

COUNTRY PROGRESS REPORT
MONTENEGRO

Reporting period: January 2012 - December 2013.

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I. Status at a glance

a) The inclusiveness of stakeholders in the report writing process

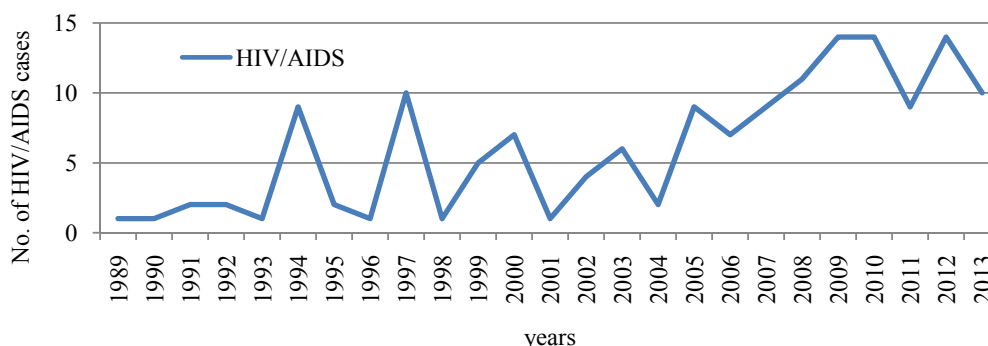
This report was prepared by the Institute of Public Health/Secretariat for HIV/AIDS in close collaboration with all members of National HIV/AIDS Commission/ especially with the members of NAC from NGO.

b) The status of epidemic

Montenegro is a low prevalence country with an estimated HIV prevalence of 0.02% in the end of 2012. 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 2013 was 152, of whom 39 persons diagnosed with AIDS have died. However, the Institute of Public Health estimated that there were 473 (range 300 to 500) people living with HIV at the end of 2012 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 discrete 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, Education and sport, Labor and Social Welfare), 5 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.

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

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. 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 24 new cases of HIV/AIDS registered from January 2012 until December 2013. Incidence of the newly discovered infections during this period was 3.8/100.000 inhabitants. During this period, 2 death cases as a result of AIDS were recorded with mortality rate 0.3/100.000 inhabitants. According to age disaggregation, 87,5% of the newly registered cases of HIV/AIDS are between 20 and 44 years of age.

Out of 24 newly registered with HIV during this period, 14 of them had already developed AIDS and 2 of them died.

From the total number of 113 persons still living at the end of 2013, there are officially registered 44 persons diagnosed with AIDS and 69 persons with HIV.

During 2012, according to the data that health institutions submitted to the Institute, the total number of people tested for HIV is 21935 (without testing for research purposes in which it was tested 200 sex workers and 307 prisoners). Out of this number, 19567 people were tested within transfusiological units. There were 15154 voluntary blood donors tested out of them 3916 new donors, and there was not HIV positive case among first time donors. Number of citizens tested on other diverse grounds (voluntary, anonymous, based on doctor's recommendation) was 6781.

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. 1.132 persons in risk of being infected with HIV were tested within these counselling centres during 2012, which is a 13% decrease compared to the previous year. Out of the total number, 9,3% were MSM and IDU. During 2012 and 2013, HIV tests were reactive for 9 persons tested in the counselling centres.

The largest number of infections was detected within the working and reproductive age group, 15-49 years of age (94%), graph 2. The largest number of HIV infections diagnosed at age 20-39 years (76%). Younger than 20 years in detecting HIV infection was 3%, and over the age of 39 years 21%.

Graph 2. Age disaggregation of HIV infected persons at the moment of detection, for the period 1989-2012

