

# National HIV/AIDS Strategy 2015 – 2020

## SUMMARY

The objective of National HIV/AIDS Strategy in Montenegro (2015-2020) is: "Montenegro is a country with low HIV prevalence rate and universal multi-sector approach to prevention, treatment and support to persons living with HIV". In order to achieve this objective, it is necessary to take significant measures so as to reduce stigma and discrimination, empower health care system, involve other sectors and NGOs which will, in accordance with agreed principles, work together in order to avoid medical, social and economic consequences of HIV and ensure sustainable multi-sector response to HIV.

Reasons for the adoption of this Strategy are, among others, increasingly growing needs for health protection of persons affected by HIV/AIDS, which is conditioned by the increase of general and health culture, appearance and application of contemporary scientific and professional achievements and technologies in the provision of health protection.

National response to HIV/AIDS has to be intensified in order to ensure universal approach to key interventions in the field of HIV prevention and treatment. Persons living with HIV/AIDS, as well as persons at risk of HIV are still facing high-level stigma and discrimination. Factors contributing to risky behavior (level of knowledge on HIV, vulnerability and social exclusion) are still present, and the lack of assessments on the size of population for groups in greatest risk hinders the monitoring of epidemic. It is necessary to continue also with the strengthening of government sector which needs empowerment by targeted funds and human resources that will be committed to the implementation of the Strategy.

From the beginning of epidemic to the end of 2014, Montenegro recorded 41 deaths caused by AIDS (43% of all AIDS affected), 32 men and 9 women. Majority of the dead (68%) were aged between 30 and 49.

National HIV/AIDS Strategy 2015 – 2020 is based on holistic approach and cross-sector cooperation and recognizes five programme priority areas for action:

- stigma and discrimination;
- prevention;
- treatment, care and support;
- supervision and monitoring;
- coordination and partnership.

Programme areas are focused on the creation of safe and supporting environment, HIV prevention among persons at increased risk, institutions and general population and provision of accessible and equal treatment, care and support to all persons living with HIV. At the same time, via its programme areas, the strategy tends to establish efficient supervision and monitoring that will ensure response to HIV/AIDS harmonized with the existing situation and needs, as well as the creation of sustainable coordination and partnership mechanisms in response to HIV/AIDS, as the prerequisites of success of the proposed activities.

Supervision of HIV has been conducted in Montenegro for more than two decades, but it was significantly improved by the adoption of HIV/AIDS Strategy, as well as by the introduction of the Second generation of supervision, which led to the creation of basic prerequisites for more efficient and comprehensive response to HIV epidemic.



# National HIV/AIDS Strategy 2015-2020

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## Acronyms

AIDS Acquired immune-deficiency syndrome  
ART Anti-retroviral therapy  
ARV Anti-retroviral  
BBS Behavioural Bio-marker Surveillance  
BCC Behavioural change communication  
BTS Blood Transfusion Service  
CCM/NKT Country Coordinating Mechanism  
EU European Union  
FSW Female sex worker  
GFATM Global Fund to fight AIDS, Tuberculosis and Malaria  
HAART Highly active anti-retroviral therapy  
HBV Hepatitis B virus  
HCV Hepatitis C virus  
PHCC Primary Health Care Centre  
HIV Human immuno-deficiency virus  
HPV Human papilloma virus  
IDC Infectious Diseases Clinic  
IDP Internally displaced person  
IDU/IKD Injecting drug user  
IEC Information, education and communication  
IPH/IJZ Institute of Public Health  
MARA Most at-risk adolescents (for HIV)  
MARPs Most at-risk populations (for HIV)  
M&E Monitoring and evaluation  
MMT Methadone maintenance therapy  
MoH Ministry of Health  
MoHLSW Ministry of Health, Labour and Social Welfare  
MoI Ministry of Interior  
MoJ Ministry of Justice  
MSM Men who have sex with men  
NAC National AIDS Commission  
NGO Non-governmental organisation  
NHIF National Health Insurance Fund  
NHIS National Health Information System  
NSP Needle and syringe programme  
OI Opportunistic infection  
PEP Post exposure prophylaxis (for HIV)  
PMTCT Prevention of mother to child transmission (of HIV)  
PLHIV People living with HIV  
RE Roma and Egyptians  
STI Sexually transmitted infection  
SW Sex worker  
TB Tuberculosis  
UN United Nations  
UNAIDS United Nations joint programme on HIV/AIDS  
UNDP United Nations Development Programme  
UNGASS United Nations General Assembly Special Session (on HIV)  
UNHCR United Nations High Commission for Refugees  
UNICEF United Nations Children's Fund  
VCT/DPST Voluntary counseling and testing (for HIV)  
WHO World Health Organisation  
YFHS Youth Friendly Health Services

## 1. INTRODUCTION

Montenegro introduced programme for HIV/AIDS in 1985 as the part of the programme of ex Republic of Yugoslavia, four years before detection of the first case of HIV infection in Montenegro. According to revised data from HIV/AIDS registry, from the beginning of epidemic in 1989 to the end of 2014, 175 HIV infected persons were recorded, out of which 88 persons were in AIDS stadium at the moment of infection detection (50.3% of all registered HIV positive persons), while 87 persons were in asymptomatic phase or in symptomatic non-AIDS phase of HIV infection. At the same period, 41 persons died of AIDS. Although current rate of infection incidence indicates that Montenegro is a country with low prevalence (0.017%), regional trends indicate the risk of rapid spreading of HIV, which, if prevention among key target groups is not improved and if successful response is not provided in early epidemic phase, may result in long-term medical, social and economic consequences.

Since 1987, in Montenegro, special attention has been dedicated to the provision of safe blood and blood products. With the aim of coordination of total multi-sector response to HIV/AIDS, in 2001, under the then responsibility of the Ministry of Health, Labour and Social Welfare (now under the responsibility of the Ministry of Health), National AIDS Commission (NAC) was established. Political willingness was recognized in Montenegro to solve the problem of AIDS in a comprehensive manner in compliance with the guidelines of the United Nations Joint Programme on HIV/AIDS (UNAIDS), which resulted in the creation and implementation of national HIV/AIDS strategies for periods 2005-2009 and 2010-2014. National HIV/AIDS strategies provided good basis for HIV prevention – with special focus on most at-risk populations and secure blood – and improved diagnostics, treatment and care for persons living with HIV. It should be noted that non-governmental organizations (NGOs) had important role in the implementation of strategies, especially in the part covering IDU, SW and MSM<sup>1</sup>, provision of information on HIV and distribution of prevention packages to the young.

