

NATIONAL STRATEGY FOR THE
PREVENTION AND CONTROL OF
HIV/AIDS IN ALBANIA

2015-2019

NATIONAL STRATEGY FOR THE PREVENTION AND CONTROL OF HIV/AIDS IN ALBANIA,
2015-2019

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
NMCA	National Medicines Control Agency
ARV	Antiretroviral Medications
BSS	Behavioral Surveillance Survey
PHD	Public Health Department
HIF	Healthcare Insurance Fund
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HAART	highly active antiretroviral therapy
HCV	hepatitis C virus
Hep B	hepatitis B virus
HIV	human immunodeficiency virus
IEC	Information Education Communication
OI	Opportunistic infections
STIs	sexually transmitted infections
IPH	Institute of Public Health
HII	Healthcare Insurance Institute
BCC	behavior change communication
VCT	Voluntary Counseling and Testing
CCM	Country Coordinating Mechanism
MMT	methadone maintenance treatment
MoH	Ministry of Health
MSM	Men who have sex with men
NGO	Nongovernmental organization
OST	Opioid Substitution Treatment
IDU	Injection drug user
Ped/inf	Pediatric infections
PEP	Post Exposure Prophylaxy
PLWHA	People Living With HIV/AIDS
NSP	National Strategic Plan
SWs	Sex workers
UNDP	United Nations Development Programme

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PMTCT	Prevention of mother-to-child transmission
TUHC	Tirana University Hospital Center
NSPCHA	National Strategy for the Prevention and Control of HIV/AIDS in Albania
STDs	sexually transmitted disease
ART	Antiretroviral therapy
PITC	Provider-initiated testing and counseling
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization
IDS	Infectious Disease Service

Vision

Albania will move toward total prevention of new infections of HIV, to offer support, quality care and medical treatment to all infected and affected, in a society against stigma and discrimination.

EXECUTIVE SUMMARY

This strategic document represents an important framework for coordination of interventions on prevention and control of HIV 2015 -2019 at national and local level. Based on the recent epidemiologic situation and the vision , the strategy aims to maintain Albania a low prevalence country, with less number of new infections; a health system able to adequately address the increasing trends of risky behaviors, able to provide a quality health services for all PLWH; the enable a supportive environment, free from stigma and discrimination.

The strategy is organized in three main pillars: 1. Prevention; 2. Treatment and medical care; 3.Care and social support.

- Prevention

Based on the IPH there are 699 cases of HIV infections reported in Albania by the end of 2013. Albania is a low prevalence country, but the number of diagnosed cases per year is not decreasing. During 2014 there is an increase on the number on new cases from men having sex with men and also new number of PMTCT reported. Also it is important to mention that 60% of cases are reported at a late stage of the infection. This shows that most of new infections may come from uninformed people regarding their HIV positive status or other sexually transmitted infections i.e syphilis which is showing increasing rates in Albania.

The strategic document focus especially on prevention of all new infections of HIV using combined interventions including awareness and information programmes, improvement of volunteer counselling and testing, introduction of testing through primary health services, behavior change and promotion of safer sexual behaviors, prevention of transmission within health settings, treatment as prevention, improvement of legal framework etc.

A special focus is given to: i) prevention among at risk groups in Albania especially injecting drug users (IDU), men having sex with men (MSM), sex workers (SW) and detained persons within correction institutions; ii) prevention of vertical transmission

from parents to child and iii) prevention of new cases among general population especially youth, migrants, Roma & Egyptian populations and women.

- Treatment and medical care

The worldwide progress on treatment of HIV has had a great impact on the quality of life of people living with HIV who are living longer now in Albania. As such HIV is addressed as a chronic disease within this strategic document, which addresses the health and social support needed to be available for people living with HIV.

The second pillar of the strategy acquires full medical care and treatment for all HIV positive persons, close and continuing monitoring of treatment and co-infections and improvement of quality of health care. The strategy aims to support the improvement of procurement and chain management of ARV, involvement of HIF on ARV procurement as registered drugs, capacity building of human resources, establishment of home care, improvement of reference systems for PLWH and fulfilment of human rights and antidiscrimination environment.

- Care and social support

People living with HIV in Albania have faced cases of neglect, isolation, stigma and discrimination. Cause of their HIV positive status they face unemployment and lack professional integration which impact their economic life. Stigma and discrimination toward children living with HIV is high and their integration in social and education life as kindergarten and schools, remains a challenge Multidisciplinary services for PLWH is still lacking in Albania.

During 2015 – 2019, the interventions of the strategic document focus on information and education programmes for PLHW and their family members, establishment of peer groups for physical and mental health, establishment of social and legal support services and special support to the national organization of PLHW.

During the implementation of the strategy it is foreseen the improvement of legal framework against stigma and discrimination, improvement of legal mechanism to increase access to services, and capacity building of media on reporting on HIV related cases.

Monitoring and evaluation of the strategic interventions will be based on the epidemiologic data, behavioral indicators and the strategy focus on building of monitoring capacities of responsible public entities. This is reflected at pillar 4 of the strategy. It is important to foresee a midterm revision of the strategy.

The implementation of the national strategy and successful fight against HIV infections in Albania is based on the close collaboration of national and local public institutions, involvement of civil organizations, private sector, PLWH and their family members and international organizations.

1. STRATEGY BASIC PRINCIPLES

The National Strategy for the Prevention and Control of HIV/AIDS in Albania (NSPCHA) has been designed based on the following principles:

- NSPCHA is the basic document stating the vision for the approach to HIV/AIDS, the management of strategic components, the coordination of all available players and resources, and the orientation of efforts made by government, non-government and international organizations operating in the area of the prevention and control of the spread of HIV/AIDS in Albania.
- NSPCHA considers HIV/AIDS prevention and control, treatment and care to be a multidimensional problem involving health, social, cultural, and economic issues. HIV/AIDS prevention and control will take a crosscutting approach which will involve the cooperation of partners at all levels of public, private and non-government sectors. This approach should be taken in line with existing national and international strategies and will take individual, community and society needs into account.
- NSPCHA is based on Law No. 9952 of 14 July 2008 “On Prevention and Control of HIV/AIDS” and the relevant Council of Ministers’ Decrees.
- NSPCHA considers early and appropriate treatment of HIV/AIDS as important elements of preventing and controlling HIV/AIDS.
- NSPCHA reflects recommendations from international organizations (particularly those from UNAIDS and WHO) and recommendations from previous national HIV/AIDS conferences. NSPCHA ensures the continuity of all work in the area of prevention, treatment, care and control of HIV/AIDS in Albania.
- NSPCHA enables the establishment of a favorable climate for assuring respect for human rights pursuant to the Albanian legislation and international conventions, making it the focus of all prevention, treatment and care activities.

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- NSPCHA recognizes the significance of risk behavior and the inhibiting effect of stigma and discrimination in the provision of meaningful prevention, care and treatment programs. NSPCHA also gives priority to strengthening the response to specific needs of vulnerable groups, groups at risk, and marginalized groups, addressing issues related to stigma and discrimination.
- NSPCHA will aim at building integrated prevention actions, including a number of existing methods (such as the use of condoms, reduction of the number of partners, use of circumcision, treatment as prevention, prevention prior to exposure, etc.).
- NSPCHA recognizes the importance of addressing HIV/AIDS/STI issues at a country level but it requires a response at every level of administration organization, thus enabling the building of local capacity, raising local awareness, and strengthening the coordination, monitoring and evaluation role of central institutions.
- NSPCHA treats HIV/AIDS as a chronic condition which requires not only all the health services but also the suitable social services.
- NSPCHA recognizes the significance of fair gender policies in HIV prevention and control programs, paying attention to gender equality and empowerment of women.
- The strategy will be reviewed and modified every three or four years, based on data monitoring and evaluation, changes in the epidemiological situation, findings of research, available capacities, and organizational possibilities. An action plan, incorporating the National Strategy priorities, will be prepared every two years.

2. SITUATION ANALYSIS

2.1 Population Issues

2.1.1 Location and Geography

The Republic of Albania is located in Southeast Europe to the west of the Balkan Peninsula. It has a surface area of 28,748 square kilometers. Albania shares a border with Montenegro in the north (172 km), Kosovo in the northeast (115 km), with Macedonia in the east (151 km) and Greece in the south and southeast (282 km). Albania has a coastline of 487 km, along the Adriatic and Ionian Seas. The country is mainly mountainous except along the central coast.

Albania is divided into 12 prefectures, which include 36 districts. Albania has embarked upon an administrative reform which should be completed in 2015. However, the reform does not affect such basic services as education, health and social services. These three services will continue to be provided to citizens at the closest point possible (where they are currently) in the same form.

The capital of Albania is Tirana, which is also the largest municipality in the country.

2.1.2 Demographic Issues

According to the data from the Population and Dwelling Census, in October 2011 Albania had a resident population of 2,821,977. Compared with 2001 Census data the number of resident population fell by 8%. (2001 Census: population of 3,069,275.) The number of births fell from 54,000 to 34,000 in the period 2001-2011. This is thought to be one of the reasons for the fall in the number of population in Albania. Another important factor for the population reduction is the emigration of 481,601 people in 2001-2011. About 139,827 people, mainly male, returned to Albania in the same period. The number of returnees increased every year, especially after 2008 (INSTAT, 2011). Registered returnees have mainly been male (about 2/3 of them). Most of returnees are 30-34 years of age.

The average age of the population increased from 30.6 in 2001 to 35.3 in 2011. The index of the population aged 65 years and older increased from 0.8% in 2001 to 11%

in 2011. The share of the population aged 15 years and under fell from 29% in 2001 to 21% in 2011.