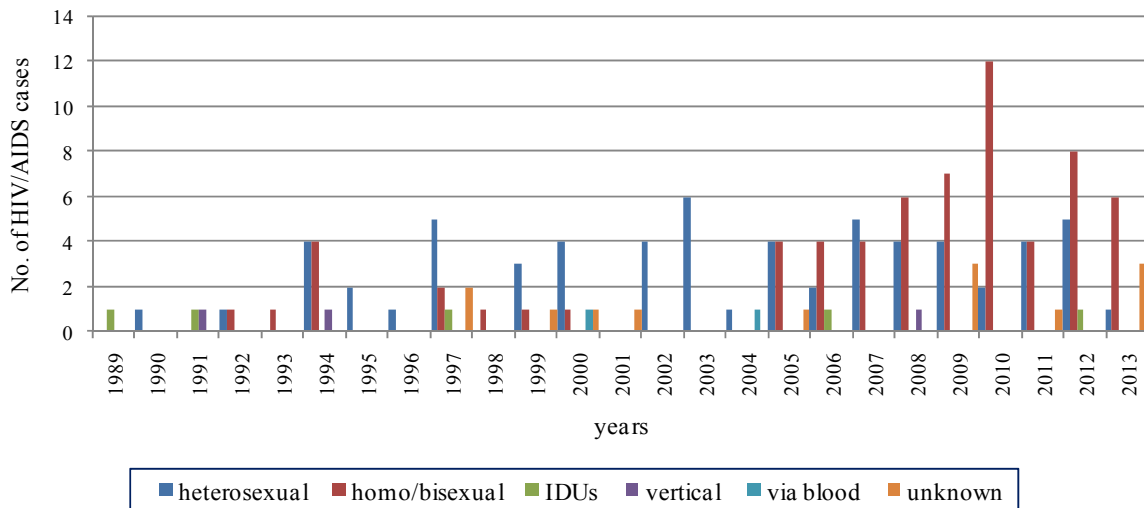


The male to female ratio of HIV infection is almost 5,5:1 (85% of people registered with HIV are male).

Geographic desegregation 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 (44%) and Podgorica (37%).

The leading form of HIV transmission in Montenegro is through sexual intercourse (86%). 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 45% 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 1989-2012



Since the start of epidemic until the end of 2013, there were registered 39 people that 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 2012, 9 persons started with ARV and out of them 7 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. Two of pregnant women born a baby without HIV during the 2012 and 2013. One of them were lost to follow up. And the other, she takes ART and her baby stay healthy because he takes ART first 28 days after born.

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

Despite some encouraging trends in behaviour detected in recent surveys implemented from 2006 to 2013 among MSM, IDU, and SW, poor RAE youth, merchant marines and prisoners 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.

These next surveys are implemented within the Second Generation HIV Surveillance framework and their results are necessary for getting insight into the epidemiological situation in the country: among prisoners, SW, merchant marines, youth RAE and young people form 15-24. Project „Scale up of HIV response among most at risk populations in Montenegro“ financed by Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) from Geneva, through Project Implementation Unit for HIV/AIDS Programme within UNDP Country Office Montenegro provided financial resources needed for conducting this survey

² Montenegro_GFATM Round 9_HIV_Project Proposal

In 2012, bio-behavioral cross sectional survey based on the snowball sampling was conducted among **prisoners**. There is one prison in Montenegro with approx. 1400 prisoners. This is the first bio-behavioural survey among prisoners in Montenegro. Data and blood samples were collected during March 2012. Survey included 309 out of 755 prisoners from the Institute for the Execution of Criminal Sanctions eligible to participate in the study, with is 41%. In regard to gender, there were 293 (40.3%) male prisoners out of 729 of them and 19 female prisoners out of 26 that is 73%. This survey among representative sample of prisoners has provided certain information about prevalence of HIV, viral hepatitis B (HBV) and viral hepatitis C (HCV), as well as socio-demographic and behavioural characteristics (prevalence of risky and protective behaviour associated to indicated infections), based on which it would be possible to develop targeted, evidence based programs for prevention and control of these infections in subjected population. According to findings from this survey, HIV epidemics in population of prisoners in Montenegro belongs to low level epidemics (according to criteria of WHO) as no HIV positive person found in this study. Findings confirmed that prevalence of risky behaviours associated to risk of HIV, HBV and HCV infections, is significantly high:

- One in ten participants reported risky behaviour related to these infections;
 - Among drug users in prison there are significantly more of those sentenced for criminal actions associated to drug abuse (43.6%);
 - 33.3% of all drug users among participants, reported drug injection;
 - 36.4% of participants, of injecting drug users, shared injecting equipment, that is 11.6% of those who have ever use drug or 5.4% of all participants;
 - Tattooing is widely spread in the prison; over half of participants (51.8%) reported being tattooed;
 - Over half of tattooed participants (53.2%) claimed that sterile equipment had not been always used or did not know if it had been used;
 - Almost one fifth of participants (18%) used condoms at sexual intercourse with casual partner;
- It has been confirmed that knowledge about HIV infection is insufficient:
- Slightly over one third of participants showed knowledge about HIV prevention (37.8%);
 - Slightly over one quarter of participants showed knowledge about HIV transmission modes (26.5%);

- UNAIDS indicator for knowledge of prisoners showed that 23.2% of prisoners have sufficient knowledge level;

- Only 1% of participant has well formed and desirable attitude related to HIV;

There is a need for increased use of anonymous HIV counseling and testing and other STIs:

- Over half of participants (51.4%) did not know where they could get HIV testing;

- 34.1% of participants did not know their test results;

- Over half of participants (51.2%) believed that HIV testing in prison would not be provided or did not know that;

- Only slightly over one fifth of prisoners received counseling and education about HIV and other sexually transmitted infections.

