UNGASS COUNTRY PROGRESS REPORT

SLOVENIA

Reporting period: January 2008 – December 2009

Submission date: 31st March 2010

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II. Status at a glance

II. (a) Report writing process

Preparation of this report was coordinated by:

- Assist. Prof. Irena Klavs, AIDS, STI & HAI Unit, Communicable Diseases Centre, National Institute of Public Health

All members of the National AIDS Committee at the Ministry of Health were forwarded the Guidelines on construction of core indicators, 2010 reporting and were asked to contribute any available information to the National Institute of Public Health.
The following members contributed:

- Miran Solinc, SKUC-MAGNUS (non-governmental organization (NGO));
- Evita Leskovsek, Unit of Mental Health, Security & Other Key Issues, Center for Health Promotion, National Institute of Public Health;
- Prof. Janez Tomazic, Infectious Diseases Clinic, University Clinical Centre Ljubljana;
- Prof. Mario Poljak, Institute of Microbiology and Immunology, Medical School, University of Ljubljana;

In addition, the following individuals contributed:

- Janja Krizman, Directorate for Public Health, Ministry of Health;
- Nejc Bergant, AIDS, STI & HAI Unit, Communicable Diseases Centre, National Institute of Public Health;
- Tanja Kustec, AIDS, STI & HAI Unit, Communicable Diseases Centre, National Institute of Public Health;
- Zdenka Kastelic, AIDS, STI & HAI Unit, Communicable Diseases Centre, National Institute of Public Health;
- Urska Rahne Potokar, Blood Transfusion Centre of Slovenia;
- Dare Kocmur, STIGMA (NGO).

Before submission of the report all members of the National AIDS Committee at the Ministry of Health and all other individuals who contributed information were asked to comment on the draft. The report was adopted by the National AIDS Committee at the Ministry of Health on 15th April 2010.

II. (b) Status of the epidemic

Slovenia is a low-level HIV epidemic country. Less than one individual per 1000 inhabitants is living with HIV infection.[1]

Men who have sex with men (MSM) have been most affected, but the proportion of infected has stabilized at a level of a few percent, and has not risen above five percent.

There is as yet no evidence of a substantial HIV infection burden among injecting drug users (IDU) and their sexual partners or any other population group at higher behavioral risk.

During the 2009, the annual reported incidence rate of newly diagnosed HIV infection cases has been 23.5 per million population, equal to the reported incidence rate in 2008.

In 2009, MSM represented 58% of newly diagnosed HIV infection cases (29% other/undetermined transmission) in comparison to 71% in 2008 (21% other/undetermined transmission).

In 2008, a substantial proportion of reported early syphilis cases (26%) occurred among MSM who were known to live with HIV infection[2].

During the period from 2000 to 2009, a cumulative total of two cases of HIV among IDU were reported, the last one in 2001.

During the period from 2000 to 2009, a cumulative total of three cases of mother-to child transmission (MTCT) of HIV infection were reported, the last one in 2004.

In 2009, HIV diagnosis was established very late, within three months of AIDS diagnosis, in 33% of all new diagnoses and in 2008 in 56% of all new diagnoses.

The overall diagnostic HIV testing rates have been relatively low however have increased to 1.8 tests per 100 population in 2009 in comparison to 1.5 tests per 100 population in 2008.

In 2009, 17 AIDS cases were diagnosed (8.3 per million population) of which none presented with pulmonary tuberculosis and in 2008, 11 AIDS cases (5.4 per million population) among which also none presented with pulmonary tuberculosis.

One AIDS death was reported in 2009 and five in 2008.

II. (c) The policy and programmatic response

Since mid-eighties, prevention, treatment and care have been mainstreamed into different governmental sectors' activities. Information, education and communication activities have aimed at reducing risk-taking behavior and encouraging responsible sexual behavior among youth and the general population. In addition, NGOs have been implementing preventive and harm reduction interventions targeted to groups at highest behavioral risk, mostly MSM and IDU. Universal access to client-initiated voluntary confidential and also anonymous counseling and testing, effective treatment for sexually transmitted infections and to high quality clinical treatment and care for HIV infection, including highly active anti-retroviral therapy has been provided.

Recognizing the need for multi-sector approach, in 1995 the Ministry of Health, lead the process to prepare the national strategy for HIV prevention, treatment and care, "AIDS Prevention and Control Program, 1995-2000". Program has been adopted at the multi-sector national consensus conference with the participation of civil society. The three broadly defined objectives of the national Program were: (1) to prevent the spread of HIV infection, (2) to reduce the personal and social impact of HIV infection and AIDS, and (3) to mobilize and unify the national efforts for prevention and control.

In 2009, revised Strategy for preventing and controlling HIV infection for the period 2010-2015 has been adopted by the Slovenian Government. The strategy was prepared by the Ministry of Health and the National Institute of Public Health in close collaboration with all members of the National AIDS Committee at the Ministry of Health that represented many governmental sectors, Catholic church, civil society (NGOs), and people living with HIV/AIDS (PLWHA).

This strategy is based on three PILLARS and follows eight AIMS within those pillars:
Preventing infections (pillar 1):

Preventing transmission through sexual intercourse (aim 1),

Preventing transmission through blood (aim 2),
Preventing mother to child transmission (aim 3),

Provision of early detection of infections, preventing transmission and treatment (pillar 2):

Decrease in the number of undetected infections (aim 4),
Counselling infected persons and informing their contacts (aim 5),
Provision of quality treatment (aim 6),

Decreasing personal and social impact of HIV infection and AIDS (pillar 3):

Integration of infected persons in society (aim 7),
Limitation of discrimination and stigmatisation (aim 8).

Preventing HIV infections is the most important pillar of the Strategy.

II. (d) UNGASS indicator data overview

In view of our low level HIV epidemic and limited resources, sufficient personnel and financial resources have not been allocated for the development of a comprehensive HIV response monitoring and evaluation system. Thus, existing data sources do not provide data for most UNGASS indicators to monitor the Declaration of Commitment to HIV/AIDS.

HIV surveillance coordinated by the National Institute of Public Health is based on:
- universal case reporting of HIV infection, AIDS and AIDS deaths,
- monitoring HIV infection prevalence in selected easily accessible groups at different behavioral risk (IDU, MSM, patients with sexually transmitted infections (STI) tested for syphilis, and pregnant women screened for syphilis) with unlinked anonymous testing and
- behavioral surveillance in two groups at higher behavioral risk (MSM and IDU).

Additional data are available to inform policies and strategies. For example:
- national HIV and sexually transmitted infections related behavioral survey "Sexual Lifestyles Attitudes and Health" was conducted in a probability sample of the general population in 2000,
- "Health Behavior in School-Aged Children" (HBSC), World Health Organization Cross-National Study has been conducted in 2002 and 2006.

UNGASS indicator data overview:

Government HIV and AIDS Policies

1. AIDS spending
   Indicator relevant to our country - no data available.

2. Government HIV and AIDS Policies (NCPI-National Composite Policy Index)
   Indicator relevant to our country – data provided.

INDICATORS

NATIONAL PROGRAMME INDICATORS

3. Blood safety
   Indicator relevant to our country – data provided:
   Values for 2008 and 2009: 100% and 100% respectively.

4. HIV Treatment: Antiretroviral Therapy
   Indicator relevant to our country – no data available.

5. Prevention of Mother-to-Child Transmission
   Indicator relevant to our country - no data available.
   Monitoring this indicator is not considered a priority, since during the period from 2000 to 2009, only a cumulative total of 3 MTCT HIV cases were diagnosed, the last one in 2004. Our results from the national unlinked anonymous monitoring of HIV prevalence change among pregnant women indicate a very low prevalence of HIV. By 2009, HIV screening of pregnant women has not been introduced.

6. Co-management of Tuberculosis and HIV treatment

Indicator relevant to our country – no data available:

7. HIV testing in the General Population

Subject matter relevant. Indicator not relevant.

Slovenia is currently a low level HIV epidemic country. By the end of 2009, less than one HIV infected person lived per 1000 population. HIV testing of the general population is not considered a priority.

8. HIV testing in Most-at-risk Populations – Sex workers

Indicator relevant to our country - no data available.

8. HIV testing in Most-at-risk Populations – Men who have sex with Men (MSM)

Indicator relevant to our country – data provided.

Values for 2008 and 2009: 27% and 38% respectively; pooled estimate: 33%.

Additional results from SIALON project for 2008-2009: 38%[3].

8. HIV testing in Most-at-risk Populations – Injecting drug users

Indicator relevant to our country - no data available.

9. Most-at-risk Populations: prevention Programmes – Sex Workers

Indicator relevant to our country - no data available.

9. Most-at-risk Populations: prevention Programmes – MSM

Indicator relevant to our country - data provided.

SIALON project results for 2008-2009: 85% (Solinc M, personal communication)

9. Most-at-risk Populations: prevention Programmes – Injecting Drug Users

Indicator relevant to our country – no data available.