For the first time in Albania the share of the urban population (53.5%) is higher than the rural one (46.5%). This shows a high movement of the population within the country from rural areas to urban ones in 2001-2011. 2011 Census data confirm that 10.6% of the population moved from rural to urban areas, while 4.0% of the respondents confirmed that they had lived abroad in 2001.

2.1.3 Ethnic, Cultural and Religious Composition

Albania's population is made up of about 83 percent ethnic Albanians. The main minority groups are Greeks, Vlachs, Romany, Serbians and Bulgarians (2011 Census).

In November 1990, religious practice was permitted after prohibition by the communist government in 1967. According to 2011 Census data, about 57 percent of Albanians are Muslims, 7 percent Albanian Orthodox and 10 percent Roman Catholic. A significant percentage of the people did not respond to the question about their religious denomination.

2.2 Health System and HIV/AIDS

2.2.1. General Issues

The Albanian health system is mainly public, but the private system of service provision is increasingly being involved. Public structures continue to be the largest provider of health services, promotion, prevention, diagnosis and treatment. The private sector, which was previously focused on pharmaceuticals and stomatology, is increasingly involved in the sector of providing diagnosis services, including laboratory and treatment. In the past two years there has been a trend of provision of some public services in the private sector, too.

The Ministry of Health (MoH) leads the development of health policies and monitors the implementation of health strategies. It performs this function through a number of institutions at central and local levels.

Diagnosis and treatment in the public health system in Albania is organized at three levels: primary care (healthcare centers), secondary hospital service and tertiary hospital service. Public health services are provided within the primary healthcare package and are coordinated and monitored by the Institute of Public Health.

Effectiveness is low for both primary and hospital care and it also varies considerably across regions and facilities. Due to low perceived quality, bypassing of primary care in favor seeking care at polyclinics or hospital outpatient facilities is widespread even for simple conditions. This results in low utilization of primary care facilities and extremely low productivity of primary care staff.

The law provides that the entire population should be covered by health insurance but only about 40 percent of the population appear to be covered by insurance. Survey data shows considerable variations in coverage between regions; more than 60 percent of the population in Tirana have cover while less than 20 percent is covered in the mountainous regions. Low coverage is due to two factors: (i) a large share of the active labor force works in the informal sector and thus avoids contribution payments; and (ii) knowledge of benefits is limited.

Outpatient care in polyclinics and hospitals, and inpatient care, are, in principle free of charge if a patient has been referred by the primary care physician but surveys show that the vast majority seeking care at these levels incur significant out-of-pocket payments. Survey data suggests that being insured does not significantly lower the amount of out-of-pocket expenses for outpatient care nor does it affect the likelihood of having to pay for care, particularly outside Tirana.

Social health services are almost non-existent.

The Institute of Public Health is the main institution in Albania operating under the Public Health Law and coordinating all actions in the area of health protection and prevention. It includes the structures that coordinate the fight against infectious disease and the actions in the area of HIV/AIDS and the national HIV/AIDS program.

Other institutions reporting to the Ministry of Health include: National Blood Transfusion Centre; National Center for Development and Rehabilitation of Children; National Center for Health Facility Quality, Safety and Accreditation; National Center for the Control of Drugs; Continuous Education Center, and National Biomedical Engineering Center.

2.2.1.1 Diagnostic capacities

The first HIV/AIDS diagnostic center was established at IPH, followed by another one at the Tirana University Hospital Centre (TUHC). Diagnostic capacities of IPH have increased and viral load measurement techniques were introduced. TUHC often suffers from lack of kits and reagents. Outside Tirana, HIV testing is done in voluntary testing centers at PHD laboratories. The staff at those centers have been trained in both the quality of health service provision and in relation to stigma and discrimination. It should be noted that, under the 2008 Law, the private sector, too, provides HIV testing. HIV testing at public institutions is carried out on a voluntary basis, anonymously and free of charge.

The TUHC Laboratory has been strengthened in the area of CD4, and the IPH Laboratory has been strengthened in measuring the viral load. There are, however, problems regarding the supply with kits and reagents. TUHC Laboratory needs to be strengthened further for measuring the viral load and resistance so it can provide better support to the Infectious Disease Clinic.

2.2.1.2 HIV/AIDS Surveillance

The general methods used for HIV/AIDS surveillance are, in general, no different from those used for other diseases and infections. However, they should be adapted to

the unique epidemiology, wide variation in prevalence levels, and the very long incubation period of HIV infection prior to the development of AIDS. In addition, the severity of AIDS and the extreme social and personal implications of identifying HIV-infected people make surveillance of HIV/AIDS much more difficult and make issues such as anonymity and confidentiality of paramount importance.

Confidentiality of personal data is a universally accepted right, but anonymity in the public health management of any infectious or communicable disease is a new and difficult concept to accept in Albania.

Surveillance has monitored major biological, behavioral and social and demographical indicators for newly-reported cases. *Sentinel surveillance* has focused on IDUs and serums have been tested for HIV and hepatitis. Almost all drug users who have benefited from provided services have been tested.

Data from other sources such as HIV and AIDS case reporting have been collected by direct contact with practitioners at the Infectious Disease Department. The reporting improves with the establishment of the outpatient clinic at TUHC, which enables the information to be centralized at the clinic. The HIV and AIDS template records have been developed containing clinical information about AIDS cases.

Despite the good work of the reporting systems among public institutions, there is a lack of involvement of private sector.

2.2.1.3 Blood safety and blood donors

Blood screening for HIV and other infectious agents is now regulated by law whereby all donated blood units are screened for infectious agents that can be transmitted through blood such as HIV, Hepatitis B and C, CMV and syphilis. The first case with HIV among blood donors was detected in May 1993 and in October 1993 HIV screening was introduced to the country's 26 blood banks. The number of paid blood donors fell from 18,000 in 1991 to 4,000 in 2004. While there is a policy for reducing the number of blood transfusions, the need for blood is clearly still present and a significant number of paid blood donors are from vulnerable groups who have low awareness of self-exclusion.

Voluntary blood donation became established in mid-1990s, but only 5% of blood donation is voluntary in Albania. Thanks to campaigns carried out by various organizations and especially by the Red Cross, there has been an increase in the number of blood donors, but it still remains low. Donation among family members has increased steadily. It reached the amount of 24,469 in 2013.

From 1993 till 2005, 26 HIV-infection cases were found during blood donation routine screening and epidemiological investigations have shown that HIV infection occurred due to infected blood in only three cases. Further investigation confirmed that the transmission had occurred during seroconversion. The findings underlined the need for improving testing techniques. In 2000 a blood safety manual was adopted.

Promotion of voluntary blood donation is the best way to ensuring the needed amount of blood, and only after this is achieved a legislative reform can be put in place to ban paid blood donations.

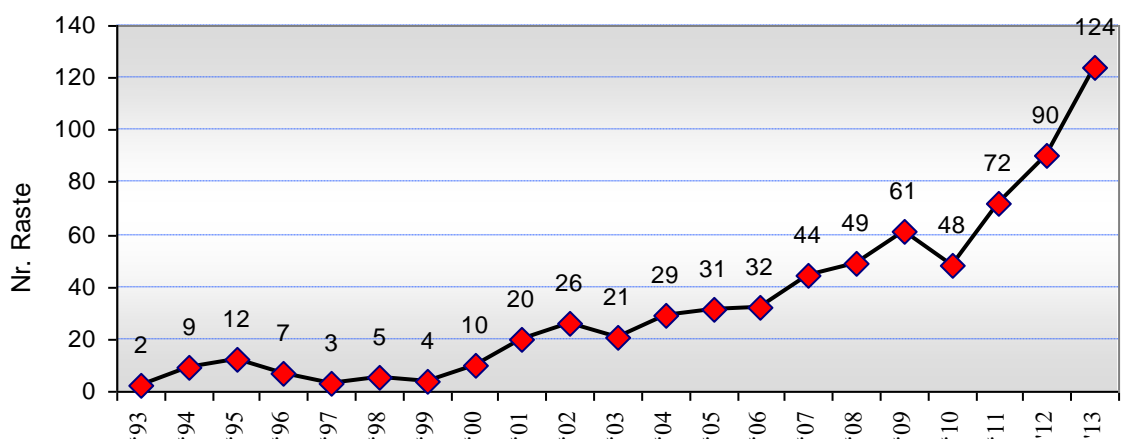
2.2.2 Epidemiological situation

Twenty years have passed since the diagnosis of the first HIV case in Albania (1993). The total number of HIV positive cases at the end of 2013 was 699¹. 124 new cases of HIV infections were reported in 2013. The last year of 2013 marks the highest figure ever reported since the appearance of HIV/AIDS in Albania. While the HIV infection prevalence is low, there are indications of an increasing trend in the number of new cases over the last years, as clearly shown in the following graphs. Calculations show the HIV prevalence in the general population in Albania is 0.02% and the incidence is 0.004% (based on the number of population according to 2011 Census).

