I. Status at a glance

This report was prepared with the full collaboration and participation of relevant stakeholders including Government, MoH- Officer for HIV/AIDS, M&E Officer for HIV/AIDS, NIPH experts, Prison Health Department, UNKT, Focal point, the Responsible expert from the Infectious Disease Clinic, NGOs, etc.

Kosovo is situated in the western Balkans covering around 11 thousand square kilometers. The World Bank categorizes Kosovo as a lower-middle-income country with a solid economic growth since end of conflict, averaging at 4.5 per cent yearly. However, Kosovo continues to be the poorest area in Europe with a per-capita domestic product in 2013 of about $3,900 (11 per cent of European Union average) and with one-third of population living below poverty line and nearly one-eighth in extreme poverty with regional disparities. The poorest live in rural areas (65 per cent). Furthermore, Kosovo has the highest unemployment rate in Europe of around 30 per cent (39 per cent women, and 27 per cent men) with nearly 70 per cent long-term unemployed. The unemployment rate among young people aged 15-24 is about 56 per cent (68 per cent women and 51 per cent men).

According to the 2014 report from the Agency for Statistics (2), Kosovo has a population of approximately 1.8 million people, of whom the majority are Albanians (92%), followed by Serbs (4%), Bosniaks and Gorans (2%), Turks (1%), and Roma, Ashkali and Egyptians (1%). About 96% of the population are Muslim, while the Christian population is estimated at 3.69% (Catholic 2.2% and Orthodox 1.48%). The capital city is Pristina with population of 200,000 (3). Kosovo has a very young population - in 2013, 60% of citizens were below 25 years of age.

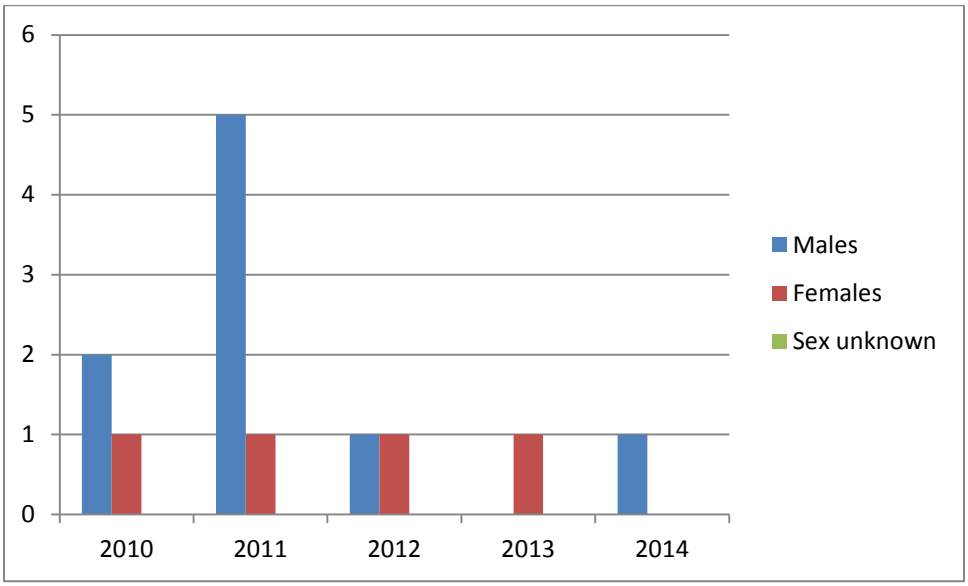
Around 50 per cent of population is under the age of 25 and only 6 per cent over 65 years. Women of fertile age (15-49 years) account for 26 per cent with the Total Fertility Rate of approximately two children per women and the annual rate of population growth is 0.9 per cent. Life expectancy at birth is 70.2 years, 10 years lower than the European Union average of 80.2 years.