10. Support for Children Affected by HIV and AIDS

Subject matter not relevant.

During the period from 2000 to 2009, a cumulative total of 3 cases of MTCT HIV infection cases were diagnosed, the last one in 2004. Not a single orphan with HIV infection has been known to have lived in Slovenia by the end of 2009.

11. Life Skills-based HIV Education in Schools

Indicator relevant to our country - no data available.

KNOWLEDGE AND BEHAVIOUR INDICATORS

12. Orphans: School Attendance

Subject matter not relevant.

During the period from 2000 to 2009, a cumulative total of 3 cases of MTCT HIV infection cases were diagnosed, the last one in 2004. By the end of 2009, not a single child with HIV infection had been known to have not been able to attend school in Slovenia.

13. Young People: Knowledge about HIV Prevention

Indicator relevant to our country - no data available.

14. Most-at-risk population: Knowledge about HIV Transmission Prevention – Sex Workers

Indicator relevant to our country - no data available.

14. Most-at-risk population: Knowledge about HIV Transmission Prevention – MSM
Indicator relevant to our country – no data available.

14. Most-at-risk population: Knowledge about HIV Transmission Prevention – Injecting Drug Users
Indicator relevant to our country - no data available.

15. Sex before Age of 15
Indicator relevant to our country - no data available.
Data were published for a similar indicator (a different denominator) for the year 2000 (probability sample of the general population 18 to 49 years old)[4].

16. Higher-risk sex
Indicator relevant to our country - no data available.
Data were published for a similar indicator (a different denominator) for the year 2000 (probability sample of the general population 18 to 49 years old)[5].

17. Condom Use During Higher-risk Sex
Indicator relevant to our country - no data available.
Data were published for a similar indicator (a different denominator) for the year 2000 (probability sample of the general population 18 to 49 years old)[5].

18. Sex Workers: Condom Use
Indicator relevant to our country - no data available.

19. Men Who Have Sex with Men: Condom Use
Indicator relevant to our country - data provided.
SIALON project results for 2008-2009: 43%[3]

20. Injecting Drug Users: Condom Use
Indicator relevant to our country - no data available.
Similar indicator data are given in the chapter Overview of the AIDS epidemic below.

21. Injecting Drug Users: Safe Injecting Practices
Indicator relevant to our country - no data available.
Similar indicator data are given in the chapter Overview of the AIDS epidemic below.

IMPACT INDICATORS

22. Reduction in HIV Prevalence
Indicator relevant to our country - no data available.
Sentinel surveillance methods to monitor prevalence change in several sentinel groups at different behavioral risk for HIV infection, including pregnant women screened for syphilis, and overview of results for the period from 1993 to 2002 were published in 2003.[6] Results for the period from 1999 to 2008 were published in 2009 in the National Institute of Public Health annual report on HIV infection in Slovenia.[1] Results for the period from 2005 to 2009 are given in the chapter Overview of the AIDS epidemic below.

23. Most-at-risk Populations: Reduction in HIV Prevalence – Sex Workers

Indicator relevant to our country - no data available.

23. Most-at-risk Populations: Reduction in HIV Prevalence – Men Who have Sex with Men

Indicator relevant to our country – data provided.

Prevalence estimates in 2008 and 2009 were 2.2% and 0.9% respectively.

Sentinel surveillance methods to monitor prevalence change in several sentinel groups at different behavioral risk for HIV infection and overview of results for the period from 1993 to 2002 were published in 2003.[6] Results for the period from 1999 to 2008 were published in 2009 in the National Institute of Public Health annual report on HIV infection in Slovenia. Results for the period from 2005 to 2009 are given in the chapter Overview of the AIDS epidemic below.

23. Most-at-risk Populations: Reduction in HIV Prevalence – Injecting Drug Users

Indicator relevant to our country – data provided.

Prevalence estimates for 2008 and 2009 were 2.2% and 0.9%; pooled: 1.6%

Sentinel surveillance methods to monitor prevalence change in several sentinel groups at different behavioral risk for HIV infection and overview of results for the period from 1993 to 2002 were published in 2003.[6] Results for the period from 1999 to 2008 were published in 2009 in the National Institute of Public Health annual report on HIV infection in Slovenia.[1] Results for the period from 2005 to 2009 are given in the chapter Overview of the AIDS epidemic below.

SIALON project results: 5.1%[3]

24. HIV Treatment: Survival After 12 Months on Antiretroviral Therapy

Indicator relevant to our country - no data available.

25. Reduction in Mother-to-child Transmission

Indicator relevant to our country - no data available.

Monitoring this indicator is not considered a priority, since during the period from 2000 to 2009, only a cumulative total of 3 MTCT HIV cases were diagnosed, the last one in 2004. Our results from the national unlinked anonymous monitoring of HIV prevalence change among pregnant women indicate a very low prevalence of HIV[1,6]. By 2009, HIV screening of pregnant women has not been introduced.

III. Overview of the AIDS epidemic

Slovenia is a low-level HIV epidemic country. Less than one individual per 1000 inhabitants is living with HIV infection.[1] MSM have been most affected, but the proportion of infected has stabilized at a level of a few percent, and has not risen above five percent. There is as yet no evidence of a substantial HIV infection burden among IDU and their sexual partners or any other population group at higher behavioral risk.

For the period of last five years, Table 1 presents the results from monitoring HIV prevalence with unlinked anonymous testing for surveillance purposes in three easily accessible groups at higher behavioral risk, IDU, MSM and clients of sexually transmitted infections (STI) clinics, and also in one low-risk group, pregnant women.

TABLE 1: PROPORTION OF HIV INFECTED AMONG INJECTING DRUG USERS, MEN WHO HAVE SEX WITH MEN, PATIENTS WITH SEXUALLY TRANSMITTED INFECTIONS AND PREGNANT WOMEN, SLOVENIA, 2005-2009

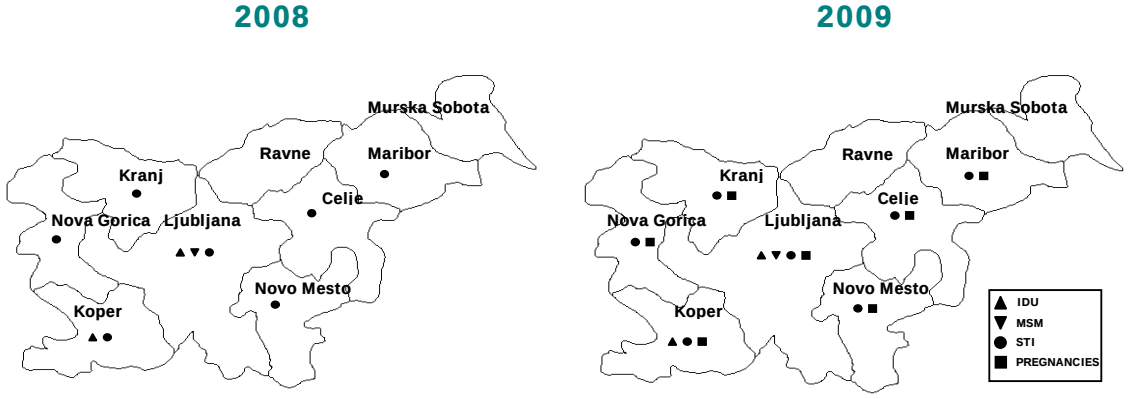
	Year	Number of sentinel sites	Number of tested		Number of HIV infected		% HIV infected	
			Male	Female	Male	Female	Male	Female
IUD	*2005*	3	137	57	0	0	0 %	0 %
	2006	3	125	35	0	0	0 %	0 %
	2007	3	130	44	0	0	0 %	0 %
	2008	3	142	34	0	0	0 %	0 %
	2009	3	127	32	0	0	0%	0%
MSM	*2005*	1	82		**3**		**3,7 %**	
	2006	1	94		**2**		**2,1 %**	
	2007	1	124		**3**		**2,4 %**	
	2008	1	137		**3**		**2,2%**	
	2009	1	117		**1**		**0,9%**	
STI	*2005*	7	403	170	**1**	**1**	**0,2 %**	**0,6 %**
	2006	7	419	211	**10**	0	**2,4 %**	0 %
	2007	7	484	257	**11**	0	**2,3 %**	0 %
	2008	7	677	264	**23**	**2**	**3,4 %**	**0,8 %**
	2009	6	412	597	**-**	-	**-**	**-**
Pregnancies	*2005*	8		8008		**1**		**0,01 %**
	2007	8		8963		0		0 %
	2009	6		7880		-		-

IDU – injecting drug users, MSM – men who have sex with men, STI – sexually transmitted infections.
- results of testing not available by 31st March 2010.