The support provided by the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) accelerated the activities already undertaken by governmental and non-governmental organizations, with the support of international partners, such as United Nations Development Programme (UNDP), United Nations High Commission for Refugees (UNHCR), UNICEF, Swedish International Development Agency (SIDA), Canadian International Development Agency (CIDA) and Canadian Public Health Agency (CPHA).

These efforts have provided the following results: a number of national guides have been created as well as protocols for HIV prevention and AIDS treatment, existing laws and policies have been revised or new ones have been adopted, key target groups have obtained information on HIV prevention, needed material and treatment services, capacities of health care workers, prison staff, employees in police, social services and judicial authorities have been developed, peer educators, youth and NGOs have been trained. At the same time, the capacities of governmental institutions have been strengthened in the fields of monitoring and evaluation, including biological – behavioural supervision. The establishment of Country Coordinating Mechanism (CCM) composed of the representatives of ministries, institutions and NGO has also contributed to more coordinated response.

These results have to be maintained, while national response has to be intensified in order to ensure universal approach to key interventions in the field of HIV prevention and treatment. Persons living with HIV/AIDS (PLHIV), as well as persons at HIV risk (SW, MSM, IDU), are still facing high-level stigma and discrimination. Factors contributing to risky behavior (level of knowledge on HIV, vulnerability and social exclusion) are still present, and the lack of assessments on the size of population for groups in greatest risk hinders the monitoring of epidemic. The existing support services in NGOs have not achieved sustainability level, and it is necessary to continue also with the strengthening of government sector which needs

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<sup>1</sup> IDU - Injecting drug users, SW - sex workers, MSM - men who have sex with men

empowerment by targeted funds and human resources that will be committed to the implementation of the Strategy.

## **2. DEVELOPMENT OF NATIONAL AIDS STRATEGY (2015-2020)**

National HIV/AIDS Strategy 2015-2020 was created by the Ministry of Health (MH) in close cooperation with NAC and CCM<sup>2</sup>, with technical support from NGO CAZAS via grant provided by German Agency for International Cooperation – GIZ and participation of key institutions and organizations from governmental and NGO sector. Ministry of Health appointed Working Group composed of the representatives of key institutions and organizations involved in national response to HIV/AIDS, and the process was implemented with the support of engaged professional consultant.

Participatory approach was used in all segments of document creation process. The first phase of the process entailed online questionnaire<sup>3</sup> which ensured the analysis of achievements of previous strategy, definition of priority areas and activities. Within this research method, 30 representatives of institutions and national and international organizations provided their opinions and proposals. Obtained data were the basis for two three-day multi-sector meetings, at which there was active work on the creation of action plan. All relevant entities provided their contribution at these events: NAC and CCM members, as well as the representatives of other ministries (Ministry of Finance, Ministry of Education and Ministry of Labour and Social Welfare), institutions (Fund for Health Insurance) and organizations (of UN system) and national and international NGOs engaged in the protection and support to persons living with HIV and persons at risk of HIV.

The presence of the representatives of most at-risk population, who directly participated in the development of the strategy was of special importance for the process, and this was not the case in the creation of previous strategies as there were no NGOs led by persons living with HIV and most at-risk of HIV persons (MSM, etc.).

The Strategy is also based on the results and achievements of previous strategies (2005 – 2009 and 2010 – 2014), as well as on identified weaknesses during their implementation, based on the findings of the Midterm Review of National HIV/AIDS Strategy and Universal Approach plan, results of biological – behavioural supervision (BBS) and other studies implemented during ten-year period, as well as the reviews of activities and reports on achievements during the implementation of projects implemented by GFATM within the period 2007 – 2014.

During the creation of National Strategy for the period 2015 – 2020, it was proposed to revise programmes and activities within the existing strategic areas, so as to correspond by its concept to current state and priorities defined after comprehensive analyses and group discussions conducted in the process of creation of this document. The activities within operational goals largely represent the follow-up of the action from previous strategies. However, taking into account the fact that in the national response to HIV/AIDS, by the termination of GFATM grant, actors will have less available funds in future, the working group has chosen the concept of rationalization of activities within strategic areas. However, it was particularly intended that the reduction of the scope of envisaged activities in no way endanger the goals set by the Strategy, but contribute to efficient response to HIV.

The Strategy will be implemented through coordinated activities of various actors from state or public sector, civil society (especially NGOs) and private sector, with the support of the Government, international, regional and national donors.

## **3. GOALS AND LEADING PRINCIPLES**

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<sup>2</sup> National Aids Committee; Country Coordinating Mechanism

<sup>3</sup> <https://docs.google.com/forms/d/1L4TkAxFhhfQhFX5gD29w8YeUKwhMamT8frK7OiSZaCs/viewanalytics>

The objective of the National HIV/AIDS Strategy in Montenegro (2015 – 2020) is: “**Montenegro is a country with low growth rate of HIV infection and universal multi-sector approach to the prevention, treatment and support of persons living with HIV**”.

In order to achieve this objective, it is necessary to undertake important measures for the decrease of stigma and discrimination, empower health system, involve other sectors and NGOs which will, in accordance with agreed principles, work together so as to avoid medical, social and economical consequences of HIV and ensure sustainable multi-sector response to HIV.

