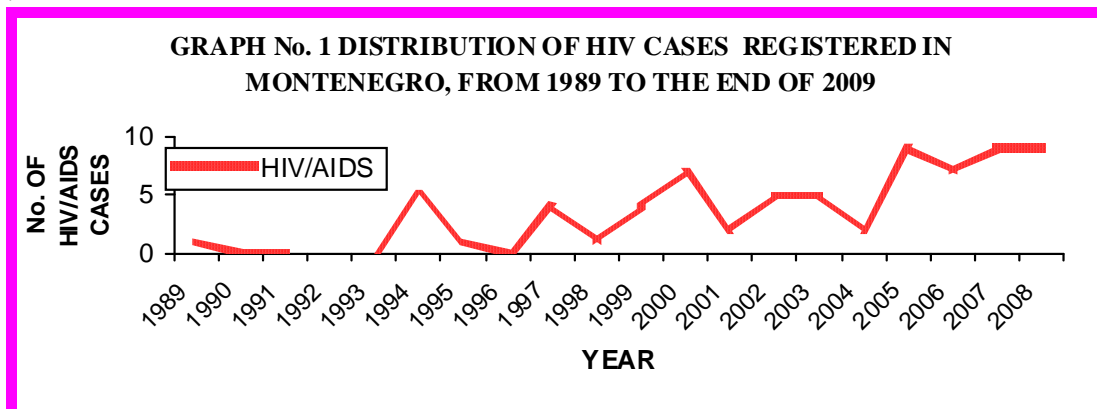
## II. Status at a glance

### 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. After preparing the draft report, a meeting was held with relevant stakeholders who took part in writing the report. During this meeting, the participants gave their suggestions and proposals and, after a short discussion an agreement for writing the report was reached. Preparation of the report was aided, with their direct and/or indirect participation, by 19 members of NAC and another 10 organizations which all together make CCM/state regulatory mechanism.

### b) The status of epidemic

Montenegro is a low prevalence country with an estimated HIV prevalence of 0.014%. 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/AIDS by the end of 2009 was 101, out of which 50 had developed AIDS, 22 HIV and 29 died. According to the World Health Organisation (WHO), the estimated number of people living with HIV (PLHIV) in Montenegro is 388, out of which 95 are women, ie 24.4% of all infected according to this estimate. 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 discrete trend of increase (graph No. 1)



### c) The policy and programmatic response

The most recent official census data for Montenegro puts the population total at 626,188 / (211.244, age >25 female and 194.599, age>25 male).<sup>1</sup> In the age structure of population the youth are dominant (under 25 years), but for several years the aging tendency of population has

<sup>1</sup> MONSTAT, Statistical Yearbook of Montenegro 2008, p.40.

been registered. Population of Montenegro is consisted also of 4365 refugees from former YU republics and 13.986 displaced persons from Kosovo. According to the above mentioned census, there are 16 different nationalities in Montenegro. Capital and administrative center is the city of Podgorica, with 173.000 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 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 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 year 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.

The Government is fully covering costs of blood screening (in amount of 103,000 €), VCT centres (from 2009, in amount of 90,000 €), costs of treatment out of Montenegro (in average 35,000 €), salaries of health professionals involved in HIV response (in amount of 392,000 € in 2008). In 2007 for ARV it was allocated 110,718 € while for diagnostic tests it was allocated 61,500 €. It is estimated that amount for ARV will increase up to 374,000 € in 2014, while costs of related diagnostics and CD4 tests will rise up to the 272,000 in 2014. Government is also covering inpatient costs and costs of therapy for opportunistic infections for HIV patients.

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.**

### **III. Overview 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 13 new cases of HIV/AIDS registered during 2009. Prevalence of the newly infected was 0.92/100,000, while the number of people with AIDS is 0.46/100,000 inhabitants. Total prevalence of the newly discovered infections during 2008 was 1.38/100,000 inhabitants.