Methods for monitoring HIV prevalence with unlinked anonymous testing for surveillance purposes were published previously.[6] In brief, residual sera from specimens obtained from STI patients for syphilis serology are sampled continuously in several laboratories; residual sera from specimens obtained from pregnant women who are screened for syphilis are sampled continuously in several laboratories every second calendar year; saliva specimens are continuously voluntarily obtained from IDU entering one substitution program (Centre for prevention and Treatment of Drug Abuse in Ljubljana) and from IDU at two needle exchange programs. Once per year (one day survey) saliva specimens are voluntarily obtained from MSM in a community venue (disco). Figure 1 presents the sentinel sites geographical coverage for the years 2008 and 2009. In addition to the information about the type of sentinel population, sampling period and sentinel site, all specimens are labeled only with sex and age group, frozen and stored at -20^0 C. At the end of each sampling period, after

each calendar year, all serum specimens are tested in pools of 12 for the presence of anti HIV-1/0/2 antibodies. Individual sera from reactive pools are re-tested using the same assay. Saliva specimens are tested individually for the presence of anti HIV-1/2 antibodies.

FIGURE 1: UNLINKED ANONYMOUS HIV PREVALENCE MONITORING SENTINEL SITES AND SENTINEL POPULATIONS, SLOVENIA, 2008-2009



IDU–injecting drug users, MSM–men who have sex with men, STI–sexually transmitted infections.

This component of our national HIV surveillance system is relatively modest in terms of numbers of tested specimens for all higher risk groups, but the results provide for crude monitoring of trends and early warning.

In 2009, the annual reported incidence rate of newly diagnosed HIV infection cases has been 23.5 per million population, equal to the reported rate in 2008 (Figure 2).

In 2009, MSM represented 58% of newly diagnosed cases (29% other/undetermined transmission category by 31st March 2010) in comparison to 71% in 2008 (21% other/undetermined transmission category by 31st March 2010) (Figure 3). More detailed surveillance information about the disproportionate and increasing burden of HIV diagnosis among MSM in Slovenia during the period 1999-2008 has been published in 2009.[7]

In 2008, a substantial proportion of reported early syphilis cases (26%) occurred among MSM who had been known to live with HIV infection[2].

During the period from 2000 to 2009, a cumulative total of two cases of HIV among IDU was reported, the last one in 2001 and a cumulative total of three cases of MTCT of HIV infection, the last one in 2004 (Figure 3).

In 2009, HIV diagnosis was established very late, within three months of AIDS diagnosis, in 33% of all new diagnoses. During 2000-2009, the proportion of very late diagnoses has remained unacceptably high (Figure 4).

The overall diagnostic HIV testing rates have been relatively low, however have increased to 1.8 tests per 100 population in 2009 (Figure 5).

In 2009, 17 AIDS cases were diagnosed (8.3 per million population) of which none presented with pulmonary tuberculosis and in 2008, 11 AIDS cases (5.4 per million population) among which also none presented with pulmonary tuberculosis (Figure 2).

One AIDS death was reported in 2009 and five in 2008.

FIGURE 2: NEWLY DIAGNOSED HIV CASES, AIDS CASES AND DEATHS AFTER AIDS DIAGNOSIS, SLOVENIA, 2000-2009

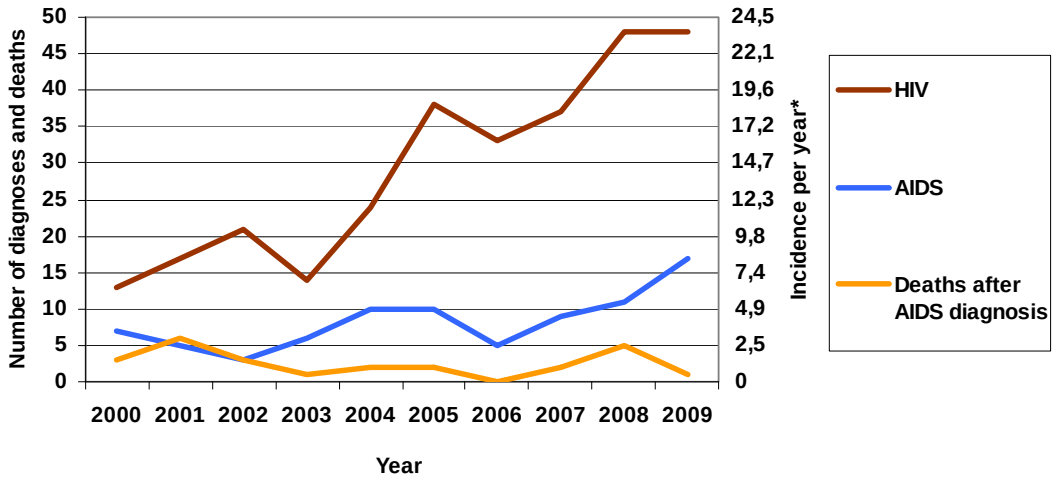


FIGURE 3: NEWLY DIAGNOSED HIV CASES ACCORDING TO TRANSMISSION CATHEGORY, SLOVENIA, 2000-2009

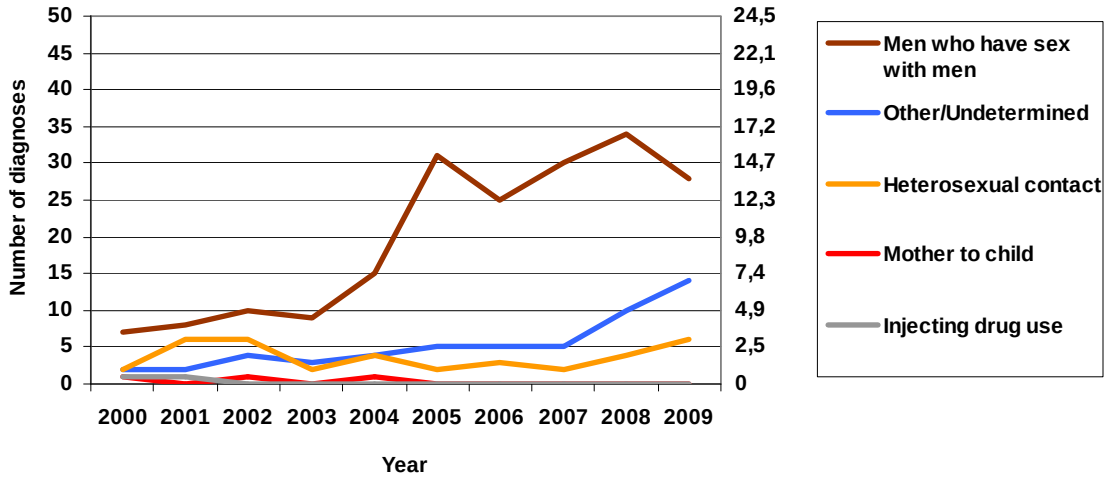


FIGURE 4: LATE DIAGNOSES OF HIV, SLOVENIA, 2000-2009

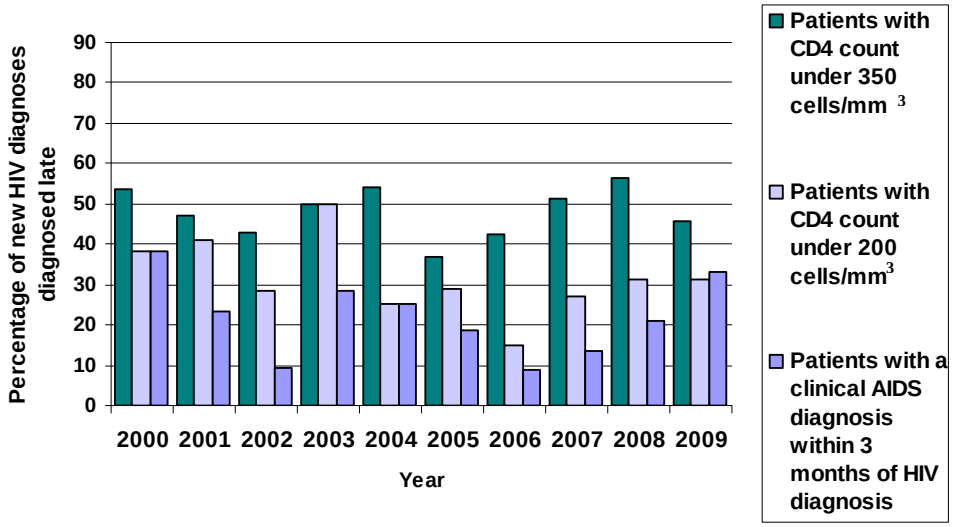
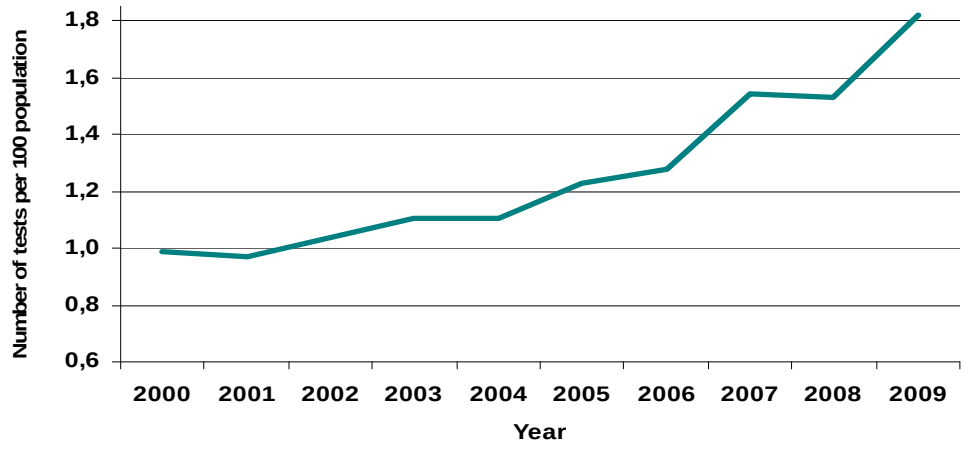