Distribution of cases with HIV/AIDS over the years, 1993-2013

1

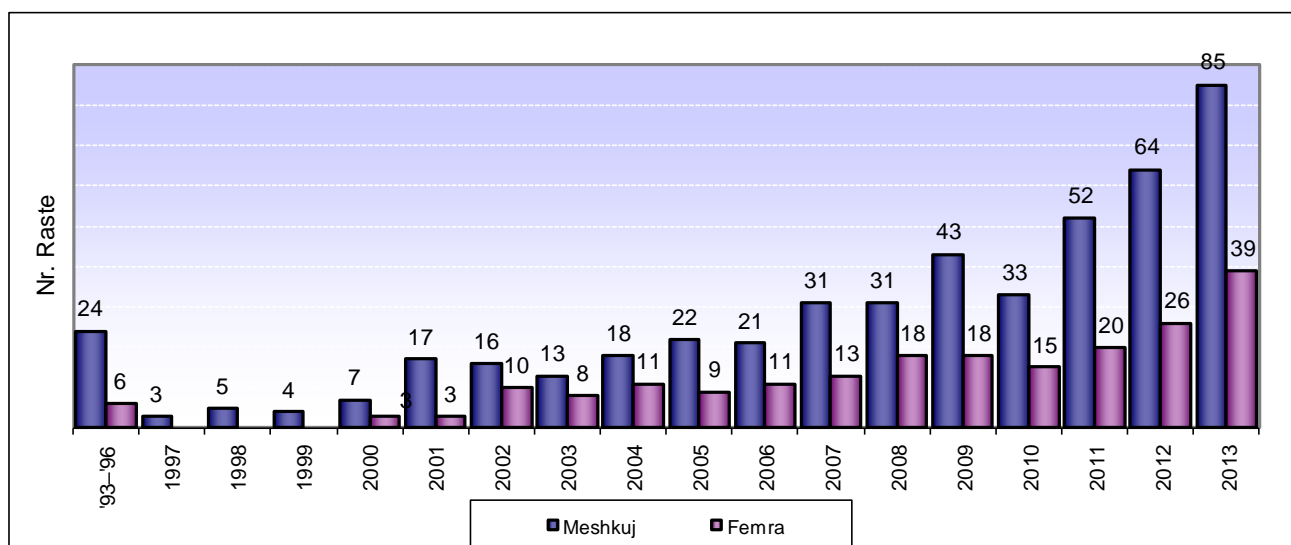
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Source:

Distribution by sex shows that males predominate, with a share of 70% of the cases. This ratio is maintained in the past few years, in terms of new annual cases. In 2013, 85 males and 39 females were diagnosed.

Distribution of cases with HIV/AIDS, by sex, 1993-2013



Source:

Regarding the method of HIV transmission, the sexual method of HIV transmission predominates with 93% of the cases (83% through heterosexual relations and 10% through homo-bisexual).²

²

Distribution by age-group shows that the age-group 35-44 years old predominates (31%), followed by the age-group 25-34 years old (29%) which is a sexually active age-group. The age-group 45-54 years old accounts for 16.6%, young adults 16-24 years old account for 9 %, 55-64 years old account for 7.3% of the total number of HIV-infected persons, while children (0-15 years old) account for 4.9 %. A smaller share is taken by the age-group over 65 years old, with 2.1%.³

Despite the importance given to HIV/AIDS in the past two decades, it can be said that the stigma still prevents young people from testing for HIV.

Late diagnosis remains a problem that is also demonstrated by the high number of cases reported at the AIDS stage. This phenomenon was also identified in 2013, with 80 persons (65% of the cases) being identified at a late stage of HIV.

Antiretroviral treatment has been provided since 2004. Currently 316 adults and 19 children receive antiretroviral therapy. The total number of deaths of AIDS is 122, with seven deaths of AIDS in 2013. Late reporting of deaths is the problem here. Hospital deaths are reported to IPH (which are reported to the National Program), while the data on deaths at home are collected informally (often from family members of the deceased) because AIDS is not identified as the cause of death.

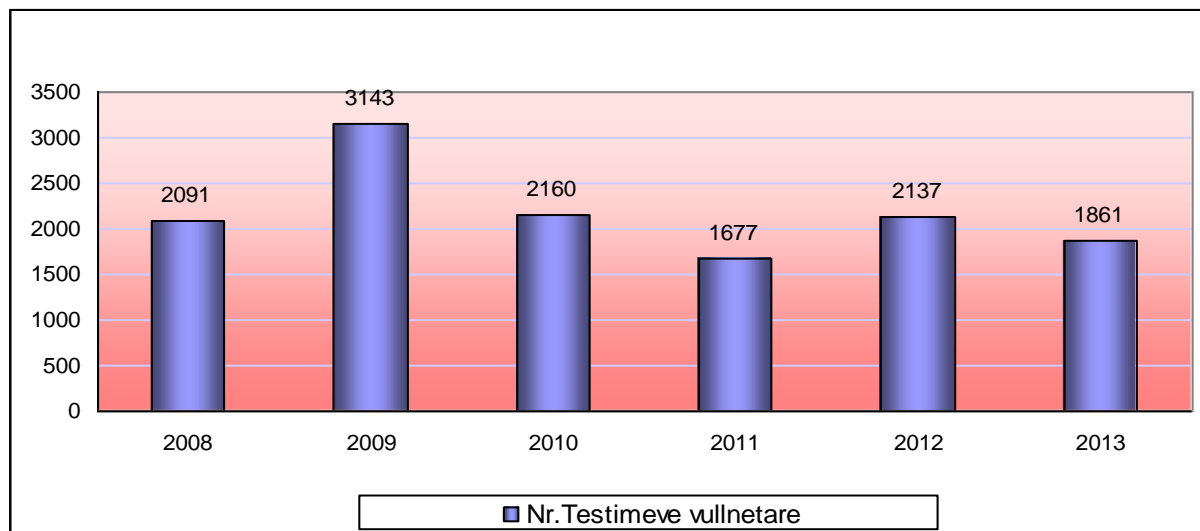
Opportunist co-infections that accompany HIV show various levels: so, HBV was diagnosed in 18% of the cases, HCV in 4%, TB 12%, syphilis 22%. Another important co-infection in Albania is visceral leishmaniasis. Of course these levels are underreported due to weaknesses in the reporting system among the institutions providing health services.

Voluntary HIV testing remains a very important indicator used in the assessment of the HIV/AIDS epidemiological situation. Albania still has a small number of tests. While the establishment of voluntary counseling and testing centers has been considered as a success, their functioning did not result in the expected increase in the

3

number of testing cases. The level of voluntary testing remains low, and there are no indications of an increase in that number of in the past few years.

Voluntary tests, 2008-2013



Source:

It should be noted that most of the HIV testing cases pertain to blood donors, which include the HIV test in the list of mandatory tests. In 2013, family donors account for the largest number of tests at the National Blood Center, with a total of 24,469 family donors. The percentage of samples suspected to be HIV positive in the group of family donors is 0.1%, with the percentage of confirmed cases being 0.05%. The percentage of samples suspected to be syphilis positive in the group of family donors is 0.4%, with the percentage of confirmed cases being 0.2%.

Six children were diagnosed to be HIV positive through the vertical transmission path in 2013. The total number of children infected vertically is 26 cases. The increase in the number of children diagnosed with HIV/AIDS, combined with the increase in the number of infected women (30% of the total) suggests that the HIV testing of pregnant women is a must in terms of preventing the mother-to-child transmission by ensuring treatment and specified protocols. Albania has seen well managed cases of preventing the birth of healthy children by HIV-positive mothers where they have been diagnosed. Their number, however, is very small. It should be noted, however, that there is a high level of stigma and discrimination against women living with HIV,

and mother-to-child HIV transmission prevention services remain concentrated exclusively in Tirana.

HIV/AIDS remains an urban phenomenon in Albania, with 73.5% of the cases coming from urban areas and 26.7% from rural areas. Regarding the geographical distribution, the highest number of cases (48.9%) have been reported in Tirana, followed at a large difference by such other districts as Durrës (6.1%), Elbasan (5.7%), Vlora (5.1%), Shkodra (4.2%), Lushnja (4 %). Cases diagnosed with HIV are, however, dispersed across the territory.

2.2.3 Prevention Activities

2.2.3.1 Information Education Communication (IEC) and Training

Awareness raising activities in the area of HIV/AIDS issues began in the early 1990s. With the establishment of the National Program these efforts became more organized and included awareness-raising media campaigns, development and distribution of information and education materials, and active participation in global campaigns.

The Department of Health Education and Promotion at the IPH serves as a reference center on IEC problems related to the prevention of HIV/AIDS under the National Program technical and scientific leadership. School HIV and sex education programs have been assisted with the preparation of literature and manuals and while teachers have been trained, there are considerable gaps in the implementation of the curricula. In 2008, the National HIV/AIDS/STI Program established the “Let Us Talk about HIV/AIDS” program, which aims at establishing a broader HIV/AIDS communication program focusing on the youth.

In addition, in 2009-2010 IPH took the initiative “Let Us Know HIV/AIDS”. Under that initiative, local government structures, people living with HIV/AIDS or their relatives discussed HIV/AIDS openly for the first time in Albania.

Training programs for nurses, physicians, and social workers, and in the areas of behavioral surveillance and sex education have been organized in cooperation with

IPH, University Medical School, University Social Sciences School and UN agencies; however, sexual health, HIV/AIDS and STIs have not been clearly stated in their curricula.

It should be noted that due to the lack of relevant budgets, but also due to the low level of perception of HIV as an issue and the lack of attention towards it as a public health issue among MoH structures, no constant information campaigns have been in place and the printed and televised media and the social media have not been used constantly.

2.2.3.2. Condom use and promotion

Contraceptive use, including condoms, was first introduced in Albania in 1992, when the Government of Albania approved family planning activities. No political or legal barriers to selling or promoting condom use exist in the country. Since 1993, with UNFPA support, contraceptives have been distributed free of charge in all family planning services, and they are currently covered by an IPH national program.

All healthcare centers provide contraceptives under the national family planning program. Condom use is impeded by the embarrassment or timidity to obtain condoms from public sources that require person-to-person contact. For this reason, their provision at healthcare centers, especially in family planning ones, cannot solve this problem. Training programs with health service providers have been organized in the area of changing attitudes to condom use.

However, condom use remains low, and this is related to the low level of sex education and other factors affecting behavior.

