COUNTRY PROGRESS REPORT

MONTENEGRO

Reporting period: January - December 2014.

Table of contents:

I. Status at a glance

a) The inclusiveness of stakeholders in the report writing process

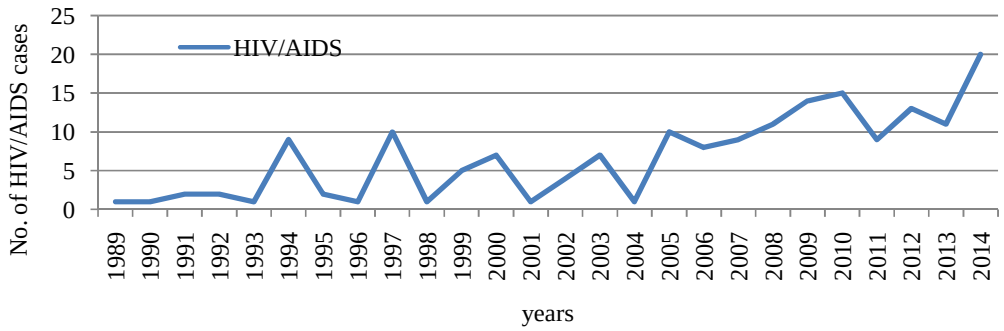
This report was prepared by the Institute of Public Health/Secretariat for HIV/AIDS in close collaboration with all members of National HIV/AIDS Commission/ especially with the members of NAC from NGO.

b) The status of epidemic

Montenegro is a low prevalence country with HIV prevalence of 0.02% in the end of 2014. 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 2014 was 175, of whom 41 persons diagnosed with AIDS have died. However, the Institute of Public Health estimated that there were 463 (range 300 to 500) people living with HIV at the end of 2014 using the World Health Organisation (WHO) methodology for HIV estimations and regional trends suggest the potential for an increase in HIV transmission. According to this estimate, 20,4% of all infected are women.

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

Graph 1. Distribution of HIV/AIDS cases registered in Montenegro, from 1989 to the end of 2014



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 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.

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.

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

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 was 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.

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 20 new cases of HIV/AIDS registered from January 2014 until December 2014. Incidence of the newly discovered infections during this period was 3.2/100.000 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, 90% of the newly registered cases of HIV/AIDS are between 20 and 44 years of age. Out of 20 newly registered with HIV during this period, 7 of them had already developed AIDS and 2 of them died.

During 2014, according to the data that health institutions submitted to the Institute, the total number of people tested for HIV is 22141 (without testing for research purposes in which it was tested 470 IDUs and 120 MSM). Out of this number, 18623 people were tested within transfusiological units. There were 15120 voluntary blood donors tested out of them 5482 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 6571.

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. 1.321 persons in risk of being infected with HIV were tested within these counselling centres during 2014, which is a 29% increase compared to the previous year. Out of the total number, 18% were MSM, IDUs and SWs. During 2014, HIV tests were reactive for 10 persons tested in the counselling centres.

The total number of registered HIV infections cases, in the period from 1989 to the end of 2014, is 175. At the end of 2014, there were 134 people living with HIV, making the prevalence of this infection in Montenegro 0.02%, one of the lowest in the region and Europe.

From the total number of 134 persons still living at the end of 2014, there are officially registered 95 persons diagnosed with AIDS and 39 persons with HIV.

The largest number of infections was detected within the working and reproductive age group, 15-49 years of age (91%), graph 2. The largest number of HIV infections diagnosed at age 20-39 years (77%). Younger than 20 years in detecting HIV infection was 3%, and over the age of 39 years 20%.