FIGURE 5: DIAGNOSTIC HIV TESTING RATES, SLOVENIA, 2000-2009

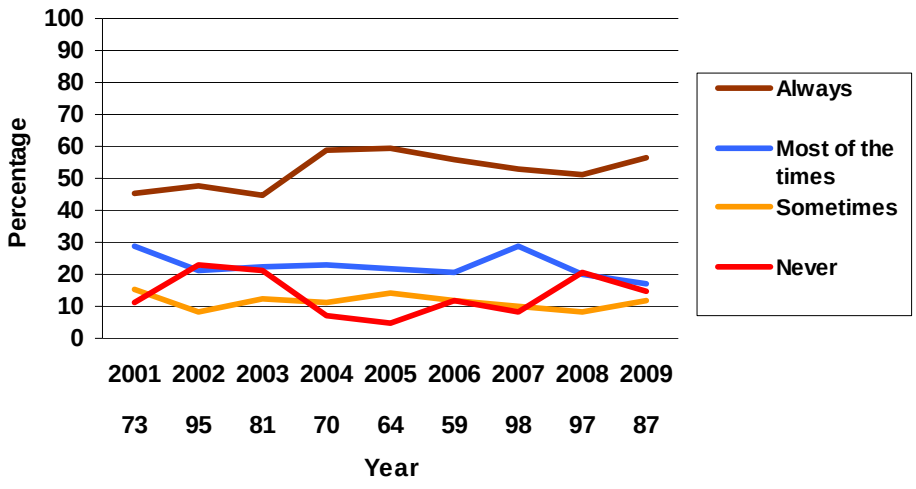


Very modest behavioral HIV surveillance has been established among MSM in 2000. It was linked to HIV sentinel surveillance described above.[6] MSM participating in one day surveys at one of the gay venues in Ljubljana who consent to contribute a saliva specimen for unlinked anonymous HIV testing are also invited to anonymously complete a self-administered questionnaire about their recent sexual behavior. The results about the reported frequency of condom use at homosexual anal sex during the preceding year do not suggest major recent deterioration of safer sex practices among MSM in this sentinel population (Figure 6).

During 2008 and 2009, Regional Institute of Public Health Maribor and SKUC-MAGNUS participated in a multi-center bio-behavioral survey in MSM with a specific focus on HIV prevalence and use of UNGASS indicators in six cities in Southern and Eastern Europe. The methods used and some preliminary results were published by the end of 2009.[3] In brief,

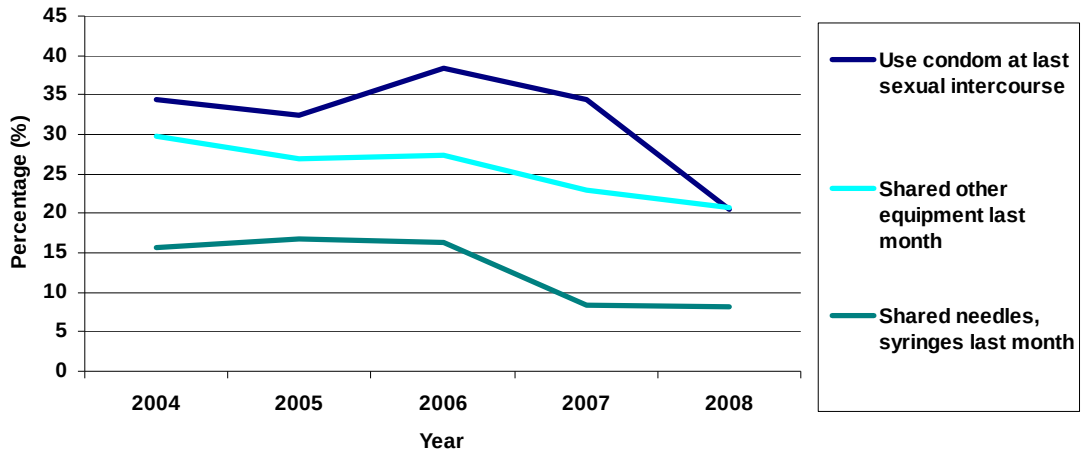
time-location sampling was used to recruit approximately 400 men visiting the gay scene in the capital city of each participating country, in Slovenia in Ljubljana. Self-administered pen-and-paper questionnaire was used to obtain information on the social, cultural and environmental context of respondents, access and barriers to voluntary counseling and testing, behavioral data on sex practices, risk-reducing strategies, condom use, STI history, self-reported/perceived HIV infection status and type of partner. Oral fluid specimens were obtained and tested for HIV 1/2. Among 389 MSM recruited in Ljubljana, the estimated overall HIV prevalence was 5.1% (95% confidence interval (CI): 2.9 – 7.3) (UNGASS indicator 23).[3] HIV point prevalence estimates differed between different sampling venues, ranging from the highest of 25.0% in cruising area, 11.9% in sauna, 8.0% in a bar to the lowest of 2.0% in a disco (oral communication Mirandola M). To had been tested for HIV infection during preceding 12 months and to had received the test result (UNGASS indicator 8) was reported by 38.2% (95% CI: 33.4 – 53.0) and to had used condom during the last anal sex episode during preceding six months (UNGASS indicator 19) by 43.0% (95% CI: 37.4 – 48.6).[3] An additional UNGASS indicator value had been estimated: UNGASS indicator 9 - MSM reached by preventive programs (84.7%) (personal communication Solinc M).

FIGURE 6: USE OF CONDOM AT ANAL SEX AMONG MEN WHO HAVE SEX WITH MEN, LJUBLJANA, SLOVENIA, 2001-2009



Monitoring of drug use related risk behavior indicators among IDU demanding treatment for the first time was established within network of Centers for Prevention and Treatment of Drug Addiction with national coverage. Available results for the period 2001-2009 (Figure 7) suggest that the availability of clean needles and syringes in pharmacies and the gradually expanding needle and syringe exchange and distribution programs in Slovenia had the desired impact on the reduction of sharing injecting equipment among IDU. Also, the intensive promotion of condom use targeted to general population, youth and IDU seems to have had some impact.

FIGURE 7: SELECTED BEHAVIOURAL INDICATORS FOR CURRENT IDU AT FIRST TREATMENT DEMAND, SLOVENIA, 2004-2008



Bases:						
	235	**149**	**110**	**83**	**96**	**injecting**
	197	**123**	**86**	**58**	**68**	**condom use**

To conclude, Slovenia is a low HIV epidemic country. It seems that we have not missed the window of opportunity for promotion of safer sex, especially condom use, targeted to general population, youth and population groups at higher behavioral risk and for the development of harm reduction programs for IDU. MSM are the most affected population group, but HIV prevalence had not risen above 5%. Available data from the very modest behavioral surveillance conducted among MSM does not suggests recent major deterioration of safer sex behavior. However, recent substantial increase in early syphilis cases among MSM who were known to live with HIV infection indicates continuing high risk behavior in this group.

IV. National response to the AIDS epidemic

Early response

The Slovenian Ministry of Health has been leading an early and effective response mounted together with other governmental sectors and NGOs. Some milestones are given below.

In 1985, the first governmental Working Group on AIDS was established at the Institute of Public Health of the Republic of Slovenia. HIV laboratory diagnosis became available and HIV reference laboratory was established at the Institute of Microbiology and Immunology, Medical School, University of Ljubljana.

Among NGOs, the gay men NGO SKUC-MAGNUS / ROZA KLUB was the first to respond to the news about the developing AIDS epidemic among homosexual men elsewhere. They launched their first campaign in 1985 in the gay club “Amerikanec” in the capital city Ljubljana. Leaflets with information about HIV infection, transmission modes and safer sex practices had been distributed. Since then, safer sex promotion campaigns targeted to MSM were organized annually, during recent years also by several other MSM NGOs.