2.2.3.3 Confidential Voluntary Counselling and Testing (VCT)

HIV transmission can be reduced by promoting behavior change and providing psychosocial support to people with HIV/AIDS. Research has shown that VCT programs are effective in promoting behavior change, and they are cost-effective and practical as one of the most effective strategies for HIV infection prevention in

countries with limited resources. HIV/AIDS counselling and testing plays two major roles in preventing and controlling HIV/AIDS: first, prevention through behavior change, using risk assessments and reduction planning; and second, care through psychosocial support to help PLWHA plan their future. People who receive negative test results have a chance to change their behavior in order to keep their HIV test results negative and those who are HIV-positive can protect themselves against reinfection and opportunistic infections, can seek medical care for early symptoms and, perhaps most importantly protect other people who they could infect.

VCT centers adjacent to public health departments have been established in the 12 prefectures with GFTAM funds. These centers have already been integrated organically into the PHD services, and provide counselling and voluntary testing for HIV/AIDS and other STIs in order to serve the entire population in the districts they are located in or at prefecture level. The National Program has developed protocols and guidelines for those services, as well as the training curricula for center staff. Three further VCT units are operated by NGOs in Tirana and two others are operated by the Ministry of Health also in Tirana. They have not been found to be effective, however, towards the expected increase in voluntary testing, since the mandatory counseling prior to the testing results in decreased testing. These centers have operated in an isolated way, disconnected from healthcare service providers. They have failed to be friendly to the Roma and Egyptian and LGBT communities and injecting drug users.

2.2.4 Care and treatment for PLWHA

Treatment and care for persons with HIV/AIDS is provided at Tirana University Hospital Center “Mother Theresa”, mainly by its Infectious Disease Service and Pediatrics Service, which are two services where direct care is provided, and also in other auxiliary services, such as imagery, Clinical Laboratory Service and Microbiology Service, Immunology Service, and pharmacy service. The service is centralized due to many reasons: The yet not so large number of cases, similar models of care in other countries in the region with the same epidemiological situation as in Albania, human and logistical capacities (both diagnostic and therapeutic) which can

be provided only at Tirana University Hospital Center, and issues related to stigma and discrimination especially in primary and secondary healthcare facilities. It should also be noted that services for teenagers and persons growing with HIV/AIDS are not in place.

Under the current laws and regulations of MoH and HIF, people living with HIV/AIDS (PLWHA) may receive healthcare services in the same way as the rest of the population. However, those people do not receive those services (at family practitioners or specialist physicians in the areas where they live) due to their fear of any potential discriminating and stigmatizing attitudes or behavior among the medical staff in those facilities. Such information comes from both patients and various studies in this area, which shows the urgent need for training the medical staff in HIV/AIDS.

In addition there are shortcomings in terms of providing the specific healthcare services for the people living with HIV/AIDS, in relation to the PHC and hospital service package, which makes for impediments to the access to some of the treatment options for those people.

At the Infectious Service in Tirana University Hospital Center, people living with HIV/AIDS are followed both in the inpatient and outpatient context. TUHC Outpatient Clinic for adults living with HIV/AIDS was opened at the end of 2007. The main function of this clinic is the provision of outpatient medical care in line with the clinical protocols adopted for PLWHA, with the main activities being the provision and monitoring of combined therapy with ART, diagnosis, management of opportunist infections and co-infections, and psychosocial support.

Despite the constant efforts made by the Albanian Government or the foreign funding, problems continue to arise with this service. The physical infrastructure of the clinic premises and of the services (where inpatient care is provided to such persons) needs improving and maintaining because no investment has been made since GFATM investment. Due to the concentration of this service and the increasing number of patients, it is necessary to increase the number of medical and service staff.

The medical, infirmary and sanitary staff currently working for this Service have been trained in HIV infection prevention and in the prevention of other infections that spread through blood in the premises where medical care services are provided. The guidebook and standard working procedures for the prevention of HIV in hospital premises have also been prepared, despite any shortcomings in terms of implementing them.

Antiretroviral therapy has been provided to persons living with HIV/AIDS in Albania since mid-2004. This therapy is carried out in inpatient and outpatient settings at Tirana University Hospital Center “Mother Theresa” Pediatrics Service and Infectious Disease Service. The drugs are procured through UNICEF with Albanian Government funds, under a Memorandum of Understanding between MoH and UNICEF. UNICEF is responsible for the procurement of the entire quantity of antiretroviral drugs at competitive prices, based on the request-lists prepared by TUHC every year. In 2008-2012, the project of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) ensured the procurement of second-line antiretroviral drugs.

As of February 2014, there were 316 adults and 20 children receiving therapy combined with antiretroviral (ART) treatment. Only in 2013, ART was started for over 80 cases of HIV/AIDS (the total number of adult cases with ART in the past was 208 cases in 2008, 135 cases in 2009, 166 cases in 2010, 208 cases in 2011, 226 cases in 2012 and 346 cases in 2013)

The requirements for beginning, applying and monitoring the antiretroviral treatment are laid down in a guideline adopted by the Infectious Disease Service and the Albanian Infectious Disease Association. The guideline is based on the World Health Organization’s 2007 Guidelines, as revised in 2011. The major criteria applicable to ART initiation include all PLHIV showing clinical symptoms compatible with HIV/AIDS and PLHIV with a CD4 count of ≤ 350 cells/mm³ (WHO 2010 criterion). A revision of the ART initiation criteria based on WHO last recommendations would result in an increased number of patients with indications requiring initiation of this therapy.

The therapy and its side effects are monitored through routine check-ups and various laboratory tests. But it should be noted that there are shortcomings in terms of monitoring and measuring the HIV viral load, a test that both WHO and EC protocols require to be done at least once a year.

Their clinical problems what with the serious opportunistic infections and pathologies is in contrast with the limited diagnostic and therapeutic capacities and services available at TUHC. Primary and secondary treatment and prophylaxis for opportunistic infections is an issue due to the occasional shortage of specific antibacterial, antiparasitic and antiviral drugs and preparations for hospital use (such as shortages of fluconazole, valganciclovir, peginterferon, benzathine penicillin, etc.). Given that family practitioners avoid providing clinical services, the application of such long-term medical and prophylactic treatments of opportunistic infections for these people in outpatient conditions is insufficient.

In addition, monitoring protocols should also include control and management of chronic, metabolic and neurocognitive pathologies, HPV test or PAP test, the application of special immunization schemes, etc. Interspecialist referral schemes should be improved by underlining the importance of training and fighting the phenomenon of stigma and discrimination by non-infectious disease specialists towards these people.

The improvement of diagnostic capacities of the microbiological and virological laboratory at the TUHC Microbiology Service is a necessity in order for those diagnostic services to be more accessible for patients. Based on WHO recommendations that laboratory should provide diagnostic capacities for all important infections and co-pathologies accompanying the HIV/AIDS infection: HIV serological diagnosis (ELISA and Western Blot), HIV viral load, serological diagnosis of B, C, and D viral hepatitis, toxoplasmosis, syphilis and other STIs, CMV, pneumocystis jiroveci, TBC (PPD), tuberculosis interferon-gamma, TBC culture, TBC culture, candidosis, cryptosporidiosis, isosporidiosis.

Infectious Service physicians have been trained in various issues related to the management HIV/AIDS through the implementation of various continuous medical education activities in Albania and abroad. In addition, training events have been organized with secondary school medical staff and auxiliary staff on ART application and general medical care for patients with HIV/AIDS.

In the past few years there has been an increase in the number of within-family and mother-to-child transmissions. Late diagnosis in children and identification of the status the parents after such diagnosis is a significant fact and problem, raising the urgent need to intervene in our health system and develop and implement a mother-to-child transmission prevention program. Medical care and treatment for children with HIV/AIDS is provided only at the TUHC Pediatric Service, while children aged 14 years and older are referred to the Infectious Disease Service at TUHC Infectious Disease Clinic and its Outpatient Clinic. Remaining problems include the absence of an outpatient service center for HIV-positive children; carrying out of periodic medical consultations and being in constant touch with the doctor; round the year coverage with diagnostic services; supply with ARV drugs in pediatric formulations and round the year coverage; standard protocols for the treatment of children; supply with drugs for the treatment of opportunistic infections (IO); provision of financial support for HIV-positive children and their families; increasing medical staff awareness of the need to respect the rights of the child; increasing medical staff awareness of the need to observe the requirements of professional ethics and internal rules of the clinics, etc.

There is no model at hospital level or any experience on providing advice to parents or how to talk to HIV-positive children in relation to their status, nor there is professional staff of psychologists and social workers to support the parents and other family members in this difficult process. In order to ensure a safe environment for all HIV-positive children in their transition from childhood to adolescence, there is a need to develop a guidance that would help be basic material for the psychological staff of the Pediatric Clinic during the conversations with HIV-positive teenagers in relation to their status, which would also help their parents.

The application of ART in the Infectious Disease Service and the increased number of patients has resulted in increased probability of professional exposure to HIV infection. For this reason, a number of measures have been taken which have improved the work towards professional prevention of HIV infection; however, they remain at very low level, especially in terms of injection safety, non-use of vacutainers or lack of management of hospital waste. TUHC Infectious Disease Service provides post-exposure prophylaxis (PEP) anti-retroviral (ARV) treatment. The PEP protocol was published by the Albanian Infectious Disease Association. Training in universal prevention measures has been organized with all the IDS and Pediatrics and Infectious Disease staff. IEC materials on this issue have been produced (booklets, brochures, posters). PEP has been used applied in some cases of professional exposure among Health Care Workers (HCW).

HIV care and prevention services are separate from reproductive health services, and the integration of care or prevention services does not exist.

2.3. Social Issues

2.2.3. Social Aspects and Stigma and Discrimination against PLWHA

HIV/AIDS issues and its multidimensional treatment aspects are still new in Albania. Crosscutting services for PLWHA and their family members, including standardized healthcare, psychosocial, support, educational, legal and referral services, information on the disease, facilitation of financial problems for the families of the children, treatment of abandonment cases and palliative care are almost non-existent. Stigma and discrimination against PLWHA are a major challenge resulting in late testing for HIV, late diagnosis and access to care. This set of issues, which needs addressing, remains a responsibility, burden and commitment of health institutions, welfare institutions and local government bodies.