II. Overview of the AIDS epidemic

Kosovo is grouped among low HIV/AIDS prevalence countries, with the prevalence of < 1% among general population, and < 5% in key population at risk. Total number of registered HIV infections in Kosovo from the first registered case in 1986 up to 2014 is 97, of whom 67 (69%) are male and 30 (31%) are female.

HIV incidence during the years 2010-2014 is as follows: 3 new infections discovered in 2010, in 2011 are discovered 7 cases, in 2012 are discovered 4 cases, in the year 2013 are discovered 3 cases and 7 cases so far in 2014. All donated blood units are screened for HIV, HBV and HCV. The HIV epidemic is the smallest, in terms of registered cases, in the EURO region, and one of the smallest in the world.

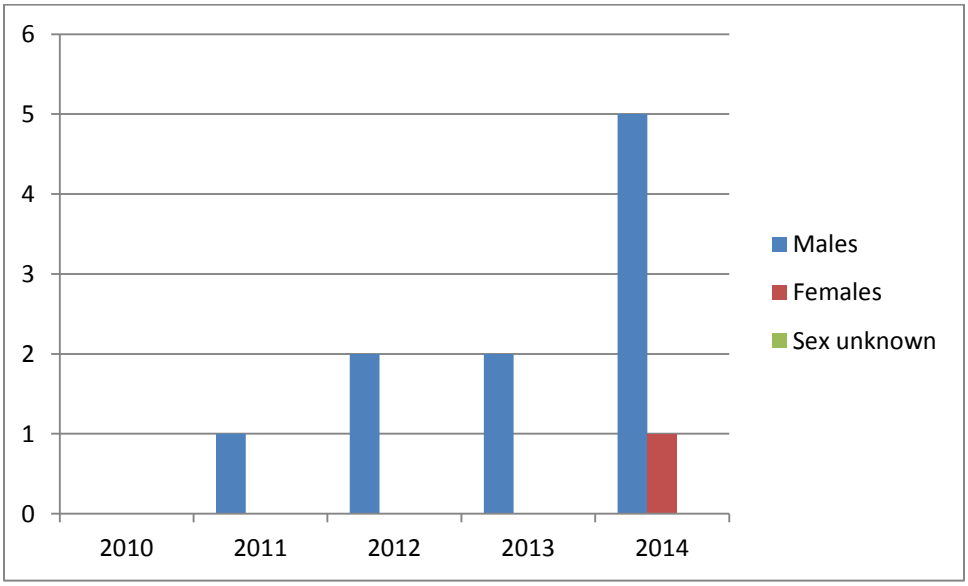
Number of AIDS cases diagnosed by sex from the year 2010 - 2014



Number of AIDS diagnosed cases by sex reported by the National Institute of Public Health (2010-2014)

Number of HIV cases diagnosed by sex from 2010 – 2014

The figure shows the trend in number officially reported HIV cases from 2010-2014

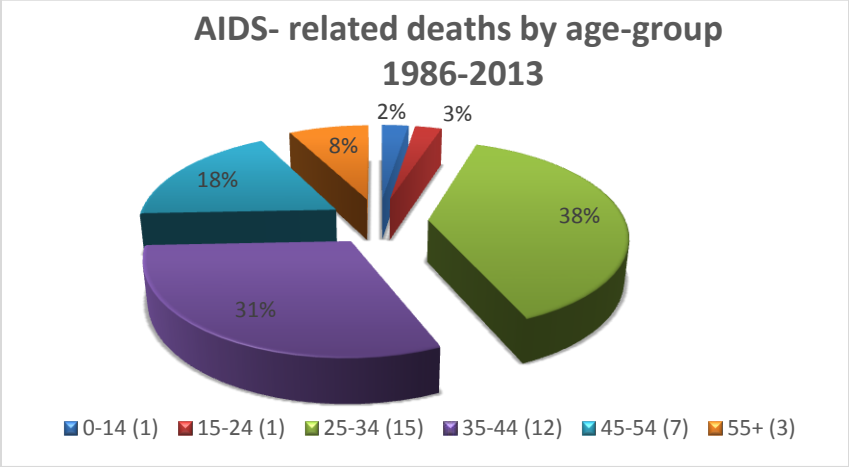


Number of HIV cases by sex reported by the National Institute of public Health (2010-2014)