The Strategy is based on the following leading principles:

- **Protection and indivisibility;**
- **Equal approach and availability** to health prevention services for all;
- **Universal approach** to the package of basic cost-effective HIV interventions for most at-risk groups and persons living with HIV;
- **Confidentiality and privacy** of all data guaranteed at all levels in health and other sectors;
- **Best interest of beneficiaries** through the provision of services which are to a greatest extent aligned with the needs of beneficiaries along with the respect for human rights and dignity;
- **Participation, responsibility and independence of beneficiaries** in making decisions on the manner of satisfying their needs;
- **Continuity of protection and possibility of choosing services and service providers** through the development of various and easily accessible services within public, non-governmental and private sector;
- **Pluralism of service providers** through the encouragement and creation of conditions for establishment, work and spreading of non-profit sector of society;
- **Active participation** of all populations encompassed by the Strategy in the creation, implementation and evaluation of proposed programmes;
- **Promotion** of healthy lifestyles and interventions for the prevention and strengthening of individuals and groups in order to protect themselves from HIV infection;
- **Multi-sector approach** to HIV based on involvement of partners at all levels within public, private and NGO sector, in accordance with other existing strategies and internationally accepted obligations;
- **Integrated response** to HIV via bio-medical aspect and socio-economic factors which increase the risk to HIV;
- **Development, learning and readiness to positive changes** of all actors involved in the process of implementation of the Strategy;
- **Programming**, monitoring and evaluation based on the existing evidence and result-orientation.

## **4. INTERNATIONAL AND NATIONAL FRAMEWORK**

National HIV/AIDS Strategy in Montenegro is based on national legislation and international instruments for human rights, legal documents of United Nations, Council of Europe, European Union and specialized international organizations in the part related to HIV/AIDS.

### **4.1. International Framework**

- Millennium Development Goal (MDG) 6: fight against HIV/AIDS, 2000;
- United Nations General Assembly Special Session (UNGASS) on HIV/AIDS, 2001;
- United Nations General Assembly Special Session (UNGASS) on HIV/AIDS, 2006;
- Towards universal access: Scaling up priority HIV/AIDS interventions in the health sector by WHO, 2008;
- Convention on Elimination of all Forms of Discrimination Against Women (CEDAW, 1979);
- Convention on the Rights of the Child, 1989;
- WHO European Regional Strategy on Sexual and Reproductive Health; 2001;
- Declaration of WHO European Ministerial Conference on Young People and Alcohol, 2001;
- Declaration of Commitment on HIV/AIDS in South-Eastern Europe, Bucharest, 2002;
- European Ministerial Conference on HIV/AIDS, Dublin, 2004;
- Vilnius Declaration on HIV/AIDS in Europe, 2004;
- EU Statement on HIV Prevention for an AIDS Free Generation, 2006;
- Bremen Declaration on Responsibilities and Partnership – Together against HIV/AIDS, 2007;
- Resolution of Parliamentary Assembly of the Council of Europe 1536 from 2007 (HIV/AIDS in Europe);
- Joint Programme of United Nations for AIDS (UNAIDS);

### **4.2 National Framework**

National legislation and strategies provide the context in which HIV activities in certain population groups are undertaken within health and other relevant actions.

- Constitution (2007)<sup>4</sup>
- Law on the Protection of Population from Infectious Diseases (“Official Gazette of the Republic of Montenegro”, no.32/05 and “Official Gazette of Montenegro”, no. 14/2010);
- Law on Blood Provision (“Official Gazette of the Republic of Montenegro”, no. 11/07);
- Law on Medications (“Official Gazette of Montenegro”, no. 56/2011);
- Law on Data Collections in Health System (“Official Gazette of Montenegro”, no. 80/08);
- Law on Health Care of Patients (“Official Gazette of Montenegro”, no. 25/2010);
- Law on the Prevention of Drug Abuse (“Official Gazette of Montenegro”, no. 28/2011);
- Law on Health Protection (“Official Gazette of Montenegro”, no. 14/10);
- Law on Mandatory Health Insurance (“Official Gazette of the Republic of Montenegro”, no.39/04 as of 09/04/2004, 23/05 as of 12/04/2005, 29/05 as of 09/05/2005 and “Official Gazette of Montenegro”, no. 12/07 as of 14/12/2007, 13/07 as of 18/12/2007, 73/10 as of 10/12/2010, 40/11 as of 08/08/2011);
- Law on the Prohibition of Discrimination (“Official Gazette of Montenegro”, no. 46/2010 – 40/2011-1);
- Criminal Code (“Official Gazette of the Republic of Montenegro”, no. 70/2003, 13/2004, 47/2006 and “Official Gazette of Montenegro”, no. 40/2008, 25/2010, 32/2011, 40/2013 and 56/2013);

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<sup>4</sup> Article 69 of the Constitution of Montenegro prescribes that everybody shall have right to health protection.

By the means of Amendments to the Criminal Code in 2010 criminal offence “Transmission of HIV infection” referred to in Article 289 of the Criminal Code was deleted. This Article sanctioned the act of exposing a person to a danger of HIV infection; the non-compliance to regulations and measures related to the prevention of HIV infection spreading and incidental transmission of HIV infection, as well as intentional HIV transmission.<sup>5</sup> The explanation for the deletion of this Article states that this offence is “covered by another criminal offences from the field of criminal offences against health, and that today some of the forms of this criminal offence have become anachronous, as due to the development of medicine and discoveries of new medications, HIV infection does not always entail fatal outcome”<sup>6</sup>. Criminal Code envisages criminal offences Failure to act in compliance with health regulations for combating dangerous infectious disease (Article 287) and Transmission of dangerous infectious disease (Article 288). In case of serious consequences or death due to the failure to act in compliance with regulations, more severe punishments are envisaged.

The Government of Montenegro, in the previous period, adopted a number of strategies closely related to response to HIV:

- Strategy of Development of Health Care System (2003 – 2020);
- Strategy of Safe Blood, adopted in 2006;
- Strategy of the Preservation and Improvement of Reproductive Health (2013 – 2020);
- Strategy of the Prevention of Drug Abuse (2013 – 2020);
- Strategy of the Development of Social and Child Protection (2013 – 2017);
- Strategy of the Improvement of Quality of Health Protection and Security of Patients (2012 – 2017);
- HIV/AIDS Strategy (2004 – 2009; 2010 – 2014).

HIV/AIDS Strategy 2010 – 2014 was developed on the basis of the National HIV/AIDS Strategy 2005 – 2009 and adopted in December 2010. The objective of both strategies is to maintain the status of a country with low prevalence of HIV infection, ensure universal approach to HIV infection and treatment and improve the quality of life of persons living with HIV through coordinated multi-sector approach.