In April till end of July 2012 was conducted bio-behavioral (snowball sampling) survey among **SWs**. The study included 200 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 abroad in Montenegro at least three months before the survey started. Although “snowball” sampling method does not provide representative sample and does not allow generalisation of results to entire population of sex workers here are some main results: HIV epidemic still belongs to the level epidemic (according WHO criteria).

2. Knowledge on HIV transmission and prevention, although still not at the satisfactory level, indicates progress, especially among sex workers of lower education level;

3. Prevalence of risky sexual behavior is still significant, considering that a high percentage of sex workers do not use condoms regularly during sexual relationships with clients. In comparison to previous survey, it was not revealed a significant change in the consistency of condom use with the client. Attitude of client towards condom use still seems to be a significant predictor of regular condom use, with decreasing percentage of clients insisting on sex without condom and increasing percentage of sex workers who, despite the negative client attitude, insist on condom use;

4. Prevalence of drug abuse is still very high, as well as injecting drug use among sex workers with prevalence slightly lower than in previous survey;

5. Use of anonymous testing and counseling on HIV and other sexually transmitted infections should be increased. Increased implementation of health educational programs (primarily

focused on the strengthening of negotiation skills of sex workers when negotiating condom use with the client who would result in more regular condom use during sexual intercourse with the clients) and harm reduction programs, primarily through condom distribution and needles and syringe exchange, is needed.

Bio-behavioral survey on knowledge, attitudes and behaviours related to HIV/AIDS among **young Roma and Egyptians** in Montenegro, was conducted in the period from December 2012 until the end of July 2013.

National Strategic Response to HIV/AIDS in Montenegro 2010 - 2014 defines, as a priority by 2015, the provision of basic package of interventions for the prevention of STIs and HIV and interventions for young Roma and Egyptians (socially excluded young people) in whom HIV related risky behaviour is more prevalent than in the general population³. Young RE is at higher risk not only due to their behaviour, but also because of social distance (as a result of poor socio-economic status, low education and other reasons). It is also emphasized that the young RE are largest and most diverse group among vulnerable population groups in Montenegro. At the same time, their awareness and knowledge about HIV are at a very low level which obstacle prevention of the disease in this population group.

The study involved 400 members of RE population living in collective centres (from several locations) in the four municipalities in Montenegro (Podgorica - two locations Berane - two locations, Niksic - two locations and Tivat - two locations), aged between 15 and 24 years.

The survey has shown that the educational level of RE population is very low. The study indicated that members of RE population showed a very low level of knowledge about HIV/AIDS. The indicator of level of knowledge about HIV transmission modes showed that 22.5% of respondents knew all HIV transmission modes. In addition, there is a significant difference between genders related to knowledge about HIV / AIDS. Male respondents showed better knowledge, which is associated with a higher coverage of males with educational programs.

One part of respondents (mostly from the camps at the territory of Podgorica) was included in the health education activities of NGO and therefore they are able to educate their peers (through peer education).

³ Government of Montenegro. National Strategic Response to HIV / AIDS in Montenegro 2010 - 2014. Podgorica, 2010.

The study has shown that behaviour of respondents is risky for their health. Mostly, respondents have first sexual intercourse at early ages; two-thirds of respondents had sexual intercourse at 15 years. Males significantly more often have several sexual partners.

Frequency of condom use in the RE population is not adequate. Respondents did not use condom during each sexual intercourse with casual partners (reported by male respondents while female respondents reported sexual relations with a steady partner, husband). Male respondents did not always use condom, even at sexual intercourse with commercial female partners. Respondents (more male than female) mainly knew where they could get condoms. Most of them cited a pharmacy as a place to buy condoms, but it is the fact that a number of respondents (mostly female respondents) did not know where condoms could and should be obtained

Respondents, mostly (significantly more female than male) did not know in which health care institutions voluntary HIV testing is available in their town. Very few respondents did voluntary HIV testing (significantly more male) and even lower number knew their HIV status. This data is associated with insufficiency of general knowledge about HIV/AIDS, resulting in the lack of knowledge about the importance of regular testing and being aware of personal HIV status.