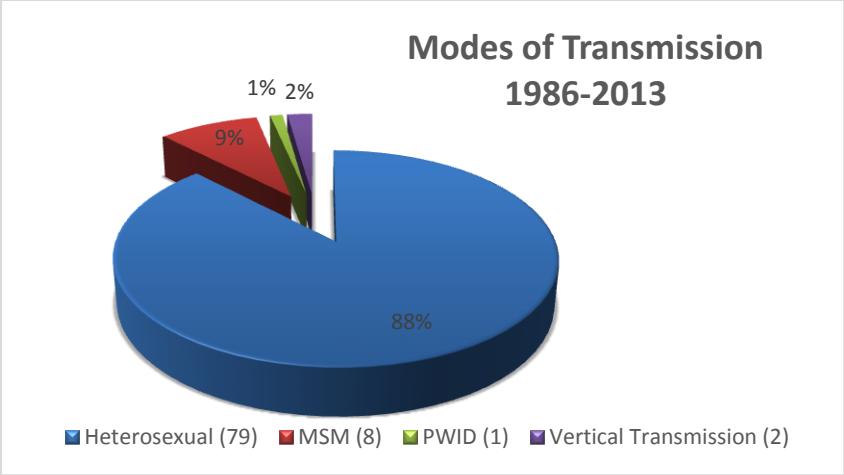
HIV cases disaggregated per age group, 1986-2013

00-14	*3 (3%)*
15-24	8 (9%)
25-34	32 (36%)
35-44	28 (31%)
45-54	15 (17%)
55+	4 (4%)

Of the registered HIV cases, 52 are registered AIDS cases. The number of AIDS related deaths is 40 to date. Of the 56 who are believed to be still alive, only 20 are followed up on treatment in Kosovo, of whom 6 are being monitored and 14 are enrolled in antiretroviral therapy (ART). PLHIV not accounted for in Kosovo surveillance system is relatively high, at around 60%. Various sources suggest that explanation for this rather large percentage may lie in the fact that Kosovar PLHIV may be receiving HIV services in some of the neighbouring countries. This seems plausible given the highly stigmatized society attitudes towards PLHIV and key affected populations (KAPs) and the ease of registering for provision of ART in neighbouring countries, such as Macedonia, Serbia and Albania (due to proximity and dual citizenship). AIDS related deaths disaggregated per age group are shown below.



Mode of transmission, cumulative (1986-2013), for registered cases is as follows: heterosexual – 79 (88%), MSM – 8 (9%), PWID – 1 (1%), and Vertical Transmission – 2 (2%). Given the much higher rates of transmission among MSM in particular in surrounding countries, it should be assumed that same people who have stated "heterosexual" transmission are actually MSM. Lately, more transmission has been reported among men who have sex with men.



General Population

HIV/AIDS knowledge and attitudes, HIV testing and Sexual behavior among general population and among minority population, Roma, Ashkali and Egyptian (RAE)

The age of sexual debut and initiation of drug use is declining rapidly. Nearly one-third of young men and two-third of young women used no condom during last sexual intercourse with non-marital, non-cohabiting partners in last 12 months. 13.3per cent of the students aged 11-15 had their first sexual intercourse and 26.5 per cent of them have not used protection. Only 17 per cent of young people correctly identified ways of preventing sexual transmission of HIV and rejected major misconceptions about HIV transmission.