Within the response to AIDS, national guides and protocols for HIV prevention and AIDS treatment have been development:

- Protocol for Anti-Retroviral Therapy (Government and GFATM);
- Prevention of Mother to Child Transmission of HIV (Government and UNICEF);
- Safe Blood (Government and GFATM);
- Sexually Transmitted Infections (Government and GFATM);
- Universal Protection Measures in Health Institutions (Government and GFATM);
- Voluntary Counseling and Testing (Government and GFATM);
- Rulebook on detailed contents of informative material, form of approval for donation of blood or blood components and contents and format of questionnaire for donation of blood or blood components, published in “Official Gazette of Montenegro” no. 10/2014.<sup>7</sup> This Rulebook integrated the Directive of the Commission 2004/33/EC as of 22 March 2004 on the implementation of the Directive 2002/98/EC of the European Parliament and Council in terms of certain technical provisions related to blood and blood components.

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<sup>5</sup> Explanation for the adoption of the Law on the Amendments to Criminal Code, Ministry of Justice: [http://www.skupstina.me/cms/site\\_data/AKTI%202010/obrazlozenje%20iymjena%20krivicnog%20zakona.pdf](http://www.skupstina.me/cms/site_data/AKTI%202010/obrazlozenje%20iymjena%20krivicnog%20zakona.pdf)

<sup>6</sup>

<sup>7</sup> “Official Gazette of Montenegro” no. 10/2014

## 5. ANALYSIS OF THE SITUATION AND PROBLEM DIMENSION

### 5.1 COUNTRY PROFILE

#### 5.1.1. Population Structure – Demographic Characteristics

According to the latest population census<sup>8</sup> conducted in 2011, there were 620029 citizens living in Montenegro, out of which number 50.61% or 313793 were women and 49.39% or 306236 men. The largest number of citizens live in Podgorica – 185937 or 30% of the population of Montenegro, then in Nikšić and Bijelo Polje. Around 50% of the whole population of Montenegro live in these three municipalities. Municipalities with lowest number of citizens are Šavnik – 2070, Plužine – 3246 and Žabljak 3569. Urban settlements record 392000 citizens, which represents 63% of the total population, while other settlements record 228009 citizens.

Montenegrin population is composed of Montenegrins – 44.98% (278865), Serbs – 28.7% (178110), Bosniaks – 8.65% (53065), Albanians - 4.91% (30439), Muslims – 3.31% (20537), Croats – 0.97% (6021), Bosnians – 0.07% (427) and other (population according to national or ethnic belonging and mother tongue).

Average age of the population in Montenegro is 37. Women on average are aged 38 and men are aged 36. Average lifespan for men is 68.48 and for women 73.78. Grown-up population is 76.5% of the total population. Population with working ability (between 15 and 64 years of age) is 68% of the total population, while the population aged 65 and above is 12.8%.

According to data as of July 2012, there are 8611 internally displaced persons and 3600 refugees<sup>9</sup> residing in Montenegro. While 80% Montenegrin population live in Montenegro since their birth, one fifth are emigrants from other countries. The largest number of migrants was recorded in nineties of the previous century, when almost 42 thousand people migrated to Montenegro. In 2011, slightly more than 4000 persons moved to Montenegro – 53.2% women and 46.8% men.

According to the criteria of the United Nations Development Programme (UNDP), Montenegro is treated as a mid-developed country and it occupies 54<sup>th</sup> position in 2011 Human Development Index/ HDI ranking<sup>10</sup>.

#### 5.1.2. Gender Equality

Gender equality does not promote uniformity of men and women, but appreciates their right to being different, and it also promotes equal division of benefits from activities they participate in, as well as just treatment, which may be equal or different treatment, but which is considered equivalent in terms of law, benefit, duties and opportunities. Gender equality in Montenegro has not only been recognized as human right, but it is regarded as closely connected to poverty reduction, enforcement of laws and political and economic empowerment of women.<sup>11</sup>

The state guarantees equality of man and woman and develops the policy of equal opportunities.<sup>12</sup> Constitutional Parliament of Montenegro, on 22 October 2007, adopted the first Constitution which, among others, stipulates the obligations of the State and guarantees fundamental human rights and freedoms, prohibits discrimination on any grounds and guarantees gender equality. Article 8, paragraph 2 prescribes that the implementation of special measures directed towards the creation of conditions of exercising gender equality shall not be regarded as discrimination. In

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<sup>8</sup> Monstat 2011

<sup>9</sup> UNDP, *Montenegro Economic Brief*, 2008

<sup>10</sup> UNDP/International human Development Indicators, 2011

<sup>11</sup> UNDP, 2008

<sup>12</sup> Article 18 Gender Equality – Constitution of Montenegro

Montenegro, there are two institutional mechanisms for gender equality: Parliamentary Commission for Gender Equality (founded in 2011) and Government Office for Gender Equality (active since 2003).

The first and the most significant law in the area of gender equality is the Law on Gender Equality<sup>13</sup> adopted by the Parliament of Montenegro on 24 July 2007. Article 2 of the Law on Gender Equality defines equal participation of women in all areas of public and private sector, equal position and equal opportunities for exercising their rights and freedoms and the use of personal knowledge and abilities for society development, as well as for the achievement of equal benefit from the results of work.

Action Plan for Gender Equality in Montenegro 2013 – 2017 is of special importance, as it envisages 9 strategic goals for the establishment of society of equal opportunities and removal of all forms of gender based discrimination. Strategic goal 4 which reads as follows: “Provision of high-quality and available gender sensitive health protection” envisages the improvement of methodology of collecting statistical data on the health of population according to gender, improvement of prevention and early discovery of malign diseases, prevention of sexually transmitted diseases and increase of the level of personal responsibility towards one’s own self and others, measures for the preservation of reproductive health of women, high quality availability of health protection especially to vulnerable group of women (women from rural areas, women with disabilities, women belonging to minorities (especially RE), women refugees and displaced persons, female victims of human trafficking), increase of sensibility and level of knowledge of health workers on gender sensitive health protection.