In 1986, the first national AIDS related campaign targeted to general population was launched by the Red Cross and the Association of the Socialistic Youth of Slovenia. The Blood Transfusion Centre of Slovenia ensured blood safety, a national voluntary confidential HIV testing and counseling site was established at the Infectious Diseases Clinic, University Clinical Centre Ljubljana, and health care for the first recognized cases of HIV infection, then limited to treatment of opportunistic infections and malignancies was provided. The National Institute of Public Health started with HIV surveillance, initially based on reporting of diagnosed HIV infection and AIDS cases. The Ministry of Justice in collaboration with the Ministry of health prepared Guidelines for the prevention of HIV transmission in prisons.

In 1987, anonymous, free of charge HIV testing and counseling became available at the Institute of Microbiology and Immunology, Medical School, University of Ljubljana and HIV/AIDS guidelines for health care workers were prepared and distributed by the National Institute of Public Health.

In 1988, the National Institute of Public Health coordinated the implementation of the first national HIV/AIDS mass media campaign.

In 1989, antiretroviral therapy with zydovudine was introduced at the Infectious Diseases Clinic, University Clinical Centre Ljubljana, where all HIV infected individuals were receiving treatment.

In 1990, the National institute of Public Health drafted the first comprehensive Slovenian HIV/AIDS prevention and control strategy document. The Ministry of Justice introduced HIV prevention program in prisons. Methadone substitution for IDU was introduced at two health care sites.

In 1992, STIGMA, the NGO working with IDU in Ljubljana started the first needle exchange program. By then, injecting drug use related harm reduction policy with HIV prevention had gained broader support and the initiation of this program was supported by the Ministry of Health and the former World Health Organization Global Program for AIDS.

In 1993, the Ministry for Labor Family and Social Affairs started supporting programs for the prevention of drug use, rehabilitation programs and harm reduction programs for IDU implemented by NGOs.

In 1995, the Ministry of Health established a national network of outpatient services, Centers for Prevention and Treatment of Illicit Drug Use, on primary health care level that provided different services including substitution treatment for IDU and the first NGO dedicated exclusively to issues related to AIDS, "AIDS Foundation Robert", was established in Ljubljana, as it was perceived that some HIV infected would prefer receiving psychosocial support from dedicated volunteers in a NGO setting outside governmental institutions. This NGO, in 2000 also integrated the former STIGMA and continued to provide harm reduction program for IDU, including needle exchange. In 1995, under the lead of the Ministry of Health, the new national strategy for HIV prevention and care had been adopted at the multi-sector national consensus conference.

In 1996, first protease inhibitor saquinavir was introduced into treatment and since 1997 all patients with medical indications had access to highly active antiretroviral therapy (HAART).

In 1997, youth HIV/AIDS peer-education project VIRUS was started by the Association of Medical Students of Slovenia. Guidelines for management of IDU in prisons were prepared by the Ministry of Justice in collaboration with the network of Centers for the Prevention and Treatment of Drug Addiction.

In 1998, the main psychosocial emergency hot-line at the Centre for Mental Health in Ljubljana integrated HIV/AIDS issues into their anonymous telephone counseling.

Previous HIV prevention and control national strategy and more recent response

Recognizing the need for multi-sector approach, in 1995 the Ministry of Health, lead the process to prepare the national strategy for HIV prevention, treatment and care, "AIDS Prevention and Control Program, 1995-2000". Program has been adopted at the multi-sector national consensus conference with the participation of civil society. The three broadly defined objectives of the national Program were:
- to prevent the spread of HIV infection,
- to reduce the personal and social impact of HIV infection and AIDS, and
- to mobilize and unify the national efforts for prevention and control.

Prevention, treatment and care had been mainstreamed into different governmental sectors' activities. In addition, NGOs implemented preventive interventions targeted to groups at highest behavioral risk. There was no national budget for HIV prevention, treatment and care and no earmarked budgets for HIV within the budgets of different ministries.

Prevention of HIV infection was identified as the most important objective. Different strategies according to transmission modes were identified:
- prevention of sexual transmission,
- prevention of transmission through blood, and
- prevention of transmission from mother to child.

Five interventions to prevent sexual transmission of HIV defined in the Program were:
- promotion of safer sexual behaviors,
- provision of condoms and lubricants,

- provision of STI health care and promotion of STI health care seeking behavior,
- provision of testing and counseling, and
- partner notification.

The prime focus of action for interrupting transmission was to promote safer sexual behavior. Five safer sexual behaviors promoted were:
- mutual fidelity,
- abstinence from sexual activity (for example for youth to delay the first sexual intercourse),
- safer sexual acts (non-penetrative rather than penetrative sex),
- decrease in the number of non-regular sexual partners,
- correct use of a condom every time an individual has a sexual intercourse at risk (e.g. sex outside a long-term relationship between uninfected partners based on mutual fidelity).

Information, education and communication activities aimed at reducing risk-taking behavior and encouraging responsible sexual behavior among youth and the general population, especially condom use, have continued. The National Institute of Public Health coordinated national HIV/AIDS campaigns annually, at least once per year, for the World AIDS Day (WAD). In addition, occasional campaigns were implemented at Valentine's Day and before summer holidays (Europe against AIDS – Flying condom). Most campaigns involved promotion of safer sex, especially condom use, but some also included messages aimed at countering stigmatization of people living with HIV/AIDS and gender issues. The overview of the WAD campaign messages for the period of last 10 years is given below.

Year	Target population	Messages
WAD 1999	Youth	prevent HIV - safer sex
WAD 2000	general population	gender issues involve men
WAD 2001	general population	get HIV test
WAD 2002	general population	combat discrimination
WAD 2003	general population decision makers	combat stigma and discrimination
WAD 2004	general population	decrease vulnerability of women
WAD 2005	general population decision makers	commit to HIV prevention
WAD 2006	vulnerable groups	be aware of HIV prevent HIV transmission
WAD 2007	vulnerable groups MSM	prevent HIV transmission get HIV test
WAD 2008	MSM	prevent HIV transmission get HIV test combat homophobia
WAD 2009	general population MSM	Spread the word, not the virus! use condom

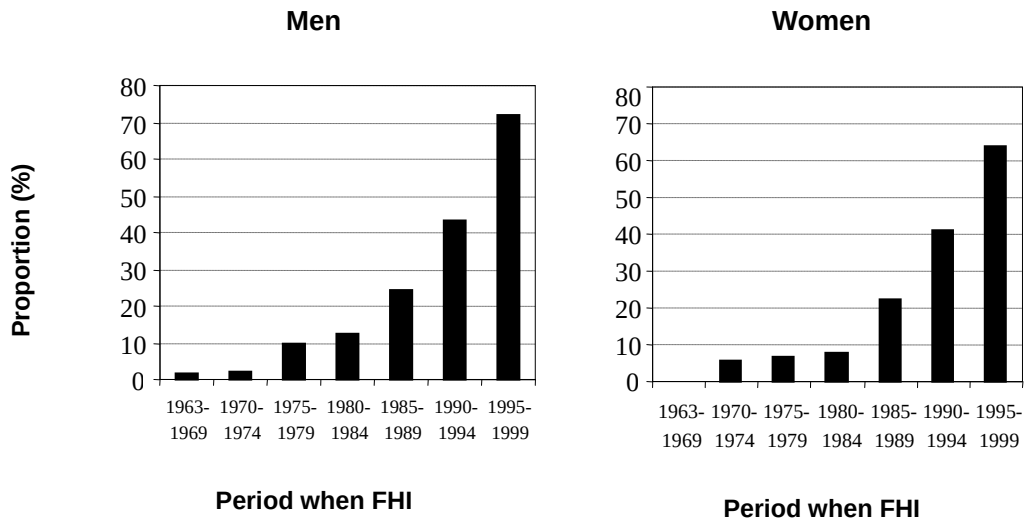
1 – WAD – World AIDS Day

Some primary and secondary schools had been organizing different HIV educational activities, although sexual and reproductive health life skills-based education, including HIV issues, had not been integrated into the primary school curriculum. Ministry of Education and Sport together with the Institute of Education coordinated activities within the healthy schools network that also included promotion of sexual health with promotion of safer sex including condoms promotion, e.g. through optional curriculum units, activities on WAD, and distribution of HIV educational materials.

Also, numerous governmental sector initiatives often implemented by the network of regional Institutes of Public Health as well as NGO initiatives had contributed to sexual health promotion among youth in Slovenia. These activities had not been coordinated or systematically monitored on the national level. For example, youth HIV/AIDS peer education project VIRUS that was started in 1997 by the Association of Medical Students of Slovenia, during the first 10 years of its existence implemented: 1100 peer education sessions for approximately 30000 young people, two international education seminars, eight national education weeks with 320 volunteers, seven STOP AIDS WAD concerts, eight national WAD campaigns, two pre-summer campaigns, published a peer education manual, maintained a website with over 15000 visits per year and established an internet forum for HIV topics where answers are provided by experts.