The following are key findings according to Multiple Indicator Cluster Survey (MICS), Kosovo 2013-2014:

Percentage of people age 15-49 years who have heard of AIDS	General Population	RAE Population
Women	9.14	57.7
Men	93.4	78.4
Percentage of young people age 15-24 years who correctly identify ways of preventing the sexual transmission of HIV, and who reject major misconceptions about HIV transmission		
Women	16.8	11.9
Men	17.4	3.9
Percentage of people age 15-49 years who correctly identify all three means of mother-to-child transmission of HIV		
Women	44.7	28.5
Men	38.3	37.5
Percentage of people age 15-49 years expressing accepting attitudes on all four questions toward people living with HIV		
Women	6.2	4.2
Men	8.2	6.3
Percentage of people age 15-49 years who state knowledge of a place to be tested for HIV		
Women	15.5	6.8

Men	31.0	26.9
Percentage of people age 15-49 years who have been tested for HIV in the last 12 months and who know their results		
Women	0.7	0.1
Men	1.4	2.8
Percentage of young people age 15-24 years who have had sex in the last 12 months, who have been tested for HIV in the last 12 months and who know their results		
Women	1.3	0.0
Men	1.1	7.4
Percentage of women age 15-49 years who had a live birth in the last 2 years and received antenatal care during the pregnancy of their most recent birth, reporting that they received counselling on HIV during antenatal care	3.6	2.7
Percentage of women age 15-49 years who had a live birth in the last 2 years and received antenatal care during the pregnancy of their most recent birth, reporting that they were offered and accepted an HIV test during antenatal care and received their results	2.1	0.0
Percentage of people age 15-49 years who had sexual intercourse with more than one partner in the last 12 months		
Women	0.0	0.0
Men	7.1	7.0
Percentage of people age 15-49 years who report having had more than one sexual partner in the last 12 months who also reported that a condom was used the last time they had sex		
Women	*	-
Men	36.8	39.6
Percentage of sexually active young people age 15-24 years who had sex with a non-marital, non-cohabitating partner in the last 12 months		
Women	6.9	1.5
Men	37.1	27.0
Percentage of young people age 15-24 years reporting the use of a condom during the last sexual intercourse with a non-marital, non-cohabiting sex partner in the last 12 months		
Women	37.3	*
Men	67.6	66.9

The following risk factors are contributing to heightened HIV vulnerability of RAE communities:

- Exposure to discrimination;
- Economic marginalisation, greater unemployment and worse housing conditions in Kosovo;
- Limited access to healthcare and lower life expectancy;
- Low education levels due to greater difficulty staying in school.

The percentage of men aged 15 to 49 who report having been circumcised is 91.5%. This rate is even higher (96.1%) among Roma, Ashkali and Egyptian communities. Apart from this there are no other significant factors identified so far that could explain lower HIV prevalence than in neighbouring countries.

TB incidence in Kosovo (47/100,000) is considerably higher compared to its four neighbouring countries: Albania (16/100,000), Macedonia, Montenegro (18/100,000) and Serbia (23/100,000).

Key Affected Population

To date three Bio BSS studies have been conducted in Kosovo, in 2006, 2011, and 2014.The various years are not directly comparable as different populations were surveyed for each IBSS (for example, in 2014, only MSM in Pristina were surveyed; PWID only in Pristina and Prizren; FSW only in Ferizaj) (5, 6, 7). The hepatitis C rate among PWID, while lower than in 2011, remains a cause for concern both because it reveals a need for hepatitis C treatment, and as a predictor of how widespread HIV infection could become among PWID once it takes hold in this community.

	2006	2011	2014
HIV			
PWID	0	0	0
MSM	0	0	2.3%
FSW	0	0	0
Syphilis			
PWID	0	2%	1.6%
MSM	0	2.4%	4.2%
FSW	n.a.	3.5%	1.7%
Hepatitis B			
PWID	20.1%	6%	4.1%
MSM	14.9%	2.2%	5.6%
FSW	n.a.	2.5%	0
Hepatitis C			
PWID	12.5%	37.4%	26.7%
MSM	0	0.1	n.a.
FSW	n.a.	n.a.	n.a.