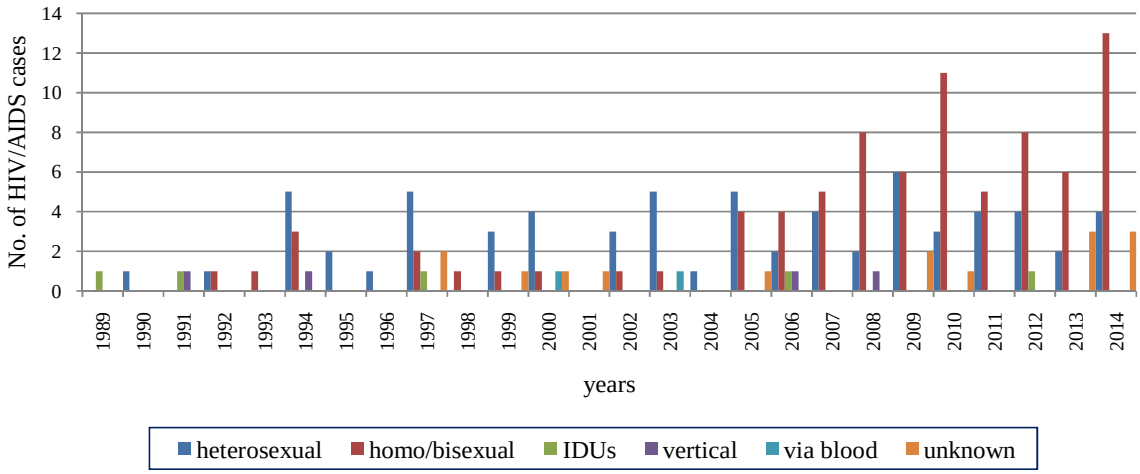
Graph 2. Age disaggregation of HIV infected persons at the moment of detection, for the period 1989-2014

The male to female ratio of HIV infection is almost 5,3:1 (84% 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 (40%) and Podgorica (41%).

The leading form of HIV transmission in Montenegro is through sexual intercourse (85%). Without taking into account the kind of sexual intercourse, epidemiological surveys of the people infected through sexual intercourse demonstrate their habit of practicing sexual intercourse without protection (heterosexuals 38% and bi and homosexuals 47%). 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 1989-2014



Since the start of epidemic until the end of 2014, there were registered 41 people that from AIDS (32 men and 9 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 2013, 9 persons started with ARV and all of them 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. There were no HIV positive pregnant women in 2014.

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

Despite some encouraging trends in behaviour detected in recent surveys implemented from 2006 to 2014 among MSM, IDU, and SW, poor RE 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 RE 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.

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

In 2014, 157 sex workers, 297 men who have sex with men and 1549 injecting drug users have been covered by preventive services (outreach, drop-in centres, VCT).

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 RE 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.

In 2014, two bio-behavioural surveys were conducted (among IDUs and MSM).

Second bio-behavioural survey among **MSM** (snowball sampling survey) was conducted in 2014 (first was conducted in 2011). Survey included 120 participants who met criteria to be classified as MSM (out of total number of respondents, 16.7% participated in the previous study). This BBS among MSM, regardless of using the non-representative sample (which does not allow the generalisation of the result to entire MSM population), has provided certain information related to this population as well as very precious data related to many important aspects of the problems this population is being faced with in Montenegro. According to the data obtained in this study (not representative), HIV epidemic in MSM population has entered in the phase of concentrated epidemic - HIV prevalence of 12.5%. The study confirmed that knowledge about modes of transmission and prevention of HIV infection is not sufficient and the prevalence of risky sexual behaviors is significant (46.6% of the respondents gave correct answer to all questions, which is significantly better than in the previous survey (31.5%); 62.1% of the respondents used condom at last anal sexual intercourse which is better than in the previous survey (49.5%); 14.7% of the respondents were selling sexual services; 46.7% of respondents had sexual intercourse with a woman, and only 23.6% regularly used condoms). Also, there is a need for wider use of anonymous testing and counseling on HIV and other STIs (during last 12 months 35% respondents tested for HIV).

Third bio-behavioural survey among **IDUs** (RDS survey) was conducted in 2014. This survey provided a possibility for determining behaviour of adult IDUs in Montenegro and to make a comparison with the results obtained during the same surveys from 2008 and 2011. Persons older than 18, who have been injecting drugs during the last month and have been living in Montenegro for more than 3 months during the last 12 months, have been included in the RDS bio-behavioral survey. Survey covered 402 respondents (90% males and 10% females). Currently, sterile drug injecting equipment (new sterile needles and syringes) is available to 99.9% of IDUs. Majority of respondents buy sterile needles and syringes in public pharmacies (61.1%), 53.5% IDUs get them, free of charge, in Drop-in center for IDUs while 17.9% get them through needle exchange programs within Primary Health Care Centre and 8.0% through