The approach to this area also involved the recommendations of the European Strategy for Improvement of Health and Sexual Rights and Reproduction, which calls member states of the Council of Europe to influence better education on sexual and reproductive health via national strategies, and create conditions for quality and systemic collection of relevant data classified according to gender. Montenegro signed the Convention on Elimination of All Forms of Discrimination of Women (2006), in which discrimination in national strategies of fight against AIDS is the subject of general recommendation 15 which advises signatory states to intensify efforts on raising awareness of public on dangers of HIV and AIDS, especially of women and children. The states are required to ensure that programmes of fight against HIV/AIDS obtain special place and attention, in terms of the right of women, as well as to take into account specific danger of women and susceptibility to HIV infection due to their reproductive role and their subordinate position.

During the implementation of previous National Strategy, special emphasis was placed on the issue of gender aspect of all implemented programmes and project. The existing laws, strategies and policies in Montenegro related to gender issue and their impact to HIV vulnerability were revised. Knowledge, attitudes and existing practices in institutions and civil society organizations were examined with regard to gender issues and their impact to HIV vulnerability, and basic guidelines were created for further action in terms of planning and implementation of gender sensitive programmes for end users, institutions, NGOs, media and overall public.

There are deep differences in causes and consequences of HIV/AIDS infection at men and women, which is the reflection of difference in biology, sexual behaviour, social attitudes and pressures, economic power and vulnerability. Due to cultural, social and economic status and pressures, women are frequently less able negotiate safe sex, due to the factors such as their lower status, economic dependence and fear from violence. Women and men are differently affected by HIV/AIDS epidemic. These differences are expressed on many levels of human activities and results in differential risk rate, approach to health knowledge and protection, interventions and disease management. At the same time, homophobia prevents many men to undertake

<sup>13</sup> “Official Gazette of the Republic of Montenegro”, no. 46/07

responsibility for their sexual practices. Men who live as “heterosexual”, but also have sex with men, are usually poorly prepared to practice safe sex. By the expansion of sex industry and sex market, with black economy related to drugs and crime and leading globalization, the number of male consumers of “sex products” is increasing. This growing widely spread availability and normalization of sex market encourages HIV spreading in numerous societal statuses.

Understanding of gender issues and HIV/AIDS dimension has to be a central part in sample analysis, planning and implementation of activities targeted towards the prevention of transmission or mitigation of disease impact. It is necessary to promote equality of men and women, as well as the respect and appreciation of different gender identities in all areas of national response to HIV epidemic, but also to adjust services and activities of HIV prevention to respond to the needs of women, men and trans-gender persons, especially those from multiple endangered population groups.

### 5.1.3 Poverty

Total poverty rate in 2009<sup>14</sup> was increased, as well as population depth and sharpness. The share of persons in poverty was increased from 4.9% in 2008 to 6.8% in 2009. Available indicators on the developments of average salaries and consumption in 2009 show that the increase of poverty rate is expected outcome of unfavourable global economic and financial trends. Poverty discrepancy, as indicator of poverty depth which shows average deviations of consumption of the poor from poverty, was increased from 0.9% in 2008 to 1.4% in 2009<sup>15</sup>, while poverty sharpness from targeted 0.3% achieved in 2008 increased to 0.5%.<sup>16</sup>

Poverty percentage below national poverty line<sup>17</sup> in 2006 was 11.30%, 8.00% in 2007, 4.90%, in 2008, 6.89% in 2009, 6.60% in 2010. Between 2008 and 2009, the share of consumption of 20% poorest population was decreased in overall consumption from 9.5% to 9.2%. Opposite to this, 20% richest citizens increased their share in the distribution of the overall consumption from 36.2% to 37.3%. In 2009, 20% richest citizens achieved consumption 4.1 times greater than consumption of 20% poorest citizens.

There is a significant difference in poverty scale between northern region and other parts of the country. Poverty rate in the northern region amounted to 13.2% in 2009, which represents 4.3% increase. A total of 30.3% population of Montenegro live in this region, while the share of the poor is 58.6%. Poverty rate in the central region is 4.0% and 4.4% in the southern region. In Montenegro, 75.2% poor individuals live in rural areas, while 24.8% live in urban areas. Rural population has been facing greater poverty risk against urban population.

The poor usually live in large households, while households with six members have the highest poverty rate. In households with more than two children, poverty risk is almost two-folds greater than national average.

Education significantly reduces poverty risk. Poverty risk is very low for persons with post-secondary or higher education, equally as for all members of households whose leader is a person with such educational degree. Remunerations, either from private or public sector, in majority of

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<sup>14</sup> Annual Report of Millennium Development Goals in Montenegro, 2011

<sup>15</sup> Indicator shows that in order to rescue all poor people from poverty, society should ensure the funds in the amount of 1.4% from poverty line per capita and then allocate those funds to each poor individual in the exact amount necessary so that their overall consumption reaches poverty line.

<sup>16</sup> Poverty sharpness measures relative deviation of consumption of the poor from poverty line, but taking into account the inequality among the poor. The assessments of population are based on national absolute poverty line obtained in accordance with the methodology recommended by the World Bank. The same methods and procedures were used for the assessments within the whole period 2006 – 2009, which ensure good comparability of results and identification of major trends in poverty.

<sup>17</sup> Monstat

cases ensure sufficient funds for a household so that its members may avoid absolute poverty.<sup>18</sup>

Some citizen groups are considerably poorer than others. Roma, Ashkali and Egyptians (RE) are socially most disadvantaged population with poverty rate of 36%, followed by refugees/displaced persons with 34% and beneficiaries of social allowances with 30%, pensioners with 15.7%, long-term unemployed with 12.3% and persons with disabilities with 11.9%.<sup>19</sup>

As a response to arising needs, the Government of Montenegro has adopted a number of strategies aimed at poverty reduction.<sup>20</sup> Generally speaking, since the adoption of Development Strategy and poverty reduction, approximately 100 million EUR is spent annually on different programmes, directly or indirectly contributing to poverty reduction in Montenegro. The programmes are developed in cooperation and with the support of the World Bank and European Commission through IPA funds.

Also, the system of social and child protection in Montenegro by its transfers encompasses more than 50% social allowances to poorest population groups. The programme of material family security and a number of other social allowances, such as free health protection, right to personal disability allowance, right to child allowance, subventions for consumed electricity of vulnerable categories are only some of the efforts taken with a view to reduce poverty consequences.