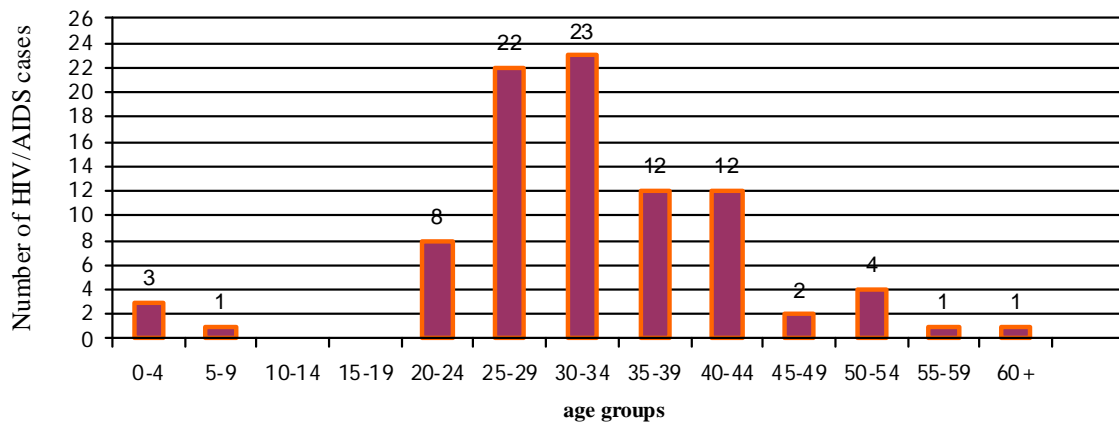
During this year, 2 death cases as a result of AIDS were recorded. According to age disaggregation, all of the newly registered cases of HIV infections and AIDS are between 20 and 37 years of age.

During 2008, according to the data that health institutions submitted to the Institute, the total number of people tested for HIV is 18.221, which is 7.7% more compared to the previous year. Out of this number, 17,782 people were tested within transfusiological units. There were 13,553 voluntary blood donors tested, out of which 3,365 were first time donors. There were no HIV positive cases among first time donors, while among old blood donors, one person who was HIV negative during previous tests was diagnosed with HIV. Number of citizens tested on other diverse grounds (voluntary, anonymous, based on doctor's recommendation) was 4229. Among these, 8 cases of HIV infection were identified.

Testing in Montenegro has been significantly improved by opening three new Counselling Centres for confidential counselling and testing/VCT, so now there is a network consisting of seven regional counselling centres in health care centres and one in the Institute for Public Health. 738 persons in risk of being infected with HIV were tested within these counselling centres, which is a 41% increase compared to the previous year. Out of the total number, 8.5% were MSM and 11.7% were IDU. During 2009, HIV tests were reactive for 6 persons tested in the counselling centres.

Detection of HIV infections in the age group under 15 is rare (4.5%), as well as in the 15-24 age group (9%). The largest number of infections was detected within the working and reproductive age group, 15-49 years of age (80.9%), graph No. 2. During detection of HIV infection, over 50.5% of people infected with AIDS were between 25 and 34 years of age.

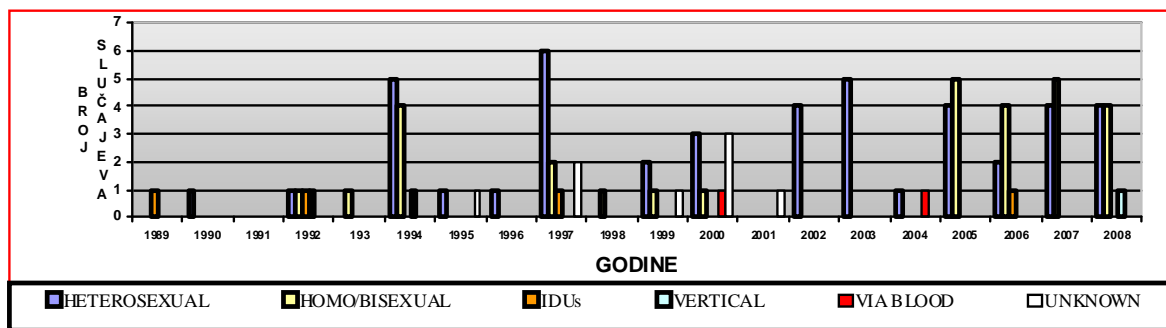
**GRAPH No. 2. AGE DISAGGREGATION OF HIV INFECTED PERSONS AT THE MOMENT OF DETECTION, FOR THE PERIOD 1989-2008**