The third round of the Kosovo HIV/ Integrated Behavioural Surveillance Surveys were founded by GFATM through the Community Development Fund (CDF) , Prishtina , Kosovo and implemented by the National Institute of Public Health (NIPH) Prishtina, Kosovo.

IBBS studies in 2014 confirmed low prevalence of HIV in all the key populations. HIV prevalence among MSM in Pristina was 2.3%, and HBV prevalence - 4.6%.No PWID were infected with HIV in Pristina and Prizren. Prevalence of HBV for Pristina was 5% and for Prizren was 2.5%, and HCV prevalence - 31% (Pristina) and 20% (Prizren). No FSW tested positive for HIV, infectious HBV or secondary Syphilis in Ferizaj.

However, 2014 IBBS studies reveals relatively high prevalence of risk behaviour in key populations, which presents a risk of swift deterioration of the epidemic situation in case HIV is introduced in KP communities. Thus according to 2014 IBBSstudy in Ferizaj only 23% of FSW always carries a condom. 33% agreed to sex without condom last time more money was offered. 38% of FSW did not use condom during the last vaginal sex with a client, and only 33% reported always using condom with clients in the past month. Only 25% of FSW used condom during the last sex with non-paying sexual partner. 67% reported their regular sexual partners also having sex with other women. There is an overlap between SW and drug use, and 22.4% of FSW in Ferizaj reported using drugs prior to sexual intercourse with clients.

Only 3.5% reported never using alcohol. Only 52% of surveyed FSW in Ferizaj had ever tested for HIV infection. Only 28% of those who ever tested for HIV did that in the last 12 months (only 14% of all respondents).

MSM are a highly mobile population with 55% reporting travelling outside of Kosovo and 90% travelling outside of Pristina in the past 12 months. 27% of those who travelled abroad reported having anal sex without a condom during their travel. Anal sex without a condom is even more common during in-country travel - 38% of those who travelled outside of Pristina reported unprotected anal intercourse during their travel. Only half of MSM who had sex with women in the past 12 months used condom. 69% of MSM reported always using condoms during anal sexual intercourse in the past 12 months.

TB incidence in Kosovo is 47/100,000 but HIV prevalence is very low among TB patients (1 HIV positive case was registered in testing services provided 300 TB patients under the current GFATM TB grant).

In conclusion, the HIV epidemic in Kosovo remains, most likely, a small epidemic with the potential for growth, particularly among men who have sex with men and people who inject drugs. Further work is required to strengthen national surveillance and to map and estimate the sizes of key populations.

III. National Response

National response is based on the National HIV Strategic Plan 2015-2019 with the following 6 objectives:

Objective 1: Reducing the risk of HIV infection among KAP:

- 1.1. HIV prevention programmes for PWID;
- 1.2. HIV prevention programmes for FSW;
- 1.3. HIV prevention programmes for MSM.

Objective 2: Reducing the risk of HIV infection among other vulnerable groups and the general population:

- 2.1. Integration of HIV and STI prevention programmes in the framework of formal education core curriculum;
- 2.2. Development of programmes to prevent HIV/STI among vulnerable groups through education and informal education activities;
- 2.3. Development of programmes for prevention of HIV/STI through education and informal education activities specific to each vulnerable group;
- 2.4. Promotion and distribution of condoms to vulnerable groups;
- 2.5. Developing programmes that promote and encourage HTC.