#### **5.1.4 Social Exclusion**

Social exclusion as one of the main problems of contemporary society entails the lack of social links and powers, disintegration, marginalization, social alienation and unfavourable position in political, economic and social sense. Social exclusion may be operationalized on three elements: unemployment (marginalization on the labour market), poverty and social isolation. Different integral elements of social exclusion influence one another, thus creating spiral of uncertainty which ends by permanent and multiple unfavourable circumstances. Under these circumstances, competitiveness of such individuals is not developed and their capabilities are not used, and this is what significantly influences the competitiveness of the system itself.<sup>21</sup>

Socially excluded individuals and groups find it hard to accede education, job, opportunities to earn, as well as social and other networks existing within local communities. Poverty and social exclusion are in cause and effect relationship, i.e. there is a two-direction process between them. Persons living in poverty are frequently marginalized and excluded from participation in different activities (economic, cultural and social) which are the norm for other people, while their approach to fundamental human rights may be limited. It is considered that refugees from RAE population in Montenegro have been facing extreme vulnerability and social exclusion. They are mostly represented among most vulnerable groups (people living in extreme poverty, without safe accommodation and educational opportunities). Several groups at risk of social exclusion have been recognized and they require special attention.

There are several identified groups at risk of social exclusion requiring special attention.

Some of these groups are of special relevance for HIV transmission, such as socially excluded young persons regarded as particularly susceptible to risky behaviour related to HIV. Although no research so far has shown a clear link between poverty and HIV (as epidemic driver), it should be

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<sup>18</sup> Analysis of Poverty in Montenegro 2008/ Monstat <sup>[1]</sup><sub>SEP</sub>

<sup>19</sup> National Human Development Report, UNDP/2009

<sup>20</sup> Development Strategy and Poverty Reduction (2003-2007); Strategy for Combating Poverty and Social Exclusion (2012- 2015); Strategy of Integration of Persons with disabilities (2008-2016); Strategy of Development of Social Protection of old Persons in Montenegro (2013-2017); National Action Plan for Decade of Roma Inclusion 2005- 2015: Strategy of Improvement of RAE Population (2012-2016) <sup>[1]</sup><sub>SEP</sub>

<sup>21</sup> G.Ćeranić, "Social Exclusion and Competitive Nature of Social System"

taken into account that reasons for social exclusion are not always and only based on economic spheres, but also on strong sociological factors which frequently include stigmatization and discrimination of particularly vulnerable categories of society.

Disadvantaged people (especially some women, youth and homo/bisexual men) have been facing increasing stress, social isolation and discrimination when accessing services of social protection, education, employment, accommodation and exercise of other rights. Men and women infected by HIV frequently lose their job or cannot retain it when AIDS starts developing, the edge of economic sustainability starts to fall down and earning opportunities of women are additionally limited.

Each socially responsible society tends to define measures for the reduction of the level of social exclusion and create atmosphere for the involvement of socially excluded persons into social life. Social institutions should provide individuals and social groups exposed to risk of social exclusion the opportunities for obtaining chances and resources necessary for full participation in economic, social and cultural life, as well as for enjoying life standards and benefits regarded as normal in the society they live.<sup>22</sup>

#### **Groups at risk of social exclusion**

**Family structures:** households with one member, self-parents, children without parental care, households with more than three children

**Age:** young people aged between 15 and 29, old persons (65+) and pensioners

**Criminal acts:** prisoners and ex-prisoners, young offenders, victims of crime and domestic violence

**Health:** persons with mental and physical disorders, persons living with HIV, drug users, alcohol users

**Sexual orientation:** sexual minorities (transgender and transsexual).

## **5.2. EPIDEMIOLOGICAL DATA**

### **Epidemiologic HIV/AIDS situation– 2014 Report**

In 2014 in Montenegro, 20 new HIV/AIDS cases were registered, so the incidence of newly-discovered infections in 2014 was 3.22/100,000 citizens. At the moment of defining diagnosis of HIV infection, 7 newly-registered persons were already in AIDS stadium (incidence of the affected: 1.13/100,000), while 13 persons were registered in the phase of asymptomatic HIV infection (incidence: 2.09/100,000).

This year another two female persons were registered with detected HIV infection in 2006 and since then until 2014, they were monitored and treated abroad. Also, during this year, two deaths caused by AIDS were recorded. Mortality is 0.32/100,000 citizens. Three newly registered HIV/AIDS cases in this year were female.

Distribution per gender and age of newly detected persons with HIV/AIDS in 2014 is shown in table 1.

<sup>22</sup> Joint Report on Social Inclusion 2003, European Commission

**Table 1. Distribution of HIV/AIDS persons per gender and age in 2014**

VARIABLE	CATEGORY	HIV+ (number)	AIDS (number)	DEAD (number)
GENDER	MALE	13	4	1
	FEMALE	-	3	1
AGE	0-4	-	-	-
	5-9	-	-	-
	10-14	-	-	-
	15-19	-	-	-
	20-24	-	-	-
	25-29	2	2	1
	30-34	7	3	1
	35-39	3	-	-
	40-44	1	-	-
	45-49	-	1	-
	50-54	-	1	-
	55-59	-	-	-
	60+	-	-	-

According to data from the received registrations, the way of infection transmission was unknown at 15% out of all new HIV/AIDS cases registered in this year, while in 65% cases this was homosexual or bisexual contact, and at 20% cases infection was transmitted by heterosexual contact.

The largest number of new HIV/AIDS cases was registered on the territory of municipality of Podgorica (11 cases). There are two registered cases on the territory of municipality of Kotor. Also, two cases were registered in Tivat and Bar, and one case in Ulcinj, Nikšić and Bijelo Polje (table 2).

**Table 2. Geographic Distribution of HIV/AIDS registered persons in 2014 in Montenegro**

Municipality	Number of HIV/AIDS	%
Podgorica	11	55%
Kotor	2	10%
Tivat	2	10%
Bar	2	10%
Ulcinj	1	5%
Nikšić	1	5%
Bijelo Polje	1	5%
TOTAL	20	100%

According to data submitted by health institutions to the Institute for Public Health, in 2014, 22141 persons underwent HIV testing (not including testing for research purposes which covered 470 injecting drug users and 120 men who have sex with men). Out of the total number of tested persons, 18623 persons were tested in transfusion units, 2197 persons were tested in the Centre for Medical Micro-Biology of the Institute for Public Health, 1321 persons were tested in services Voluntary counseling and testing for HIV (VCT). Data on the number of HIV tested persons in private laboratory institutions in Montenegro do not exist.