Geographic disaggregation of people infected with AIDS in Montenegro is correlated with life style and location of risk groups. Most of them are situated in the coastal region (49%) and Podgorica (33%).

The leading form of HIV transmission in Montenegro is through sexual intercourse (83%). 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 46% and bi and homosexuals 37%). This form of transmission is the most frequent and retains a steady increase rate since the start of the epidemic. 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 No. 6 DISAGGREGATION OF PEOPLE INFECTED WITH AIDS THROUGH TIME AND FORM OF TRANSMISSION FOR THE PERIOD 1989-2008**



Since the start of epidemic until the end of 2009, there were registered 29 people that died from AIDS (23 men and 6 women) and the sex ratio is 4:1. 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 not relevant to our country

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

Currently there are 31 HIV infected persons receiving antiretroviral therapy. Out of this number, 5 are female and 26 are male. In the last 12 months 6 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 in the process of being adopted and it incorporates PMTCT Strategy as its integral part.

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

Despite some encouraging trends in behaviour detected in recent surveys implemented in 2006 and 2008 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 IDU, MSM, 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.<sup>2</sup>

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

Lack of understanding of HIV prevention programmes, such as harm reduction, by some key government staff continues to hinder progress. By the end of 2008 a total of 280 sex workers, 863 injecting drug users and 142 men who have sex with men have been covered by preventive services (outreach, NEP program in PHC Centre, 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

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<sup>2</sup> Montenegro\_GFATM Round 9\_HIV\_Project Proposal



diversifying in order to reach more ambitious targets and provide more effective protection from HIV. Services currently lacking include: drop-in/counselling centres for the key most-at-risk populations (IDUs, SW and MS); rapid tests and counselling, scaled up methadone maintenance treatment provided in a decentralized manner by primary health care centres; and including provision of buprenorphine in drug substitution therapy. Interventions in prisons are in place and prison staff and inmates have 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.

So far, there is no data concerning HIV prevalence among most-at-risk population groups.

Biobehavioural surveys were conducted among SWs, MSM and IDUs. Within the GF Project “Support to implementation of Montenegrin HIV/AIDS Strategy” the study (Biobehavioural RDS and snowball sampling survey)

1. In December 2007 bio-behavioural (RDS survey) among SWs has been started, and data was analyzed in 2008. The participants were 14 male SWs and 119 female SWs 18 years of age and above and with place of abode in Montenegro at least three months before the survey started. Anonymous HIV tests with informed consent were performed during the survey. Out of 133 people that were tested, only 1 person/woman was infected with HIV, which amounts to 0.76% prevalence among this population.

2. RDS survey in MSM conducted from March to September 2007 failed because the stigma, discrimination and fear are still significantly present among MSM population. On 1 March 2009 was started the first web site that deals with the issues of MSM population, [www.montenegro-gay.me](http://www.montenegro-gay.me). Among other activities, there were outreach activities among MSM population that included handing out condoms and lubricants, as well as IEC materials and counselling on sexual health. Another project, which is financed by the EU delegation in Montenegro, named „Montenegro – a bright spot on the gay map“, has the aim of creating a coalition of governmental and non-governmental organizations in a joint quest to improve human rights of the LGBT population.