Objective 3: Strengthening the capacity for quality HIV/AIDS prevention, diagnosis, treatment and care:

- 3.1. Development of programmes to expand the use and improve the quality of HTC services;
- 3.2. Strengthening prevention of mother to child transmission of HIV infection (PMTCT);
- 3.3. Blood safety programme: systematic testing of blood (and blood products) for HIV and other infections (blood-born-diseases);
- 3.4. Ensure safe working environment for the prevention of HIV infection in health care facilities and other working environments;
- 3.5. Diagnostic and laboratory support;
- 3.6. Regular supply of ARV medicines;

3.7. Strengthening the surveillance system, and STI treatment and control;
3.8. Care and support for chronically ill.

Objective 4: Improving the quality of life for PLHIV:

4.1.Continuing the work of the care and support centre for PLHIV, their relatives and partners;
4.2. Development and distribution of IEC materials targeting specific information needs of PLHIV; including web portal and telephone line for PLHIV;
4.3. Advocacy, lobbying and mass media campaigning to reduce stigma and discrimination against PLHIV;
4.4.On-going ART.

Objective 5: Strengthening the Monitoring and Evaluation system of HIV/AIDS:

5.1. Establishment of an efficient system for Monitoring and Evaluation.

Objective 6: Strengthening the legal and institutional framework in the field of HIV/AIDS:

6.1. Develop policies on HIV and AIDS that are in full compliance with international standards and recommendations;
6.2. Providing sufficient funds by the MOH and other relevant partners to ensure the sustainability of all services for HIV and AIDS;
6.3. Providing an efficient system for regular supply of ARV medicines, test kits and other laboratory supplies;
6.4. Providing an effective coordination system between institutions/organisations working on HIV/AIDS.

V. Best practices

Ministry of Health has managed to develop a strong network of international support in different levels of the Health Sector

Very good cooperation and coordination of the Ministry of Health / Office for HIV/AIDS with other relevant governmental and non-governmental organizations, including UN Agencies and Global Funds, through Kosovo AIDS Committee and other coordination mechanisms, such CCM, and working group for development of the new Strategic Plan for HIV/AIDS.

IV. Major challenges and remedial actions

Due to the budgetary limitations and insufficient technical expertise, the major challenge remains ensuring sustainability of the actions which are supported by external donations such as GFATM and UN Agencies.

HIV testing is carried out at a low level in Kosovo. While much of the HIV testing is directed towards key populations, there are insufficient numbers of key populations being tested to understand the extent of the epidemic and to ensure that people with HIV are offered treatment.

The main challenges in working with PWID and MSM will be scaling up activities to reach and test 80-90% of clients regularly as stipulated by international standards, including HIV tests for up to 90% of clients (twice a year). The number of PWID on MMT (98, less than 0.3% of the estimated number of PWID) is extremely low - the usual target is 40% - and the figures provided above highlight a serious issue with retention. A dropout rate of 56% (160 of 258 ever enrolled) is far higher than in most countries (where the average is around 20-30% due to travel, death, attempts/ success at stopping drug use). Additional activities have to be developed in order to reach the population of young female PWID, as well as Serbian-speaking PWID in Mitrovica who were hardest to reach in the past years. While scaling up reach, special attention has to be paid to retaining quality of services for PWID.

The main challenges in working with FSW in Kosovo is the decrease in the number of persons reached and services not being aligned with Comprehensive Packages of Service for this specific population. Services for FSW need to be reconceptualised and developed based on research. Based on the potential for spread among FSW and their clients, these populations should remain a priority for prevention and research activities in the future.

Non-government Organisations working with PLHIV should be adequately strengthened and provided with a clear role in the national HIV response (e.g. as “expert patients”), to reduce currently observed loss to follow-up, to provide community-based services, as well as testing services ensuring linkages to HIV treatment and care.

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VI. Support from the country’s development partners (if applicable)

Global Fund and UN Agencies and Local NGOs represent crucial partners for implementation of the National Strategy on HIV/AIDS.

VII. Monitoring and evaluation environment

Monitoring and Evaluation capacities for HIV and AIDS in Kosovo are not sufficiently developed. However, thanks to the support and cooperation with the external donors, it is to be expected that M&E unit will grow gradually and become reliable unit in the near future. In this context, with the funds from the Global Fund, MoH was able to employ an M&E officer that will support MoH to develop a comprehensive M&E framework.