The steep increase over time in condom use at first heterosexual intercourse in Slovenia suggests that HIV related condom use promotion has had an impact. Currently, the majority of Slovenian men and women use protection against HIV, other sexually transmitted infections, and unplanned conception at first heterosexual intercourse, which predicts subsequent use (Figure 8).[8] Sexually active Slovenian men and women who used condom at first heterosexual intercourse were 11 and 2.5 times more likely to consistently use condoms during the month preceding the interview.[8]

FIGURE 8: PROPORTION OF MEN AND WOMEN REPORTING CONDOM USE AT FIRST HETEROSEXUAL INTERCOURSE (FHI) ACCORDING TO CALLENDAR PERIOD AT FHI, SLOVENIA, 2000



Condom use estimates are not representative of everyone who had FHI during these calendar periods due to exclusion of individuals under 18 and over 49 years of age at time of survey. Potential bias greatest for earliest and more recent periods.

Klavs I, et al. AIDS. 2005

Similarly, the Health Behavior in School-Aged Children: a WHO Cross-National Study (HBSC), implemented in Slovenian schools in 2005-2006, reported that among the sexually experienced 15 years old, 70.9% of boys and 79.0 % of girls reported to have used a condom at first heterosexual intercourse.[9]

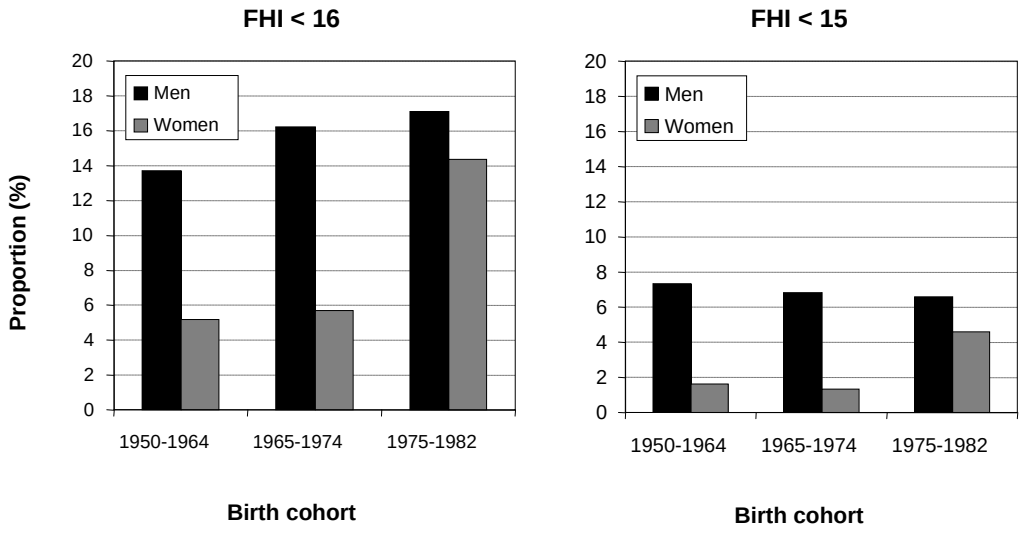
In contrast, delaying first heterosexual intercourse had proved less feasible. The proportion of young men and especially young women, who experience first heterosexual intercourse before the age of 16 still continues to increase (Figure 9)[4]. Similarly, the HBSC, 2005-2006,

reported that 29,5% of 15 years old boys and 17,0% of 15 years old girls already had sexual intercourse.[9]

With respect to knowledge, it is unacceptable, that at the time of their first heterosexual intercourse, approximately three in four young Slovenian people perceived themselves to have been inadequately prepared in terms of information about sexual matters. “Should have known more” was reported by 76.3% of men and 71.7% of women.[4] Of these, a sizeable proportion felt that they should have known more about contraception, 35.4% of men and appreciably more, 47.7% of women. In contrast, more men than women felt that they should had known more about sexually transmitted diseases, 47.7% of men and 40.6% of women.[4]

Among men and women who claimed not to have sufficient knowledge at the time of first heterosexual intercourse, many would have liked to have learned more from authoritative sources such as parents (especially mothers), school and health care institutions. Sexual education in school was the third most preferred option for men and the second most preferred option for women.[4]

FIGURE 9: PROPORTIONS OF MEN AND WOMEN WHO HAVE EXPERIENCED FIRST HETEROSEXUAL INTERCOURSE (FHI) BEFORE AGE 16 AND BEFORE AGE 15, SLOVENIA, 2000



Klavs I, et al. Sex Transm Infect. 2006

In 1999-2001, the national Institute of Public Health of the Republic conducted the first Slovenian national Sexual Lifestyles, Attitudes and Health Survey. Many estimates of sexual behaviour, HIV/STI risk, and recent condom use behaviours in the general population of Slovenia were published in 2009.[5]

In brief, overall 22.7% of men and 9.5% of women reported forming at least one new heterosexual partnership in the past year: Mean numbers of new heterosexual partners were 0.4 for men and 0.1 for women ($p<0.001$). Concurrent partnerships at least once during their lifetime were reported by 35.3% of men and 15.3% of women and during the past 5 years by 24.4% of men and 8.2% of women. Coercive sex was not uncommon. Women were asked "when, if ever, was the last time a man forced you into sexual intercourse", and

12.0% reported having ever been forced and 4.8% during past five years. Overall, 4.4% of men reported having ever paid for sex with a woman. 2.1% of men reported only one occasion of paying for sex to a woman during their lifetime, but 0.9% reported at least 10 such occasions. Overall, 3.4% of men had paid for sex with a foreign female at least once. Respondents were also asked whether they had ever received payment for sex. 0.9% of men (no MSM), and 0.6% of women responded that they had. Sex with a non-Slovenian heterosexual partner during past 5 years was reported by 12.6% of men and 12.2% of women. Vaginal intercourse was almost universal. Lifetime oral heterosexual sex was also very common, with 79.3% of men and 72.7% of women reporting fellatio and 78.1% of men and 77.3% of women cunnilingus. Ever having had heterosexual anal intercourse was reported by 31.6% of men and 22.3% of women. Any occasions of heterosexual genital stimulation not resulting in intercourse (non-penetrative sex) during lifetime were reported by 77.3% of men and 69.0% of women.

Overall, 11.6% of men and 9.1% of women reported consistent condom use during vaginal or anal heterosexual intercourse in the past four weeks, and an additional 14.7% of men and 9.9 % of women inconsistent use. Although consistent condom use during the past 4 weeks was not very prevalent, some evidence of the adoption of HIV/STI risk reduction strategies with casual sex partners in Slovenia comes from the more frequent condom use during the past four weeks among men with at least two female partners during the past year than those with only one, as well as among those still single or previously married.

The three leading MSM NGOs in Slovenia, SKUC-MAGNUS, DIH and Legebitra, implemented numerous activities aimed at promoting safer sex and HIV voluntary counseling and testing among MSM. These activities included: peer education; distribution of HIV and other STI educational leaflets, condoms and lubricants at gay venues in the community; and MSM media campaigns (radio, web, magazines). Numerous workshops for training MSM volunteers for peer safer sex promotion among MSM had been organized. Anonymous psychosocial telephone counseling including HIV issues organized by SKUC-MAGNUS (GALfon) had been operating for many years, but stopped in 2007, as the numbers of clients decreased due to new and more popular web-based communication approaches (internet chat-rooms, including an internet forum for HIV+ MSM where knowledge and experience is shared). Also, a small self-support group of HIV infected MSM had been started by SKUC-MAGNUS and HIV manual has been published.

In 2005, AIDS Fondation Robert integrated the former STIGMA and continued to provide harm reduction program for IDU, including needle exchange. In addition, they started a prevention program for vulnerable mobile population groups such as commercial sex workers, victims of human trafficking, illegal migrants, and asylum seekers in collaboration with the International Organization for Migration and the Slovenian Philanthropy. Migrants and sex workers were reached trough specific communication channels including bars and pimps. HIV/AIDS information leaflets, including information about access to anonymous HIV counseling and testing and access to psychosocial support in several languages (German, Russian, Serbian, Croat and English) were distributed together with condoms.[10]

HIV prevention interventions in prisons were implemented by the Ministry of Justice in collaboration with the National Institute of Public Health. Information and education activities were provided for the personnel and prisoners. Safer sex was promoted and condoms were provided free off charge. Access to voluntary confidential HIV testing and counseling was ensured. In 2006, among 242 prisoners tested for HIV only two (< 1%) were diagnosed with HIV infection.

Prevention of transmission through blood was achieved through three interventions:
- ensuring safe blood, blood products, sperm, tissues and organ transplants,
- ensuring aseptic conditions for invasive procedures, and
- promoting safe behaviors among injecting users of illegal drugs.

The safety of blood and blood products, sperm, tissues and organs for transplantation was ensured. Blood donors were voluntary and non-remunerated. All donated blood units were tested for HIV (using the fourth-generation enzyme immunoassay (EIA) and nucleid acid testing method (NAT) for HIV-1 RNA) and so were the donors of sperm, tissues and organs. For all plasma products the solvent / detergent method that inactivates viruses with lipid envelope was applied in their preparation.