3. Persons age 18 to 59, 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. Survey excluded persons younger than 18 and older than 59, as well as those who have not been injecting drugs during the last month or have not been living in Montenegro, during the last 12 months, for more than three months. Survey covered 322 respondents, comprising 5 seeds (three males and two females), who were excluded from the final analysis meaning that RDSAT analysis covered 317 respondents (289 males, 26 females and 2 persons who did not state their sex).

Within IDU population in Montenegro there are 89.1% of men and 10.9% of women. Currently, sterile drug injecting equipment (new sterile needles and syringes) is available to 96.8% of IDUs.

Most of the IDUs have been covered through outreach program of needles and syringes exchange (NEX) (91%), 55.9% of them has been covered through the same program implemented in Primary Health Care Center Podgorica (within injection units), while much lower number of IDUs buy sterile needles and syringes in private pharmacies (34,1%). Using the above mentioned tests, it was revealed a very low HIV prevalence (0.4%), as well as prevalence of HbsAg (0%), as opposed to very high HCV prevalence (53.6%).

## IV. 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.

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.

The new 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, and government capacity has been strengthened in monitoring and evaluation, including biological behavioural 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 2006 and 2008 detected low prevalence among all groups surveyed and showed some encouraging trends with detected improvements in behaviour among IDUs and SWs. 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 VCCT 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 50 staff have been trained and it is planned to train additional staff and open two additional VCT Centres in Podgorica. Activities in the existing eight HIV counselling centres are implemented in accordance with the Institute for Public Health (IPH) protocols for HIV testing and counselling. A network of VCT Centres has been established and undertakes regular monitoring of the services provided. It is envisaged that voluntary HIV testing and counselling and prevention services for STIs will be integrated into their work in accordance with World Health Organisation recommendations<sup>3</sup>.

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

There are 51 private laboratories in Montenegro, but their data on HIV testing is not available. In 2009, 738 people received VCT services and out of this number 62 persons were MSM and 74

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<sup>3</sup> 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.

were IDUs. 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. However, despite these efforts, by the end of 2008 only a small number of sex workers (280) and MSM (142) had been identified and it was not possible to conduct a behavioural survey amongst MSM. Larger numbers of injecting drug users (863) had been reached. As there are no national population size estimates for each of these groups in Montenegro<sup>4</sup>, it is not known what percentage of the total population at risk had been reached.

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

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

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

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

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<sup>4</sup> In 2005 Imperial College in London estimated that there were 650 injecting drug users in Podgorica.

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

Although 85% of people registered with HIV acquired the infection sexually, the prompt diagnosis and treatment of STIs for men<sup>5</sup> is not yet included as part of the basic package of health care agreed under the reform of primary health care services. Nor was this intervention integrated into the previous national AIDS response. As a consequence, minimal progress has been made with scaling-up access to services for STIs and in building capacity of health professionals in the diagnosis, treatment and reporting of STIs. It is expected that the situation will improve with the development of the National Health Information System (NHIS) which should be functional by 2010. “Chosen” or family doctors are also expected to diagnose, treat and refer STIs, although the lack of confidentiality and anonymity in the current system may be a deterrent to people consulting them. The integration of counselling for STIs into HIV testing and counselling services should improve access to confidential services.

*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

*Pharmacies* still do not distribute free syringes and needles

Table No. 1. Number of distributed syringes and needles during 2008

2008		
Place	Syringes	Needles
NVO Juventas	11564	7049
NVO Cazas	5455	3820
Health Care Centre Podgorica	2621	1608
Total	19640	12477

Currently there is only one methadone centre in Montenegro, but two more regional centres (for the Southern and Northern region) are in the process of being opened.

*HIV treatment: antiretroviral combination therapy*

Currently, there are 31 persons in Montenegro receiving ARV therapy. 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. Two patients have HIV and TB co-infection, no cases of HCV and HIV were recorded and co-infection with HBV was confirmed among two patients. During the past 12 months 6 people started using ART.