A blood test for HIV showed no association of inadequate knowledge and behaviour of RE population members and their HIV status, as none of respondents (all were tested for HIV) was HIV positive. This indicates the presence of internal isolation of this population, which means that all communication, including sexual intercourse occurs within the population. Members of RE population rarely merge with other population, and, therefore, diseases such as HIV are rarely transmitted. However, it is clear how much it is necessary to work on education of this population, to prevent infection timely.

Behavioral survey on knowledge, attitudes and behaviours related to HIV/AIDS among **merchant marines** in Montenegro, was conducted in the period from December 2012 until the end of July 2013. Survey included 1131 merchant mariners, 1037 male (91.7%) and 94 female or 8.3%.

HIV prevalence in the studied population of merchant mariners in Montenegro was 0.06% and it belongs to low-level epidemic by WHO criteria. Knowledge about HIV transmission is very low as the complete information on HIV transmission was shown by 16.2% of respondents, while complete information on HIV prevention was shown by 59.2% of respondents. Only 8.6% of merchant mariners showed complete knowledge and awareness about HIV prevention. Data on

risky behaviour suggest that there is a significant level of behaviour associated with the risk of HIV infection and other STIs. "One-night sex", that is sex with casual partner was reported by 37.4% of respondents, and 42% of respondents reported using of condom at last sexual intercourse with casual partner in the past 12 months. Counselling and education on prevention of HIV and other STIs was provided to 32.3% of merchant mariners indicating the need for more intensive work on the promotion of voluntary counselling and testing for HIV and other STIs.

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 Parliament of Montenegro adopted antidiscrimination Law which forbids discrimination on the grounds of various characteristics, including sexual orientation and gender identity. 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. 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 110 staff has been trained about basic and advanced skills for VCT 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 recommendations⁴.

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

In 2013, 1027 people received VCT services and out of this number 12% were MSM, 6% were IDUs and 1% was SW. During these period 17072 condoms, 1154 lubricants, 2424 IE printed material were provided by PU UNDP who is main Principle Recipients from the GF project.

Most-at-risk populations: prevention programmes

During the past seven 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

⁴ 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.

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 Health Center in Podgorica, Berane and Kotor. A methadone maintenance therapy programme will be operational in more three Health Centre in Niksic, Pljevlja and Bar. 31.5% of the surveyed SWs have been tested for HIV once or few times (13.5% only once and 18% more than once). Among those tested for HIV, 84% of them were tested in the last three years (2010-2012), while the other 16% were tested earlier (2001-2009). 34 respondents reported to be tested on HIV in the last 12 months (54% out of total number of respondents tested for HIV or 17% out of the total number of surveyed SWs). 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 86% of people registered with HIV acquired the infection sexually, the prompt diagnosis and treatment of STIs for men⁵ 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 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 15 injection points in the capital.

NGOs: Juventas and CAZAS outreach work in the forth city (Podgorica, Bar, Nikšić and Berane), drop-in centre for IDUs in Podgorica.

Pharmacies: still do not distribute free syringes and needles.

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

U planu je da se otvore tokom 2014 jos tri OST centra u HĆ Nikšić, HĆ Bar i HĆ Pljevlja. Ukupno je tokom 2013 god na OST bilo 161 u sva tri OST centra. Nbavka metadona je obezbijedena od strane NIF nacionalnog zdravstvenog fonda

Преведи са језика: босански

It is planned to open three OST in the Health centre in Niksic, Bar and Pljevlja in 2014. There was 208 PLWID in all three OST Centre in total during 2013. Methadone supply is provided by NIF (National health insurance fund).

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

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 2013, 65 people living with HIV or AIDS were receiving HAART. During 2012, 9 persons started with ARV and out of them 7 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. The available ART currently in Montenegro:

- Zidovudine (ZDV)
- Didanosine (ddI)
- Lamivudine (3TC)
- Abacavir (ABC)
- Tenofovir
- Lamivudine/Abacavir 3TC+ABC
- ZDV + 3TC
- ZVD + 3TC + ABC
- Tenofovir/emtricitabin
- Efavirenz EFV
- Nevirapin
- Ritonavir RTV
- Saquinavir SQV
- Lopinavir/Ritonavir LPV/RTV

- Raltegravir - Inhibitor integraza

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 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 was one new case of HIV infection among blood donors during 2011.