Prevention of HIV transmission in the health care setting was based on careful attention to infection control procedures, including the proper sterilization of equipment used for skin-piercing, surgical and other invasive procedures. All health care institutions had to provide training for and consistent use of "universal precautions" and to assure availability of the necessary supplies and equipment.

Illegal drug users had had access to different therapeutic and rehabilitation programs (e.g. detoxification program, substitution therapy, therapeutic communities). For example, a NGO Social Forum for Dependency had a therapeutic community Project Human, which was mostly funded by the Ministry of Labor, Family and Social Affairs, which also supported numerous other programs for prevention of addiction and Caritas runs a rehabilitation program (Comunita Incontro) in Nova Gorica. Substitution treatment was widely available to IDU in primary health care setting with currently 19 Centers for Prevention and Treatment of Drug Abuse operating all over the country. In addition, reducing the use of drugs by injection and reducing the use of shared or contaminated injection equipment was promoted. Clean needles and syringes were accessible for purchase in pharmacies. Needles and syringes exchange or distribution programs, including outreach, were implemented by several NGOs (e.g. AIDS Fondation Robert and STIGMA in Ljubljana, SVIT in Koper). In addition, safer sex was also promoted among IDU. All harm reduction activities and drug demand reduction activities were part of the Drug Use Prevention and Control National Program and were coordinated by the Governmental Drug Committee. Universal precautions to prevent HIV transmission in prisons were used and HIV infected individuals were not isolated. IDU on substitution treatment at incarceration were either detoxicated and enrolled into abstinence program or kept on substitution treatment.

Our HIV surveillance results indicate very low prevalence of HIV infection among pregnant women and HIV screening had not been introduced by the end of 2009. During 2000 to 2009, a cumulative total of three cases of HIV infections were diagnosed among children that resulted from mother-to-child transmission, the last one in 2004. In the case of known HIV infection in a pregnant woman appropriate treatment and prophylaxis was available to prevent mother-to-child transmission. Counseling, contraception, and other fertility regulation services were available to HIV infected women.

STI health care was provided by general practitioners and all gynecology outpatient services on the primary health care level and also within the dermatovenerology outpatient network (the Central Venerology Dispensary at the Dermatology Hospital of the Clinical Centre and regional venerology dispensaries); STI outpatient service at the Gynecology Hospital of the University Clinical Centre Ljubljana; urological outpatient service at the Urological Hospital of the Clinical Centre Ljubljana and the urological outpatient services network; and STI outpatient service at the Infectious Diseases Clinic, University Clinical Centre Ljubljana.

Everyone had access to client-initiated voluntary confidential counseling and testing through their general practitioners and, if requested, also to anonymous counseling and testing without referral at one national HIV counseling and testing site at the Infectious Diseases Clinic, University Clinical Centre Ljubljana. In addition, special HIV testing and counseling services existed in many regions within hospitals, regional Institutes of Public Health or blood transfusion centers or stations. The Ministry of Justice provided resources for voluntary testing of prisoners. Laboratories that conduct HIV testing were available in all regions of Slovenia either in regional hospitals, regional transfusion stations or regional institutes of public health. External laboratory testing quality control was ensured by the Reference Laboratory at the Institute of Microbiology at the Medical Faculty.

Universal access to high quality clinical care for HIV infection, including highly active anti-retroviral therapy was ensured at the Infectious Diseases Clinic, University Clinical Centre Ljubljana. Many asymptomatic HIV infected patients were followed-up on outpatient basis. Since Slovenia is rather small and there were less than 350 individuals with known HIV infection living in Slovenia by the end of 2009, treatment and care was available on this one location only. Psychosocial HIV counseling including safer sex promotion was available to all HIV infected followed-up. Numerous patients also received a self help manual for HIV infected that was published by AIDS Fondation Robert. Social outreach workers provided support as necessary.

New Strategy for preventing and controlling HIV infection for the period 2010-2015

In 2009, revised Strategy for preventing and controlling HIV infection for the period 2010-2015 has been adopted by the Slovenian Government.

The strategy was prepared by the Ministry of health and the National Institute of Public Health in close collaboration with all members of the National AIDS Committee at the Ministry of Health that represented many governmental sectors, Catholic church, civil society (NGOs), and people living with HIV/AIDS (PLWHA).

The Strategy is based on three PILLARS and follows eight AIMS within those pillars:

Preventing infections (pillar 1):
- Preventing transmission through sexual intercourse (aim 1),
- Preventing transmission through blood (aim 2),
- Preventing mother to child transmission (aim 3),

Provision of early detection of infections, preventing transmission and treatment (pillar 2):
- Decrease in the number of undetected infections (aim 4),
- Counselling for infected persons and informing their contacts (aim 5),
- Provision of quality treatment (aim 6),

Decreasing personal and social impact of HIV infection and AIDS (pillar 3):
- Integration of infected persons in society (aim 7),
- Limitation of discrimination and stigmatisation (aim 8).

Preventing HIV infections is the most important pillar of the Strategy.

The English translation of the document is published on the website of the Ministry of Health (http://www.mz.gov.si/en/splosno/cns/news/article/670/6002/c245f7a391/).[11]

The executive summary reads:

The pandemic of HIV infection is a human, social and economic catastrophe with severe consequences for individuals, families, communities and countries. HIV infection knows no national borders or geographical boundaries. According to the estimates of the UNAIDS and the World Health Organization, 33 million HIV-infected persons were identified at the end of 2007. In Europe, the number of detected infections is increasing and the HIV infection still remains one of the largest public health problems.

Less than one person per 1000 residents is infected with HIV in Slovenia, which is relatively low in comparison to the majority of the European Union countries; however, the number of infected persons is increasing. 48 HIV infections were detected in 2008, which is 270 percent more than ten years earlier and 30 percent more than in 2007.

When signing the Declaration of Commitment on HIV/AIDS, adopted during the United Nations General Assembly in June 2001, Slovenia has undertaken to prepare and implement a national strategy of prevention and control of HIV infection, and to collaborate in regional and worldwide efforts for more effective confrontation with this catastrophe.

The strategy is based on the prevention of HIV infections that is the most important pillar, provision of early detection of infections, prevention of transmission, provision of quick medical treatment and reduction of personal and social impact of HIV infection.

Persons who have unprotected sexual intercourse with infected persons, persons exposed to infected blood (mostly when sharing the same needle for injecting illegal drugs), or children born to infected mothers are at risk of an HIV infection. The most frequent method of HIV transmission is through unprotected sexual intercourse.

Promotion of responsible and safe sexual behaviour is the most important factor for the *prevention of sexually transmitted HIV infection*. The purpose of active promotion of safer sexuality, including the promotion of proper and regular use of condoms, is to limit as much as possible the risk behaviour among the entire population, including young people. The most efficient prevention is precaution taken before risk behaviour is formed; therefore, the inclusion of topics concerning healthy sexuality into the primary school curriculum is of fundamental importance. Prevention of sexually transmitted HIV infection is especially important among groups with higher risk behaviour. This is especially important for men who have sex with men; namely, in Slovenia this group has the highest number of HIV infections.

For the *prevention of transmission of HIV infection, when in contact with infected blood,* it is highly important to prevent the use of illegal drugs and their consequences and to incorporate drug users in treatments (including substitute treatment) and programmes for reducing damage among injecting drug users (by providing them with clean needles, injections and other tools for injecting). Availability of these programmes also needs to be provided in *prisons.*

For the *prevention of mother to child transmission of HIV,* it is highly significant to provide proper information for future parents about protection methods against HIV infection before pregnancy. In the case of eventual exposure to infection, accessibility to counselling and testing should be available. When a pregnant woman is infected, proper treatment and prophylaxis for protecting the child from vertical transmission of infection should be provided. In the future, we plan to introduce *the screening of pregnant women*.

For timely detection of HIV infections, testing is advisable to anyone with symptoms that indicate to HIV infection, patients with illnesses that indicate risk behaviour for HIV infection (for instance, patients with sexually transmitted infections), groups of people with higher risk behaviour and anyone who thinks they might have been exposed to the risk of HIV infection.

For the prevention of new infections, *early detection of infections* and *consulting for the prevention of additional transmission* are of fundamental importance.

Anyone infected with HIV must be provided with *quality treatment, care and counselling*.

HIV infection is not only a health problem, but also a social problem due to the most frequent methods of transmission (transmission through sexual intercourse, transmission during injection of illegal drugs) and the related stigmatisation. Therefore, an important objective is also the *reduction of personal and social influence of HIV infection for a better integration of infected persons in the society and limitation of discrimination and stigmatisation.*

Efficient adaptation of the Strategy to preferential needs is provided by the *system of national epidemiological monitoring of HIV infection* and *monitoring and evaluation of the Strategy.*

It shall be necessary that research in Slovenia contributes to the evidence-based prevention of HIV transmission in infection-exposed groups and to an understanding of education, standpoints and risk behaviour of HIV infection for the entire population.