In 2014, 15120 voluntary blood donors were tested, out of which there were 5482 new donors. Among tested voluntary blood donors, no HIV positive persons were detected.

On other various grounds (voluntary, anonymous, referral letter, etc.), 6571 persons were HIV tested, so the testing rate, excluding voluntary blood donors, is 10.6 on 1000 citizens. The highest rates of tested persons in transfusion units, excluding voluntary blood donors, are of ambulance/hospital patients and their share in 2014 is 35.8%.

Testing in Montenegro, in recent several years, was significantly improved by the establishment of network of eight regional services for Voluntary counselling and testing for HIV (VCT) – Bar, Kotor, Herceg Novi, Podgorica, Nikšić, Bijelo Polje, Berane, Pljevlja). In these services, in 2014, 1321 persons at HIV risk were tested, which is 29% more than in the previous year. More than 71% all voluntary counselling and HIV testing was carried out in Kotor, Podgorica and Bar. Out of the total number of persons tested in counselling services in Montenegro, 18% persons belong to HIV exposed groups (men having sex with men, injecting drug users, sex workers).

### HIV Testing in Montenegro

Information on HIV infection development in Montenegro may be obtained on the basis of HIV testing and timely registration. This entails:

- Voluntary testing in the whole population
- Testing of blood and organ donors
- Testing of health workers
- Testing of pregnant women
- Testing of workers abroad
- Testing of patients in health institutions upon the request of doctors for diagnostic purposes
- Testing of high risk population group.

The scope of HIV testing, except from voluntary blood donors, is low. In the period from 1997, testing rate did not exceed 1 on 1000 citizens and it was far lower than in all parts of ex SFRY, excluding Kosovo. Since 1997, testing rate has been continuously increasing and the last for years have recorded significant increase (table 3).

**Table 3. Number of HIV tested persons excluding voluntary blood donors in Montenegro in the period 2004 - 2014<sup>23</sup>**

Year	Number of tested persons*	Rate**
2004	3496	5.6
2005	3549	5.7
2006	3838	6.1
2007	3838	6.1
2008	4229	6.7
2009	5812	9.0
2010	6492	10.0
2011	7257	11.7
2012	6781	10.9
2013	6970	11.2
2014	6571	10.6

Seroprevalence of HIV infection among voluntary blood donors may, with caution, may serve as indicator of prevalence of HIV infection in general population in countries with low level of HIV epidemic (table 4).

<sup>23</sup> Data on testing in private laboratories are missing; The rate of anti-HIV antibodies tested on 1000 citizens

**Table 4. Seroprevalence of HIV infection among voluntary blood donors in Montenegro in the period 2004-2014**

Year	Number of tested blood donors	Number of HIV positive persons	Rate on 100,000 tested 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

In 2014, according to data submitted by transfusion services, 77 health workers were tested and among them no HIV positive persons were detected. Within the period 1997 – 2014, 1751 health workers were tested, and only two tests were positive.

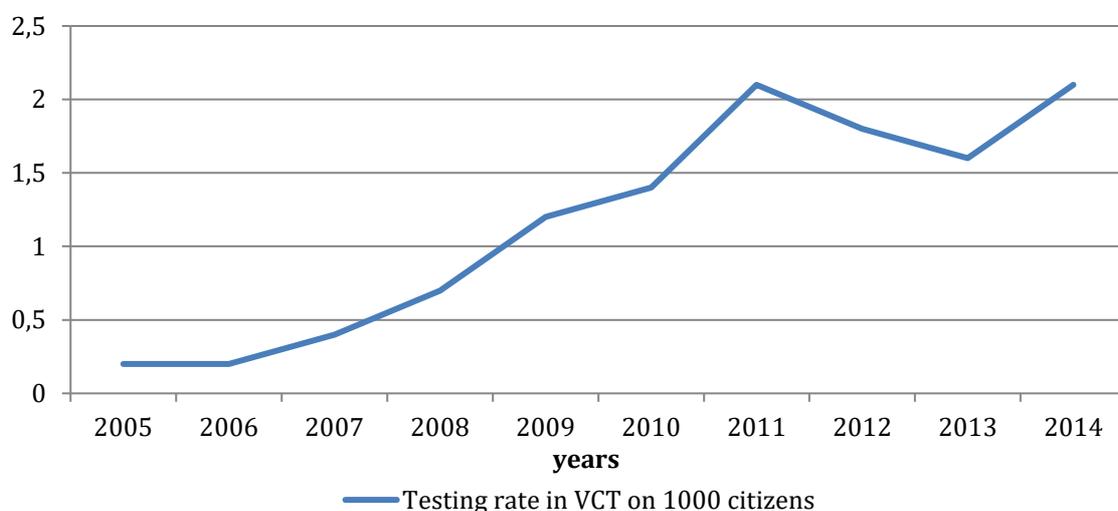
Data on tested pregnant women are not available. Only available data show that since the epidemic outburst, fourth children of HIV positive mothers had HIV antibodies detected.

Due to the lack of adequate records related to reasons for testing, there are no separate data on persons who underwent testing due to travel, employment, obtaining of immigrant visa or requests of work organization for the purpose of going abroad for work.

Within the period 1997 – 2014, the highest rates of tested persons, excluding voluntary blood donors, are at ambulance/hospital patients who are tested upon the requests of their doctors for diagnostic or pre-surgery purposes. Data showing that in this period 27398 hospitalized persons were HIV tested, out of which 54 were HIV seropositive persons, indicates that the fact that HIV positivity is largely detected at persons who have already entered symptomatic phase of HIV infection or disease. However, besides this, low seroprevalence rates are registered in the group of hospitalized patients tested upon the requests of doctors for diagnostic purposes.

Testing in Montenegro was significantly improved by the opening of the Service for Voluntary counseling and testing (for HIV) (VCT). The first Service started working in 2005 in Podgorica (in the Institute for Public Health), and later another seven services were opened in primary healthcare centres in seven municipalities of Montenegro (Bar, Kotor, Herceg Novi, Nikšić, Bijelo Polje, Berane and Pljevlja). Over the time, there was a considerable increase of the number of advised and tested persons in these centres (diagram 1).