outreach needle exchange program. During the last month, 14.1% of the surveyed IDUs shared the injecting equipment (13.3% respondents shared the injecting equipment in survey conducted in 2011 and 24.2% in 2008). If the entire "injecting drug use" experience was taken into consideration, percentage of those who had ever shared injecting equipment increased to 60.4% (almost the same as in previous surveys - 63.4% in 2011 and 61.5% in 2008). Laboratory testing revealed that the actual HIV prevalence among IDUs is very low (1.1%), as well as the prevalence of HbsAg (1.4%), as opposed to very high HCV prevalence (53%). Results of the survey suggests that preventive programmes among IDUs had a certain prevention impact on further increase of HCV prevalence and on keeping the HIV infection prevalence among IDUs in Montenegro at a low level.

III. National Response to the AIDS epidemic

The national AIDS strategy for 2010 to 2014 was developed in a participatory manner with key players from government and NGOs and the UN Theme Group on AIDS contributing to strategic planning meetings in early 2009. It combines the efforts of many stakeholders active within the National AIDS Commission/CCM with representatives from government ministries, institutions, NGOs and UN agencies.

The **aim** of the *National AIDS Strategy for the Republic of Montenegro (2010 to 2014)* is to maintain Montenegro as a low HIV prevalence country, ensure universal access to HIV prevention and treatment interventions, and to improve the quality of life of people living with HIV through a coordinated multi-sectoral response. In order to achieve this aim, significant measures will need to be taken to reduce stigma and discrimination and to strengthen the health system to provide a sustainable health sector response. In 2010 Parlament of Montenegro adopted antidiscrimination Law 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.

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.

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). Activities in the existing eight HIV counselling centres are implemented in accordance with the Institute for Public Health (IPH) protocols for HIV testing and counselling. A network of VCT Centres has been established and undertakes regular monitoring of the services provided. It is envisaged that voluntary HIV testing and counselling and prevention services for STIs will be integrated into their work in accordance with World Health Organisation recommendations[2].

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. The introduction of rapid HIV tests is proposed to facilitate access to HIV testing services.

In 2014, 1321 people received VCT services and out of this number 9.4% were MSM, 8.7% were IDUs and 0.3% were SWs. During these period 3626 condoms, 1300 lubricants, 800

[2] 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.

IE printed material were provided by PU UNDP (who is main Principle Recipients from the GF project) and delivered by VCTs.

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 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 whole Montenegro (3 Drop-in centres and outreach programme) and 92683 syringes and 91954 needles were distributed during 2014. Condoms have been distributed to IDUs, sex workers and MSM as well as amongst sailors, workers in the tourism industry, Roma and Egyptian youth and youth in schools. A methadone maintenance therapy programme is operational in the Health Centres in Podgorica, Berane, Bar and Kotor. A methadone maintenance therapy programme will be operational in more three Health Centre in Niksic and Pljevlja.

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.

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.

Although 85% of people registered with HIV acquired the infection sexually, the prompt diagnosis and treatment of STIs for men 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.

Methadone centres are operational in Podgorica, Kotor, Bar (southern region of Montenegro) and Berane (northern region of Montenegro). It is planned to open two OST in the Health centre in Niksic and Pljevlja in 2015. There was 333 PLWID in all three OST Centre in total during 2014. Methadone supply is provided by NIF (National health insurance fund).

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 2014, 83 people living with HIV or AIDS were receiving HAART. During 2013, 9 persons started with ARV and all of them 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/Abakavir 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. All blood samples taken for treatment are mandatory to be tested for Hepatitis B, Hepatitis C and syphilis. Testing of clinical and ward patients is performed at doctor's request, and for testing of interested citizens without the doctor's refferal there is the possibility to pay for the test.

EQAS are set up and SOP standard operating procedures are currently ongoing. There was no new cases of HIV infection among blood donors during 2014.

Tab 1. Prevalence of HIV among voluntary blood donors in Montenegrofrom 2004-2014.

Year	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
2013.	15869	0	0,0
2014.	15120	0	0,0

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, healthcare workers, 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.