In Albania there are cases of abandonment, social isolation, having to face stigma and discrimination at all social levels. PLWHA face unemployment or professional

reintegration and financial problems as a result of HIV/AIDS infection. These issues are exacerbated where the more than one family members are infected.

One social integration challenge is related to the stigma and discrimination in relation to the status of HIV-positive children and AIDS-related orphans. The fear of living with them denies them their civil rights to attending education facilities, such as crèches, kindergartens and nine-year elementary schools, where their identity and health condition is not kept confidential.

No studies have been carried out, yet, in order to measure and assess the level of stigma and discrimination through a monitoring and evaluation system in such priority areas as healthcare, education, social and psychological support, employment, legal aspects, and the social and economic conditions of HIV-positive people.

Nonetheless, thanks to awareness and advocacy campaigns, many issues requiring long-term solutions and institutional stability have been raised, which should focus on the general wellbeing and ensuring PLWHA's human rights in relation to their rights to health, education, employment, support and inclusion. Lack of information, fear and stigma against this virus as well as the absence of adjustment models and support and care systems have been the key factors affecting the fulfillment of the fundamental needs of PLWHA, who are often subjected to discrimination, prejudice and lack of equal access to the required services.

2.3.2 Behavior patterns – most at risk population

2.3.2.1 General population

The Albanian Demographic and Health Survey (2008-2009) showed that the population had adequate information about HIV/AIDS. 93% of women and 94% of men reported to have heard of AIDS. The level of knowledge does not vary depending on the age or civil status, but it should be noted that such knowledge is higher among the unmarried group of the population who have carried out sexual intercourse.

Knowledge of AIDS is higher in urban areas than in rural ones, with the population in Tirana having the highest level of knowledge, and the level of awareness of AIDS is in positive correlation with the educational level of women and men.

The knowledge and practices for HIV voluntary testing remain limited and do not respond to the need for early diagnosis and infection prevention in the population. Only 26% of women 15-49 years old know where to do an HIV test. Inequality in terms of knowledge is even more important if we relate it to education. 66% of women with university education can identify the location of a testing center, compared with 12% of women with eight-year elementary education. Regardless the level of knowledge and its variation, it should be noted that the number of women who tested and received the test results in 2008 was too low, at less than 1%.

The survey showed that men had somewhat more knowledge than women. About 40% of men 15-49 years old had knowledge of HIV testing centers. Both men and women in rural areas have a lower level of knowledge, in the groups with lower economic level and lower educational level. In the male population in Albania, too, the level of testing and getting the test results is still too low, at less than 3%.

2.3.2.2. Injecting drug users

In 2005, 2008 and 2011 behavior and biological surveillance studies on the groups at risk, which aimed at assessing the trend of risky behaviors among those groups and to identify the HIV prevalence of other communicable diseases.

Groups at risk are quite important to determine the future HIV prevalence in the general population especially in Albania where the prevalence is low.

Syringe sharing and injection with used needles are risky behaviors which increase the likelihood of HIV spreading, and for this reason many countries face an immediate increase of HIV prevalence among intravenous drug users (IDUs).

In 2007-2012, in the framework of GFATM grant, it was possible to support a series of activities with the goal to prevent HIV in this population. Strong support was provided to damage reduction, syringe exchange and methadone maintenance

treatment programs. After the end of the grant and in the absence of support from national or international institutions, the syringe exchange programs have limited activity only in Tirana. Currently support is given to methadone maintenance treatment (MMT), which is provided in six centers, and 505 IDUs use this service. Such a limited service might have serious consequences, given the risky behaviors of this population, the high level of Hepatitis B and the increasing level of Hepatitis C, as identified by the Bio-BSS study in 2011.

The 2011 study identified one HIV case in that population, while Hepatitis C prevalence was 29%. With regard to IDU risky behaviors, the study showed that a large portion of IDUs (43.5) injected drugs several times a day, with heroin being reported as the most frequently injected drug. While there is a good level of information on the risk of HIV spreading from the use of previously used syringes and that clean syringes are available in drugstores, a significant percentage of IDUs had shared syringes and an even higher percentage had used drug injecting equipment in groups.

Besides injection-related risky behaviors, the IDU population is also involved in risky sexual practices. More than half of sexually active IDUs had two or more partners in the previous year. The partners were regular or irregular (noncommercial) partners and the constant use of condoms was low, at only 8.5% with the regular partners and 12.6% with the irregular partners. While IDUs were aware of sexually transmitted infections, few of them were able to describe STI symptoms.

These risk behaviors related to the high prevalence of Hepatitis C illustrate IDU vulnerability to HIV.

2.3.2.3 Men who have sex with men (MSM)

Regardless the constant support from a series of organizations, including MSM/LGBT organizations, in the context of increasing the awareness of legal issues affecting MSMs and their protection against stigma and discrimination, their understating of their issues remains low. The media have not reached the adequate education for

providing clear coverage of the issues related to the stigma and discrimination against MSM.

About a third of MSM move constantly, consume alcohol and most of them have tried drugs (mainly marijuana, cocaine, heroin, ecstasy and valium). 22.5% of MSM did not go to school, and 40% had been married to women. These social and demographic indicators are crucial for the development of suitable activities for promoting behavior for this group of the population. With regard to risky behaviors, a high percentage of MSM had injected drugs in the previous year (mainly heroin) and were involved in anal sex with multiple partners in the previous six months⁴.

In addition to male risky behaviors, MSM responders during BIO BSS 2011, also reported having had sex with women recently. In the six months preceding the survey, most of MSM reported having had sex with multiple female partners (33% of MSM who had sex with women had two or more female partners). Only 12% of MSM had used condoms constantly with their female partners.

In general, the combination of MSM risk factors—involvement unprotected sex with men and women and drug injection—makes interventions in or targeting of this group as part of the strategy for HIV prevention in Albania. While HIV prevalence is much higher than in the rest of the general population (0.5%), the survey did not cover acute STIs, which could have provided a deeper perspective into the relations between risk behaviors and occurrence of infections. It should be noted that MSM are involved in various risk behaviors in relation with other population groups, making them a potential bridge between drug users and the female population, in terms of STI transmission.

2.3.2.4 Roma and Egyptian population

The Bio-BSS 2011 survey showed that the Roma population was very young, with 30% of the participants in the survey under the age of 24 years, and the average being under 30 years old. Only 38.5% of the population in the survey had ever been registered in a school.

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The phenomenon of early marriages is present among the Roma population in Albania, with 41.6% of the respondents reporting that they had married before the age of 16 years. 23.5% of the respondents reported to have had their first sexual intercourse around the age of 10-14 years. Based on BIO BSS 2011 data, 20% of the respondents reported that they were not married and were not living with a sex partner. 94% reported to have had sexual intercourse. One in five Roma women (21.3%) were forced by their partners to have sex when they did not want it.

Despite constant interventions and awareness campaigns on HIV transmission methods, there are still misconceptions among the Roma population, for instance only 25% responded that one cannot get HIV from a mosquito bite and only 28.2% believed that one cannot get HIV from sharing a meal or a dwelling with an HIV-infected person.

There was an increase in the identification of confidential HIV testing among the Roma population (40% in 2011 versus 28% in 2008). HIV testing is still at very low levels among this population, with only 7% of the respondents reporting to have tested.

It should be noted, however, that the Roma population did not report any discrimination in terms of healthcare services compared with the general population using the same centers based on the study “Barriers to Roma Community in Albania accessing health care” UNDP 2012. But there was a bypassing of primary healthcare services, and reporting of informal cash payments to doctors.

2.3.2.5 Sex Workers (SW) and their customers

Sex workers are one of the most difficult groups in terms of identification, and they continue to be outside the prevention programs. In Albania the law prohibits sex work, which means that it is performed illegally. There are no data on SWs. Clearly

this group is extremely vulnerable because knowledge of their behavior, method of operation, numbers, and health status is unknown. This puts them in a high risk position in terms of HIV infection. Their customers, too, are at risk.

Even though under the previous strategy efforts for preventing STIs have been made, the results have been limited.

CSWs may come from both sexes but female sex workers predominate and it reflects the social position and reliance of women and the trend to exploit feminine sexuality. Female CSW are often controlled by male pimps who often physically abuse their charges, and they are vulnerable to human trafficking. Trafficked women have generally been promised attractive employment in host countries only to find that they are coerced into sex work in order to survive.

2.3.2.6 Migrants and their partners

IPH and World Bank report that about 70 percent of the country's HIV infections until 2005 had been contracted abroad. Often these cases go undetected until the patient becomes ill and seeks treatment.

Upon the liberalization of the visa regime, more people are travelling. Seasonal employment (up to two months) has become easier, which in turn has encouraged the migration of the population of working age and sexually active. There are also seasonal movements within the country, from one area to another, both in the tourist summer season and in the agricultural harvesting season in the autumn.

Both internal and external migration is a phenomenon that has not received appropriate attention in national and international policies. This is considered to have been addressed in the interventions targeting the general population and little has been done to find data on this group of the population.

Migrants and their partners are considered as more at risk for several reasons: the migrating population is sexually active; they are likely to have unprotected sex; there is limited or no access to prevention services in the host countries; and HIV and other STIs show an increasing trend in the migration target countries. The infection in

Albania is through sexual transmission, especially through heterosexual intercourse. A significant number of women living with HIV have been found to be spouses of partners of people who had emigrated⁵ (source).

2.3.2.7 Women generally

The national data of violence against women (2013), although shows decrease of physical abuse of women compared to 2007, displays an increase of family violence in general. Also is good to note that the observation has shown an increase of the support requested by women. That may require greater involvement of health workers and may necessitate capacity building of health worker to better know and address the gender based violence.