Tab 4. Prevalence of HIV among voluntary blood donors in Montenegro from 2004-2012.

Y	No. of Voluntary blood donors	No of HIV positive	Rate on 100.000 tested voluntary blood donors
2004.	14694	0	0,0
2005.	13175	1	7,6
2006.	17338	0	0,0
2007.	14952	0	0,0
2008.	13553	1	7,4
2009.	14561	1	6,9
2010.	14239	3	21,1
2011.	14849	1	6,7
2012.	15154	0	0,0

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 2012*” 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 youth aged 15-24 years at the entire territory of Montenegro. This study, designed as cross-sectional study, was conducted during December 2012 on a sample of 1.200 households. Survey covered 1.171 respondents aged 15-24, out of which 611 (52.2%) males and 560 (47.8%) females. The average age of the respondents was 20.1 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?	87.0%
2. Having sexual intercourse with only one, uninfected and faithful person?	64.6%
Is there a possibility to get HIV infected:	
3. Through mosquito bites?	61.3%
4. Using public toilette?	60.4%
5. Using a glass already used by the HIV infected person?	55.3%
6. Sharing meals (food) with HIV infected person?	58.8%
7. Having sex with a healthy-looking person?	78.9%

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 21.8%. 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 (43%) would not share a meal with PLHIV, while 19% of them would buy food if they knew that shopkeeper or food seller was HIV infected. 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 (71%) think that all the members of the most-at-risk groups (IDUs, homosexuals, persons selling sex, hemophiliacs) should be tested for HIV, while more than one third (41%) think that all PLHIV should be registered in the police records.

Survey on HHIV/AIDS related knowledge, attitudes and behavior among **health care personnel**, should lead to obtaining more realistic picture of factors contributing to the spread of HIV infection, and barriers to universal access to health care services for people living with HIV/AIDS and most at risk population groups. The survey was conducted as a cross sectional bio behavioural study in 2012 on a representative sample of health workers in Montenegro. All health care institutions at all health care levels and all health care workers were included in the study.

Results of survey shows: Health workers are mostly exposed to contact with blood and other body fluids at workplace. More than one in four health workers are likely to provide health care services to people living with HIV/AIDS. Health workers often do not have access to all protective measures. In addition, gloves are always available to more than three-quarters of participants, while other protective equipment is always available to small number of surveyees. However, there is a practice that protective measures are not applied even when they are available. It has been shown that the applying of protective measures at workplace depends on risk assessment of contact with blood of patients, especially on knowing the HIV status of a patient. More than half of participants apply protective measures only when they know that their patient is person living with HIV/AIDS.

Health workers estimated that they are at risk of HIV transmission from their patients. One-third of participants experienced an accident at work. Most of them know the procedures to be applied in these cases, but more than one-third of participants do not have information about the guidelines for management of accidental injuries caused by sharp objects during work with blood or other body fluids. Health workers assessed their knowledge about HIV/AIDS as insufficient. Less than 20% of participants knew all necessary protective measures in case of contact with blood. A smaller number of them gave correct answers to questions related to possible HIV transmission modes, with difference in respect to the type of health care service provided. More than one in four health workers did not attend any form of education on

HIV/AIDS, but one-third of those attending HIV trainings reported applying of gained knowledge in the practice. It is shown that knowledge about HIV/AIDS is not comprehensive, and should be improved. More than two-thirds of surveyed health workers have never been tested for HIV. Small number of participants was tested for HIV/AIDS in the last 12 months. Only one-quarter of participant knew their HIV status. Attitudes of health workers towards people living with HIV/AIDS are insufficiently non-stigmatized. Only 11% of participants did not express any form of criticism or blame to people living with HIV/AIDS. A quarter of participants believed that people infected with HIV through sexual intercourse or drug abuse deserved it, and there is a similar number of those who believe that names of people living with HIV/AIDS should be disclosed publically. Nearly one-third of participants expressed fear of providing health care services to people living with HIV/AIDS.

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)
7. The subject of “Healthy lifestyles” is included as voluntary education in primary schools and it is in progress, introduction of the subject in high school.
8. Developed guidelines for journalists on HIV related reporting with special focus on stigma free articles and reports.

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.

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 Work plan 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, journalists/media representatives and law enforcement officers with follow-up training to address stigma and discrimination as appropriate.
- 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, prisoners and young Roma 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.