The implementation of *the Strategy* is based on co-responsibility and proportional integration of sectoral politics, disciplines and civil society.

Financial resources for Strategy activities for the period 2010-2015 are provided within the health care system and other governmental sectors and institutions.

V. Best practices

Slovenia seems not to have missed the window of opportunity for the development of treatment and harm reduction program for IDU. Three examples are given. The first two examples refer to a governmental and a NGO approach in implementing harm reduction activities for IDU to reduce the negative health and social consequences of drug use. The third example refers to the "Spread the word, not the virus" campaign targeted to young people with the aim to encourage responsible sexual behaviour and use of condoms, which is an excellent example of cooperation among different institutions (governmental and NGOs) and individuals.

1. National network of Centers for the Prevention and Treatment of Drug Addiction

In January 1995, the Ministry of Health established the national Network of Centers for the Prevention and Treatment of Drug Addiction under the coordination of the Centre for the Treatment of Drug Addiction at the Mental Health Centre in Ljubljana to provide preventive programmes and free of charge treatment for drug users at the primary health care level. The financial resources were provided by the Institute of Health Insurance of Slovenia within the mandatory insurance scheme resources. Guidelines for treatment of drug addiction adopted by the Health Council at the Ministry of Health in 1994 and Guidelines on clinical management adopted at the Symposium on Methadone Maintenance in 1994. In addition, numerous technical guidelines for managing drug users within the health care system were prepared (for general practitioners, psychiatrists, physicians treating personnel in military service, physicians treating prisoners, for emergency in-hospital treatment of drug users, for treatment of diseases linked to drug use and for other situations in which medical personnel encounter drug users). The network that currently involves 19 centers located all over the country, provides preventive programmes; individual, group and family therapy; counseling services for drug users and their relatives; community health programmes; substitution treatment (mostly methadone maintenance); assistance in rehabilitation and social reintegration; and consultations concerning health, social and educational services. They work closely with other health care services, NGOs and self-help groups. Evaluation and research are important elements of their work. The establishment of the Network was a major step towards the universal access of drug-dependent individuals to treatment.[12]

2. STIGMA – Association For The reduction of Drug Related Harm - NGO providing harm reduction for injecting drug users, counseling related to drugs and STD, preventive interventions for prisoners and support for female drug users/ violence victims in the form of Safe House.

STIGMA (NGO) was established in 1992 to implement harm reduction activities for IDU to reduce the negative health and social consequences of drug use. Its main activities were: outreach program to contact IDU who were not in contact with treatment services and din't seek medical assistance and social support services; syringe and needle exchange at the premises and through outreach work; secondary syringe and needle exchange with the participation of IDU from other Slovenian cities; drop in center for IDU; mobile needle exchange in several Slovenian cities with adapted van; counseling for imprisoned drug users in Ljubljana prison, and practical support after their release from prison (employment and housing). Stigma also provided possibilities for voluntarily work for students and served as a training site for workers in harm reduction activities targeted to IDU.[13]

3. “SPREAD THE WORD, NOT THE VIRUS” campaign

In 2008, the Ministry of Health, the National Institute of Public Health, several MSM NGOs and the Faculty of Social Sciences formed a coalition to prepare a communication campaign primarily targeted to young people with the aim to encourage responsible sexual behaviour and use of condoms. In cooperation with all coalition members, the campaign was designed under the lead of 6 students of the Faculty of Social Sciences. The campaign implementation started at the end of 2009 and will be ongoing for a year. The slogan used was »Spread the word, not the virus!«. Further information about the campaign is available on the Ministry of Health web site (information about the campaign at www.stop-aids.si/en and communication matedials developed at http://www.stop-aids.si/en/who-we-are/the-campaign/graphical-material). In addition, other communication activities for different other target population groups are planned. The campaign has been an excellent example of cooperation among different institutions (governmental and NGOs) and individuals.

VI. Major challenges and remedial actions

Because of low level HIV epidemic in Slovenia and many other competing public health priorities, resources for HIV prevention activities are not sufficient.

The most important public health challenge for HIV prevention activities in Slovenia remains to ensure the national coverage of MSM with good quality interventions for prevention of sexual transmission of HIV among MSM and promotion of HIV testing for early HIV diagnosis. Thus, sustainable and sufficient governmental funding of MSM NGOs working in the field of HIV prevention among this most affected population should be ensured. Regretfully, governmental funding of MSM NGOs has not improved since the end of 2008.

Another urgent priority is to strengthen positive prevention among people living with HIV, especially among MSM, including the support for safer sex behavioral change.

Finally, since Slovenians have expressed demand for receiving information about sexual matters in school and since sex and HIV education programs have been shown not to increase sexual activity and some programs have been shown to decrease sexual activity and increase condom or contraceptive use, sexual and reproductive health promotion should be incorporated in the elementary school curriculum to cover all generations of young people before a substantial proportion becomes sexually active. Regretfully this has not happened yet. However, Strategy for preventing and controlling HIV infection for the period 2010-2015 that has been adopted by the Slovenian Government by the end of 2009, states that the promotion of responsible and safe sexual behaviour is the most important factor for the prevention of sexually transmitted HIV infection, that the purpose of active promotion of safer sexuality, including the promotion of proper and regular use of condoms, is to limit as much as possible the risk behaviour among the entire population, including young people and that the most efficient prevention is precaution taken before risk behaviour is formed; therefore, the inclusion of topics concerning healthy sexuality into the primary school curriculum is of fundamental importance.

VII. Support from the country's development partners

Not applicable for Slovenia.

VIII. Monitoring and evaluation environment

In view of our low level HIV epidemic and many other competing public health priorities, comprehensive monitoring and evaluation of HIV prevention, treatment, and care was not developed. Thus, existing data sources do not provide for reporting data for most UNGASS indicators to monitor the Declaration of Commitment to HIV/AIDS. Our HIV prevention, treatment, and care policies are informed from the results of the national HIV surveillance system coordinated by the National Institute of public Health and some research results.

Adequate resources should be allocated to most essential monitoring and evaluation of HIV prevention treatment and care. Priorities are: monitoring of a few key behavior indicators and HIV testing uptake among high-risk groups, at least MSM and IDU. Existing small scale behavioral surveillance among MSM and IDU should expand to larger scale cross-sectional repeated behavioral surveys with the inclusion of several biological markers, HIV, other STI and hepatitis B and C. Preventive interventions among MSM and IDU should be monitored for quality and coverage. Also, routine monitoring of access to treatment and care for people living with HIV should be established.

The major remaining challenge is also ensuring integration of data collection for some of the most relevant monitoring and evaluation indicators into other national surveys with ensured funding, for example into the European Health interview Survey (EHIS). Allocation of more resources into monitoring and evaluation of HIV strategy would result in more comprehensive and better information.

IX. Report writing process

This report was prepared according to guidance published by UNAIDS.[14]

Preparation of this report was coordinated by:

- Assist. Prof. Irena Klavs, AIDS, STI & HAI Unit, Communicable Diseases Centre, National Institute of Public Health.

All members of the National AIDS Committee at the Ministry of Health were forwarded the Guidelines on construction of core indicators, 2010 reporting and were asked to contribute any available information to the National Institute of Public Health.

The following members contributed:

- Miran Solinc, SKUC-MAGNUS (NGO);
- Evita Leskovsek, Unit of Mental Health, Security & Other Key Issues, Center for Health Promotion, National Institute of Public Health;
- Prof. Janez Tomazic, Infectious Diseases Clinic, University Clinical Centre Ljubljana;
- Prof. Mario Poljak, Institute of Microbiology and Immunology, Medical School, University of Ljubljana;

In addition, the following individuals contributed:

- Janja Krizman, Directorate for Public Health, Ministry of Health;
- Nejc Bergant, AIDS, STI & HAI Unit, Communicable Diseases Centre, Institute of Public Health of the Republic of Slovenia;
- Tanja Kustec, AIDS, STI & HAI Unit, Communicable Diseases Centre, Institute of Public Health of the Republic of Slovenia;
- Zdenka Kastelic, AIDS, STI & HAI Unit, Communicable Diseases Centre, Institute of Public Health of the Republic of Slovenia;
- Urska Rahne Potokar, Institute of the Republic of Slovenia for Transfusion Medicine;
- Dare Kocmur, društvo Stigma (NGO).

Part B for the National Composite Policy Index was completed by:
Miran Solinc, SKUC-MAGNUS (NGO).

Before submission of the report all members of the National AIDS Committee at the Ministry of Health and all other individuals who contributed information were asked to comment on the draft. The report was adopted by the National AIDS Committee at the Ministry of Health on 15th April 2010.

Most of the information presented in the report had been available at the National Institute of Public Health of the Republic of Slovenia. Most of the data presented in the chapter Overview of the AIDS epidemic have been already published in Slovene and are accessible at the web-site of the National Institute of Public Health (http://www.ivz.si).

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