Also it is important to note the high rates of violence against women during their maternity leave (3 out of 4 women reported violence during this period). This requests the need of capacity building of obstetrics and gynecologists as well as neonatal health service providers.

The government of Albania has strengthened the fight against gender based violence, has improve the legal framework of sexual violence. A special focus should be given to the sexual health and reproductive health of women as they reported the lack of decision making on this issues (Demographic Health Survey - 2008),

Prevention and treatment of family violence is part of the primary health package. The services offers to women and girls are counseling, social support, health support and shelter. There are some NGOs working on addressing gender based violence but HIV/AIDS is limited and their role on support to HIV positive women and children is lacking.

2.3.2.8 Children, teenagers and youth

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Albania is a country with young and sexually active population. Despite the fall in the number of births, children and teenagers account for a significant number of the population. The rise in the number of children living with HIV as a result of lack of prevention program has made this a real problem for Albania and has underlined the lack of social and health services for them. There are shortcomings in the provision of these services for children, with a large burden of the care being placed on their families, who do not receive the adequate support and do not succeed in meeting their minimum living standards.

There is also stigma and discrimination affecting healthcare and education for children in crèches, kindergartens and schools in quite a number of districts in the country and in Tirana. The lack of services for teenagers and the rise in the number of children growing with HIV make this a problem in urgent need of addressing. Some of the children and teenagers who have been infected through blood so far have not received any damages.

Despite the good knowledge of protection against STIs, there is a very low level of condom use among young people. A recent survey of risky behaviors (2014) “Healthy behaviors among children age 11, 13 and 15” UNFPA& UNICEF showed that 19.5% of children aged 15 years old have had sex. 40% of girls and 66% of boys had used a condom when they had last had sex. There is also an increasing trend of the number of young people living with HIV/AIDS recently as per IPH data. Friendly health services for the youth remain insufficient.

Sex education is included in school curricula, and special focus is placed on the teaching quality. Teachers in all areas of the country have been trained, but the level of education on HIV/AIDS and sex education at schools remains at low levels.

2.4 Legal Issues

2.4.1 Legal issues

Law No. 9952 on HIV/AIDS was revised and adopted on 14 July 2008. The law addresses the most critical legal aspects of HIV/AIDS including discrimination, the right to keeping one's job, information consent, confidentiality, free access to information and treatment, the establishment of "safe places" where affected people have access to life saving treatment, and a complaints mechanism. The law provides for the right to treatment and care, and it also provides opportunities for new scientific research in HIV/AIDS.

Under the Law a Council of Ministers' Decree was drafted and approved in February 2011: On preventing HIV/AIDS and providing care, counseling and treatment for people living with HIV/AIDS in education, correction, medical treatment, residential welfare, penitentiary and detention facilities.

Giving priority to the social support for people with HIV/AIDS and, especially, for children living with HIV/AIDS, a Council of Ministers' Decree on setting the criteria, documentation, procedure, type and extent of social assistance benefits for people under the age of 18 years living with HIV/AIDS has been prepared for several years but has not been adopted yet. The adoption of this Council of Ministers' Decree has been protracted, but it is a vital Decree given that PLWHA and their families live in dire social and economic conditions.

3 ANALYSIS OF DECISION-MAKING, IMPLEMENTATION AND SUPPORT INSTITUTIONS

3.1 Government

3.1.1. National HIV/AIDS/STI Program

The National Program for Prevention and Control of HIV/AIDS was established at the Institute of Public Health (IPH) by the Ministry of Health in August 1987 with direct WHO support. The program aimed to establish a comprehensive, organized, and scientific evidence-based prevention and control program for HIV/AIDS in Albania.

The Albanian National AIDS Program consists of a multidisciplinary team of physicians, epidemiologists, psychologists and social workers. It is placed at IPH and is responsible for the coordination of HIV/AIDS prevention activities and for the monitoring of the epidemiological situation in Albania. The National Program is the strengthening of the biological and behavioral surveillance, through the second general surveillance and the establishment of a single monitoring and evaluation system in 2005.

In 2003 there was the establishment of a network of strategic partners to strengthen the multidisciplinary approach to HIV/AIDS prevention and care for people living with HIV. In the same year an Inter-ministerial HIV/AIDS committee was established with the goal to strengthen political efforts for fighting HIV/AIDS. The committee was replaced with the Country Coordinating Mechanism for Albania.

3.2 The National Coordinating Mechanism and other government institutions

The Country Coordinating Mechanism (CCM) is the national coordinating body established at the Ministry of Health and it includes all strategic partners and stakeholders. The CCM includes in its composition representatives from government institutions, NGOs and persons living with HIV/AIDS, thus ensuring the civil society voice in the decision-making.

Other government institutions such Ministry of Education, Ministry of Justice, Ministry of Defense, the Ministry of Social Affairs, and local government structures have designed programs related to HIV/AIDS but their contribution is practically zero and they lack independent initiative. They have always depended on initiatives taken by the Ministry of Health and other health structures.

3.3 Nongovernmental Organization

There are about 18 NGOs which focus their activities on HIV/AIDS, but many more also include HIV/AIDS prevention activities and harm reduction activities in their programs. From many years there is network which is active not only in Tirana but

also in other regions where the need for prevention and support has been strongly required. During 2013, there is establish the coalition of AIDS for a better coordination of interventions and special focus on advocacy. The PLWHA Organization has actively addressed the needs of persons living with HIV/AIDS.

Representatives of NGOs have organized IEC activities especially targeting young people, using a variety of methods, including TV and radio programs, publication of posters, booklets and leaflets, seminars, conferences, painting exhibitions, competitions etc. Training of peer educators is a method commonly used in schools, army, and prisons.

Involvement of NGOs in activities organized in the framework of International Campaigns against AIDS (finalized with World AIDS Day) has been highly effective. Periodical NGO meetings on HIV/AIDS have taken place since late 2002, as a result of UNICEF and IPH initiatives.

3.4 International Organizations

Many UN Agencies in Albania have been involved in the areas of HIV/AIDS prevention and control in Albania. For a better coordination in 1997 the United Nations Theme Group (UNTG) with the participation of UNDP, UNICEF, WHO, UNFPA and World Bank. The position of UN HIV/AIDS resident coordinator was created in November 1997.

It should be noted that the funding for the fight against HIV/AIDS in Albania have fallen significantly. The main focus has always been on the groups at risk, such as IDU, LGBT and Roma. This has left the needs for technical assistance for the development of national systems and capacities uncovered.

4. STRATEGIC PRIORITIES FOR 2015- 2019

OVERALL STRATEGIC GOAL

Albania will remain a low HIV prevalence country and its health system will be capable and provide a response to the increasing trends of HIV-risk behaviors, towards a future without new HIV infections

PILLAR 1 - PREVENTION

STRATEGIC COMPONENT 1 - PREVENTION OF NEW INFECTIONS OF HIV/AIDS AMONG GROUPS AT RISK

Goal- Strategic Component 1

Keep HIV prevalence among the especially vulnerable groups at less than 1 percent by 2019.

Indicator: HIV infection prevalence among most vulnerable groups (IDU, MSM, SW)

4.1.1 Injecting drug users (IDUs)

Objective - **increase the number of IDUs attending harm reduction programs and opioid substitution treatment.**

Indicators:

1. Percentage of IDUs reporting to have used sterile injection equipment the last time they have used injected drugs;
2. Percentage of IDUs that have used condoms the last time they have had sex with an unpaid casual partner;
3. Percentage of IDUs that have taken an HIV test in the last 12 months and have received its result;
4. Number of IDUs reached through harm reduction services (syringe exchange programs);

5. Number of IDUs reached through opioid substitution treatment programs.

Strategic Actions:

- (i) Strengthen existing syringe exchange programs (NSEP) and extend those programs through drop-in centers and mobile units;
- (ii) Increase access to, and quality of, IDU-friendly services in relation to diagnosis services, treatment (including ARV treatment) and care;
- (iii) Promote and implement age and gender appropriate programs in relation to constant use of condoms with all types of sex partners;
- (iv) Improve the legal framework in relation to the implementation of harm reduction programs;
- (v) Develop and promote effective IDU-focused strategies in order to reduce the risk of Hepatitis C and B transmission to injected drug users, including the Hepatitis inoculation;
- (vi) Develop, implement and monitor programs for reducing the demand for drugs, focusing on primary prevention interventions among young people and combine these programs with the National Strategy for Drug Demand Reduction;
- (vii) Increase HCV-infected IDU's access to be treated at the healthcare services;
- (viii) Improve and extend information and education programs of IDUs and their partners in order to reduce the risk of transmission of HIV and other infections that can be transmitted through blood and sexual intercourse.

4.1.2 Men who have sex with men (MSM)

Objective - Reduce the percentage of MSM involved in behaviors that present a risk of HIV and STI infection, and improve behaviors that reduce the risk of transmission of these infections

- Indicators:
1. Percentage of MSMs that have used condoms the last time they had sex with a male partner;
 2. Percentage of MSMs that have taken an HIV test in the last 12 months and have received its result;
 2. Number of MSMs reached through HIV prevention services.

Strategic Actions:

- (i) Provide continuous support to MSM organizations and groups particularly in the areas of capacity strengthening, public relations, and advocacy,
- (ii) Develop, implement and monitor condom and lubricant use interventions which focus on providing access and their continuous use;
- (iii) Provide services to the MSM and transgender community through existing programs and establishment of Check-Point-type centers;
- (iv) Promote and provide community-based and provider-initiated HIV and other STI testing;
- (v) Develop and implement age-appropriate behavior change interventions in order to prevent HIV and other STIs;
- (vi) Educate and sensitize medical staff and psychological and social support staff and the police of the MSM/transgender community specific needs and of issues related to the stigma and discrimination;
- (vii) Develop and implement programs which focus on harm reduction for MSMs as IDUs;
- (viii) Undertake research to determine and understand risk to MSM, especially in the context of social exclusion, stigma and discrimination.