<sup>5</sup> The basic benefit package for pregnant women includes tests for Hepatitis B, HIV and Syphilis.

### *Blood safety*

Since 1987 all donated blood products have passed through mandatory testing for HIV. During 2009, the number of donated units was 15,312, percentage of blood donorship is 2.44% and screening was performed on all of the 15,312 blood units. 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 referral 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 were three new cases of HIV infection among blood donors during 2009.

### **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 2007*” 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 symptoms of sexually transmitted infections and
- Frequency of HIV testing among youth on

a representative sample of the population of young adults aged 18-24 years at the entire territory of Montenegro. This study covered 858 respondents aged 18 to 24 years, 468 (54.5%) young men and 390 (45.5%) young women.

**Table Knowledge of HIV transmission and ways of HIV prevention**

Is it possible to prevent HIV during sexual intercourse by	Correct answer
1. Proper condom use?	84.2%
2. Having sexual intercourse with only one, uninfected and faithful person?	67.3%
<b>Is there a possibility to get HIV infected through:</b>	
3. Mosquito bites?	65.0%
4. Using public bathroom?	67.7%
5. Using glass used by people infected with HIV?	60.9%
6. Sharing meals (food) with HIV+ person?	62.3%
7. Having sex with a healthy-looking person?	76.2%

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 4.2.1.) – only 22.1%. 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.

Respondents from urban areas revealed a more positive attitude towards people living with HIV in questions regarding placement of persons with HIV in quarantine and forcing members of risk groups to be tested on HIV, but more rigid attitude in relation to the treatment of persons with HIV according to the mode of HIV transmission in relation to their peers from the rural areas. Over 70% of respondents from both types of settlements stated that members of risk groups should be legally forced to testing for HIV. In other items it was not found a statistically significant cant difference among respondents from urban and rural areas

## **V. The best practices**

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

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)

## **VI. Major challenges faced and actions needed to achieve the goals/targets**

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

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

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).

## **VII. Support required from country's development partners**

In 2007 and 2008 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 2<sup>nd</sup> 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.

**World Bank** only established an office in Podgorica in June 2007. Its mandate for HIV/AIDS work includes support to strategic, prioritised and costed national plans; financial management; human resources; capacity and infrastructure development; impact alleviation and sectoral work. However, WB Office in Montenegro did not implement nor supported any activity in regard to HIV/AIDS issues.

**UNFPA** does not have an office in Montenegro, but is responsible for providing technical support to HIV prevention interventions for FSWs and MSM.

## **VIII. 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 and sex workers conducted by the Institute of Public Health. The planned 2007 BBS with MSM was not realised due to an insufficient sample. The NGO *Protection* conducted a BBS amongst sailors in 2008. These surveys were conducted using representative sampling methods wherever possible (youth and tourist workers - multi stage cluster sampling), injecting drug users (respondent driven sampling), sex workers (snowball sampling), and sailors (convenience sampling). The results have provided baseline values for impact (HIV prevalence).

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

Weaknesses exist due to the absence of population size estimates, lack of baseline and HIV prevalence data for MSM, and inadequate reporting of sexually transmitted infections. The lack of skills to conduct bio-behavioural research and inadequate skills in project monitoring and evaluation amongst government and NGO staff has also hampered progress and resulted in the inadequate use of surveillance data for decision making, planning and programming purposes.



Initial monitoring has tended to focus on the activity level rather than on programmatic issues. There is now more emphasis on the number of at-risk groups receiving a package of interventions, rather than counting the number of condoms or needles distributed.

More research is needed on most-at risk adolescents<sup>6</sup> and HIV interventions targeted to them, especially to children living or working on the streets. The ethical considerations of conducting research and providing services to minors will be addressed in the revised strategy.

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

#### Annex 2: National Composite Policy Index Questionnaire

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.

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<sup>6</sup> The 2008 study of sex workers only included adults although started selling sex under age 18 years.