4.1.3 Sex Workers (SW)

- Objective: Reduce the risk of HIV transmission and promote safer sexual behaviors among CSW

- Indicators:
1. Percentage of sex workers that have used condoms the last time they had sex with a customer
 2. Percentage of SWs that have taken an HIV test in the last 12 months and have received its result;
 3. Number of SWs reached through HIV prevention services.

Strategic Actions

- (i) Develop, implement and evaluate information, education and communication (IEC) and behavior change communication (BCC) programs for SW
- (ii) Increase SW access to friendly HIV and other STI testing and training services;
- (iii) Improve the legal framework regarding the elimination of barriers which prevent SW from accessing regular social and health services.

4.1.4 People spending time in correctional facilities

Objective - Prevent HIV spreading among people serving time in correctional facilities.

- Indicators:
1. Number of inmates reached through HIV prevention services;
 2. Percentage of inmates that have taken an HIV test in the last 12 months and have received its result.

Strategic Actions

- (i) Promote and provide HIV and other STI testing for inmates in correctional facilities;
- (ii) Develop, implement and monitor HIV awareness and intervention programs for the prevention of HIV transmission;

- (iii) Implement and evaluate harm reduction programs in correctional facilities.

4.2 STRATEGIC COMPONENT 2 – INCREASED COVERAGE AND FREQUENCY OF HIV TESTING THROUGH EXISTING VCT SERVICES AND HEALTH SERVICES

Goal- Strategic Component 2

Increase the number of testing aiming early identification of new cases and prevention of spread of infection

Indicators: Number of persons tested for HIV

4.2.1 SERVICE PROVIDER-INITIATED COUNSELING

Objective - Increase testing and counseling initiated by service providers, and strengthen referral mechanisms in the healthcare system and other community services.

Strategic Actions:

- (i) Increase provider capacities for provider-initiated testing and counseling;
- (ii) Offer provider-initiated testing and counseling as part of STI services;
- (iii) Ensure offering of provider-initiated testing and counseling by healthcare services for mostly at risk populations that use such special services as emergency service, STI service and drug-addiction treatment service;
- (iv) Establish and strengthen effective referral mechanisms in the healthcare and community structures;
- (v) Increase access to HIV testing through the finger blood and saliva test.

4.2.2 Testing through Voluntary Counseling and Testing (VCT) services

Objective - Extend VCT services by establishing new centers, improving the service quality and systematically promoting the provided services

Strategic Actions:

- (i) Extend and improve the provision of VCT services by establishing new VCT services at municipal level;
- (ii) Increase the capacities and continuously educate VCT staff in order to promote services and extend field work focusing on the mostly at risk groups, the Roma population and the youth;
- (iii) Improve the provision of Information Education and Communication (IEC) services, including the preparation of IEC materials in line with VCT customer needs;
- (iv) Establish mechanisms in the current system with the goal to support and supervise all public and private structures that provide HIV testing;
- (v) Strengthen the IPH Reference Center, which will provide expertise and will ensure compliance with CVCT standards.

**4.3 STRATEGIC COMPONENT 3 - Prevention of vertical transmission of HIV
from parent to child**

Goal- Strategic Component 3

Reduce the number of cases of parent-to-child HIV transmission with the goal to eliminate it.

Indicators:

1. Percentage of pregnant women who have tested for HIV and have received the test results;

2. Number of HIV-positive pregnant women who have received ARV in the past 12 months to reduce the risk of transmission to child;

3. Number of children born to HIV-positive mothers that have been tested for HIV in the first two months after birth.

4.3.1 Parent to child transmission

Objective- Reduce mother to child transmission of HIV through prevention efforts and ensure appropriate care for parents and children living with HIV/AIDS.

Strategic Actions:

- (i) Promote and provide testing to pregnant women through counseling in primary healthcare facilities and women counseling centers;
- (ii) Raise awareness of HIV status among women of reproductive age;
- (iii) Ensure treatment and care for pregnant women living with HIV before, during and after birth;
- (iv) Increase focus on perinatal care given to children born to HIV-positive mothers in order to address their unique treatment and care needs;
- (v) Educate and inform HIV-positive women and their families in relation to the stigma and discrimination they might be subjected due to their HIV-positive status, by providing counseling and support;
- (vi) Increase medical staff understanding of lawfulness aspects, in order to eliminate any inequalities in healthcare services, reduce stigma and discrimination in healthcare service providers against HIV-positive pregnant women and HIV-positive children;
- (vii) Increase clinical expertise and capacity for optimal medical care for HIV-positive pregnant women before and after birth and for their children exposed to HIV or for HIV-positive children.

4.4 STRATEGIC COMPONENT 4 - PREVENTION OF NEW INFECTIONS OF HIV/AIDS AND STI AMONG THE GENERAL POPULATION

Goal- Strategic Component 4

Keep HIV prevalence among the general population at less than 0.1 percent by 2019.

- Indicators:
1. Percentage of males and females that have taken an HIV test in the last 12 months and have received its result;
 2. Percentage of males and females aged 15-24 who have had sex before the age of 15;
 3. Percentage of males and females aged 15-49 that have had sex with more than one partner in the past 12;
 4. Percentage of males and females aged 15-24 that correctly identify the sexual methods of HIV prevention and deny any misconceptions on HIV transmission.

4.4.1 Migrant population

Objective- Reduce risk behaviors that expose mobile populations to HIV/AIDS and improve their behavior relative to seeking healthcare services.

Strategic Actions:

- (i) Integrate HIV/STI prevention programs into emigrant admission and reintegration institutions and NGOs;
- (ii) Develop policies and methodologies for assessing and addressing the needs of the mobile population and their partners in order to establish a supporting environment for HIV/STI prevention;

- (iii) Focus information and education efforts, and encourage them towards safer sexual behaviors in areas with high exposure to migration such as border areas;
- (iv) Coordinate in-country interventions with the programs and institutions in host countries in order to increase knowledge, reduce risky sexual behavior, and provide care and support programs

4.4.2 Youth

Objective- Increase the level of safe behaviors and reduce the risk of HIV and STI infection among adolescents (13 to 18 years old) and young adults (19 to 24 years old).

Strategic Actions:

- (i) Develop and implement special information and education programs on HIV infection prevention with the youth by organizing effective cooperation among all the appropriate players, educational structures, healthcare service providers, peer education and civil society;
- (ii) Strengthen government institution and civil society capacities for an adequate and individual response to the needs of the youth, especially to those who are vulnerable;
- (iii) Increase youth awareness of, and commitment to, establishing a support environment and reducing stigma and discrimination against PLWHA.

4.4.3 Women

Objective - Increase the percentage of sexually active women who are engaged in behaviors that reduce the risk of HIV/STI infection.

Strategic Actions:

- (i) Establish a supportive environment, quality services for girls and women, and eliminate barriers to prevention programs and interventions among women at a sexually active age;
- (ii) Prevent HIV among women and girls through programs based on the fight against gender-based violence which leads to HIV infection risk, and recognize the role of men and boys as important factor to HIV prevention among women;
- (iii) Increase the involvement of partners in vertical HIV transmission prevention programs.

4.4.4 General population

Objective - Increase knowledge levels, reduce risky behaviors and promote safer sexual behaviors among the general population.

Strategic Actions:

- (i) Develop, implement and evaluate awareness programs on HIV/AIDS issues and promote safe sexual behaviors
- (ii) Promote male circumcision as one of the methods for preventing HIV infection transmission;
- (iii) Increase the general population awareness of, and commitment to, establishing a support environment and reducing stigma and discrimination against PLWHA.

4.4.5 Roma and Egyptian population

Objective - Prevent HIV spreading among the Roma and Egyptian community by reducing and preventing risky behaviors and promoting positive behavior.

Strategic Actions:

- (i) Develop and implement awareness campaigns and interventions for improving Roma and Egyptian population attitudes to seeking health services, including HIV and STI testing and treatment services;
- (ii) Include the Roma and Egyptian population in HIV/AIDS/STI prevention programs, and train the health centre staff so they are able to better respond to the reproductive health needs of the Roma and Egyptian population.

4.5 STRATEGIC COMPONENT 5 - HIV/AIDS PREVENTION CARE AND TREATMENT SUPPORT SYSTEMS

Goal - Strategic Component 5

Develop and maintain effective prevention, care and treatment systems to support the national response for the control and management of HIV/AIDS in Albania.

4.5.1 Blood safety

Objective - Monitor, and provide support for, programs that ensure the safety of blood, blood products, tissues, and organs for transplant purposes according to the approved National Strategy for Blood Safety

Strategic Actions:

- (i) Strengthen and enhance epidemiological follow-up of HIV infection during blood transfusion and organ transplant;

- (ii) Strengthen diagnostic capacities in relation to infections that are transmitted through blood.

4.5.2 Prevention of nosocomial infection of HIV

Objective - Reduce the possibility of nosocomial transmissions of HIV infection by increasing health care workers' awareness of universal precaution measures, and provide appropriate protection equipment.

Strategic Actions:

- (i) Guarantee the safety of injections of all types, in particular by applying new methods of handling;
- (ii) Promote among the medical staff that works in specialties with a high risk of exposure to HIV and other blood infections the knowledge of how to prevent their transmission to patients, and encourage the reporting of incidents and of the quality of provided services;
- (iii) Provide post-exposure prophylaxis measure for all healthcare workers who are exposed to the virus (PEP kits).

PILLAR 2 – MEDICAL TREATMENT AND CARE

4.6 - Strategic Component 6 - Improve treatment, care and support to people living with HIV/AIDS

Goal- Strategic Component 6

Ensure access to quality treatment care and support services for all people living with HIV/AIDS and those affected by the epidemic.

Indicators: 1. Number of adults and children receiving ARV;

2. Percentage of adults and children receiving ARV therapy 12 months after beginning;
3. Percentage of infected people treated for HIV and TB;
4. Percentage of adults and children included in the HIV care who have received prevention treatment with isoniazid;
5. Percentage of adults and children included in the HIV care who have been evaluated for their TB status in the last check-up.

4.6.1 Medical care

Objective - Ensure full medical care and treatment for all people living with HIV/AIDS.

Strategic Actions:

- (i) Ensure full and uninterrupted provision of medication with antiretroviral drugs for all patients that need it, on the basis of up-to-date protocols;
- (ii) Improve ART monitoring by constantly providing and uninterruptedly monitoring the level of CD4, HIV viral load and genotypic resistance test, by strengthening diagnostic capacities of the TUHC microbiological laboratory;
- (iii) Improve the system and capacities for planning, procuring, purchasing and monitoring ARV drugs consumption;
- (iv) Improve adherence to antiretroviral therapy (ART) through education and training activities with medical staff, patients and their family members;
- (v) Increase the quality of care by providing education and training activities with the medical and infirmary staff involved in the clinical care for PLWHA;
- (vi) Include ARV drugs in the HIF List of Reimbursable Drugs.

4.6.2 Opportunistic infections

Objective - Provide opportunistic infection, co-infections and chronic pathology management training and prevention for all HIV/AIDS patients based on up-to-date clinical protocols.

Strategic Actions:

- (i) Strengthen diagnostic capacities in relation to opportunistic infections;
- (ii) Improve the process of planning, procuring and purchasing antiviral, antifungal and antibacterial preparations.

4.6.3 Service/care quality improvement

Objective - Ensure and guarantee appropriate care services by improving infrastructure and strengthening human resources.

Strategic Actions:

- (i) Ensure and guarantee appropriate care services by improving infrastructure and strengthening human resources;
- (ii) Establish and provide home care, nursery care and palliative care services;
- (iii) Improve and adapt referral services for PLWHA based on the principles of respect for human rights, and principles of fighting the stigma and discrimination;
- (iv) Establish and strengthen educational and training programs for the medical staff at tertiary level (THUC) and secondary level (regional hospitals) on issues of life quality, care and stigma and discrimination.

PILLAR 3 - SOCIAL CARE AND SUPPORT

4.7 Strategic Component 7 – Social care and support

Ensure quality care and support services to people infected with HIV and those affected by the epidemic

4.7.1 Social care and support

Objective - Provide full social support to people living with HIV/AIDS.

Strategic Actions:

- (i) Develop, implement and evaluate information and education programs for PLWHA, their families and the community;
- (ii) Establish support groups and peer groups on such issues as adherence to medication, psychosocial support, palliative care and depression-related support;
- (iii) Strengthen PLWHA family members' capacities on issues related to home care, palliative care, mental health, and social and legal services;
- (iv) Support NGOs to provide alternative and support services PLWHA.

4.7.2 Reduce stigma and discrimination

Objective - Establish a safe and supportive environment for reducing stigma and discrimination against PLWHA.

Strategic Actions:

- (i) Improve the legal framework on reducing stigma and discrimination;
- (ii) Strengthen legal mechanisms for service providers;
- (iii) Strengthen media capacities for covering HIV/AIDS-related issues.

PILLAR 4 – STRENGTHENING HEALTH SYSTEMS

4.8 Strategic component 8 - MONITORING, IMPACT ASSESSMENT AND RESEARCH

Goal- Strategic Component 8

Strengthen and improve the monitoring & evaluation system based on epidemiological and behavioral indicators.

Objective - Strengthen the epidemiological surveillance system in order to monitor the prevalence and incidence of HIV infection and of the risk behaviors that facilitate HIV transmission.

Strategic Actions:

- (i) Carry out periodically biological and behavioral surveys for most at risk population;
- (ii) Strengthen the sentinel surveillance in relation to HIV/AIDS, especially for mostly at risk groups (IDU, MSM, SW);
- (iii) Strengthen the system for reporting and collecting routine data from the passive surveillance in relation to HIV/AIDS in public and private healthcare facilities;
- (iv) Improve epidemiological follow-up of newly identified cases of HIV infection;
- (v) Monitor the quality of services provided to people living with HIV/AIDS, by developing the care continuity cascade;
- (vi) Measure and monitor the incidence of undiagnosed HIV infection cases;
- (vii) Evaluate the size (number) of mostly at risk populations: IDU, MSM and SW;
- (viii) Strengthen capacities in relation to the second generation surveillance in line with international standards;

- (ix) Improve the information system for HIV-infected people at national behavior level.

Objective - Strengthen the monitoring & evaluation system relative to the progress of the national response to HIV/AIDS and scientific research.

Strategic Actions:

- (i) Strengthen the programmatic monitoring & evaluation system, structures and forms;
- (ii) Establish and strengthen capacities in relation to monitoring and evaluating at national and local level;
- (iii) Strengthen the development of scientific research of HIV/AIDS interventions and create a model of success for a low HIV prevalence country.

5 STRATEGY IMPLEMENTATION BODIES

5.1 Policy-Making Bodies

Although the CCM was established for facilitating the submission of an application with the Global Fund for Fighting HIV/AIDS and TB (GFATM), its functions go beyond the scope of the GFATM-supported program. Under the UNAIDS “Three Ones” Strategy, Albania is committed to having a national coordinating authority. Much of this function now rests with CCM. The functions of the Mechanism include:

- a. Coordinating the national response to HIV/AIDS and TB in Albania;
- b. Proving the environment to facilitate information sharing among National Programs for HIV/AIDS and TB and similar programs, including the Global Fund program, and receiving relevant inputs from other stakeholders;
- c. Providing a forum where stakeholders can participate in developing and reviewing the national response to HIV/AIDS and TB;
- d. Making joint decisions on the programs to be implemented, including preparation of proposals and applications for continued Global Fund funding, and selection of implementing agencies to manage grants;
- e. Supervising and monitoring national response programs, similar to the program supported by the GFATM.

The Minister of Health is the CCM Chairperson. The national response to HIV/AIDS involves many other stakeholders in addition to government. CCM has representatives from many organizations which allows for a broad exchange of ideas and information.

National HIV/AIDS and TB programs are the structures responsible for fighting HIV and TB in Albania.

5.2 Implementation Bodies

5.2.1 National HIV/AIDS/STI Program

The NSPCHA was conceived to be a reference document to be implemented jointly by organizations responsible for prevention, control, treatment and care of HIV/AIDS and the National HIV/AIDS/STI Program is responsible for coordinating the efforts of

government agencies, NGOs and international organizations to achieve program objectives and for ensuring adherence to national policies.

The National HIV/AIDS Program is a unit within the Department of Control of Infectious Diseases at IPH. It cooperates with all reference laboratories and departments within IPH and with relevant clinics and other strategic partners. Despite its successes, the established strategic partnership needs to be strengthened further in order to increase the effort for implementing effective interventions, better planning, and strengthening civil society and government, public, and private partnerships.

5.2.2 Reference Centers

In view of the need to create standards and monitor achievements, the following Reference Centers have been established

- (i) The National Clinical Reference Centre (at TUHC “Mother Theresa” Infectious Diseases Department)
- (ii) The CVCT Reference Centre (at IPH National Program and Reference Laboratory), national laboratory center at IPH.

5.2.3 Strategic Partners

Given HIV/AIDS prevention and control are crosscutting issues it is essential to establish strategic partnerships. This requires partner identification among government, nongovernmental and international agencies. Strategic partners are members of the National Coordinating Mechanism:

1. Strategic partners from policymaking structures
 - Ministry of Health
 - Ministry of Social Welfare and Youth
 - Ministry of Education and Sports
 - Ministry of Culture
 - Ministry of Justice
 - Ministry of Defense

- Ministry of Finance
- 2. Strategic partners from other government technical structures
 - University Medical School
 - University Social Sciences School
 - National Blood Transfusion Centre
 - Tirana University Hospital Centre “Mother Theresa”
 - University Military Hospital Toxicology Centre
 - District Public Health Departments
 - Institute of Curricula
 - Municipalities
- 3. Strategic partners from international organizations
 - Joint United Nations Program on HIV and AIDS (UNAIDS)
 - World Health Organization (WHO)
 - World Bank (WB)
 - United Nations Development Program (UNDP)
 - United Nations Program for Children (UNICEF)
 - United Nations Population Program (UNFPA)
 - United Nations Office on Drugs and Crime (UNODC)
 - United Nations High Commissioner For Refugees (UNHCR)
 - United States Program for International Aid (USAID)
 - International Organization of Migration (IOM)
 - United Nations Entity for Gender Equality and the Empowerment of Women (UN Women)
- 4. Strategic partners from nongovernmental organizations
 - Aksion Plus
 - Stop AIDS
 - ACPD
 - UKPR
 - APRAD
 - NESMARK
 - ALGA
 - SGA
 - Institute of Public Opinion Studies

- Health 2000
- Albanian Health Community Organization (ACHO)
- Youth Women Christian Association (YWCA)
- Vatra
- Albanian Roma Associations
- FHA
- PCEC
- NAPH
- NAE
- etc.

5.2.4 Local Implementation Structures

Local implementing structures are established at Prefecture and municipal level and follow the process of health service regionalization, in line with the existing health reform strategy. They have a crosscutting nature, comprising the Public Health Department or other local bodies, and will establish strategic partnerships with government structures at local level, civil society, community and private businesses in line with the existing healthcare and decentralization strategies. The local plan will depend on existing capacities and opportunities for creating/further strengthening local capacities. Local structures will develop local annual plan and, ultimately, strategic plans, in accordance with the objectives and NSPCHA's action plan.