**Diagram 1. Testing rates in VCT per years, period 2005-2014**



Observing HIV testing of persons more exposed to HIV, it can be concluded that it is insufficient and it represents an obstacle for consideration of realistic rate of HIV seroprevalence in these groups, and thus in general population. Valid and comprehensive data on testing of sailors, sex workers, men who have sex with men do not exist.

### Characteristics of HIV Infection in Montenegro

HIV/AIDS epidemic in Montenegro started in 1989 when the first AIDS case was registered. It is assumed that this was really the first case, as the reports of competent services from other republics of ex SFRY did not record cases from Montenegro. According to revised data from HIV/AIDS Registry, from epidemic outburst in 1989 to the end of 2014, 175 HIV infected persons were registered, out of which number 88 persons were in AIDS stadium at the moment of infection detection (50.3% all registered HIV positive persons), and 87 were either in asymptomatic phase or in symptomatic non-AIDS phase of HIV infection. In the same period, 41 persons died of AIDS (table 5).

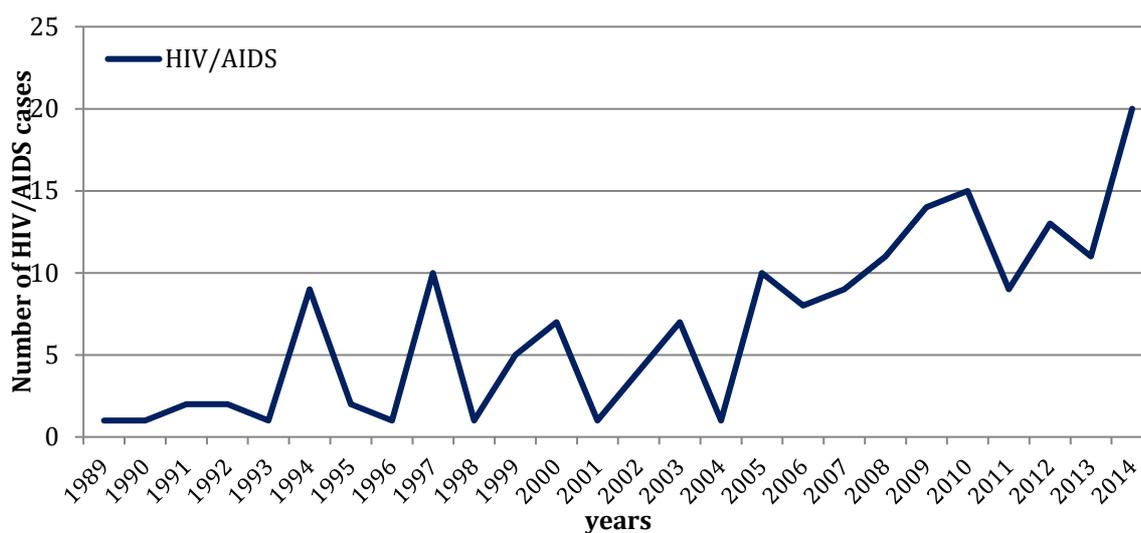
**Table 5. Registration of HIV infection, AIDS and deaths caused by AIDS per years**

Year	Number of HIV cases	Number of AIDS cases	Deaths caused by AIDS
1989	0	1	0
1990	0	1	1
1991	0	2	0
1992	0	2	3
1993	0	1	0
1994	4	5	4
1995	1	1	3
1996	0	1	1
1997	5	5	1
1998	1	0	1
1999	2	3	2

2000	2	5	1
2001	0	1	3
2002	3	1	3
2003	5	2	1
2004	0	1	1
2005	5	5	0
2006	3*	5*	1
2007	6	3	2
2008	4	7	1
2009	8	6	2
2010	8	7	4
2011	7	2	2
2012	6	7	1
2013	4 <sup>24</sup>	7	1
2014	13	7	2

If the number of HIV infected persons is regarded against the years of detection of infection, increasing trend has been noticed recently (diagram 2).

**Diagram 2. Number of HIV/AIDS cases, period: 1989-2014 in Montenegro**

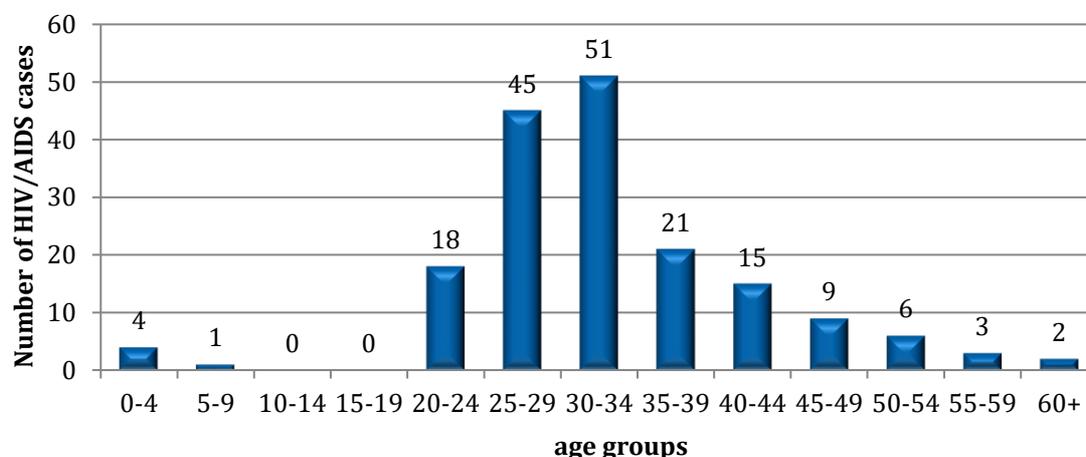


Significantly larger numbers of infected persons represent male persons (147 persons), so the ratio of all men and women infected by HIV/AIDS from the epidemic outburst is 5.3:1.

Majority of HIV infections are diagnosed at the age 20-39 (77%). During the detection of HIV infection, there were 3% persons below the age of 20 and 20% above the age of 39. Most infections (91%) were detected at the age which belongs to working and reproductive age from 15 to 49 (diagram 3).

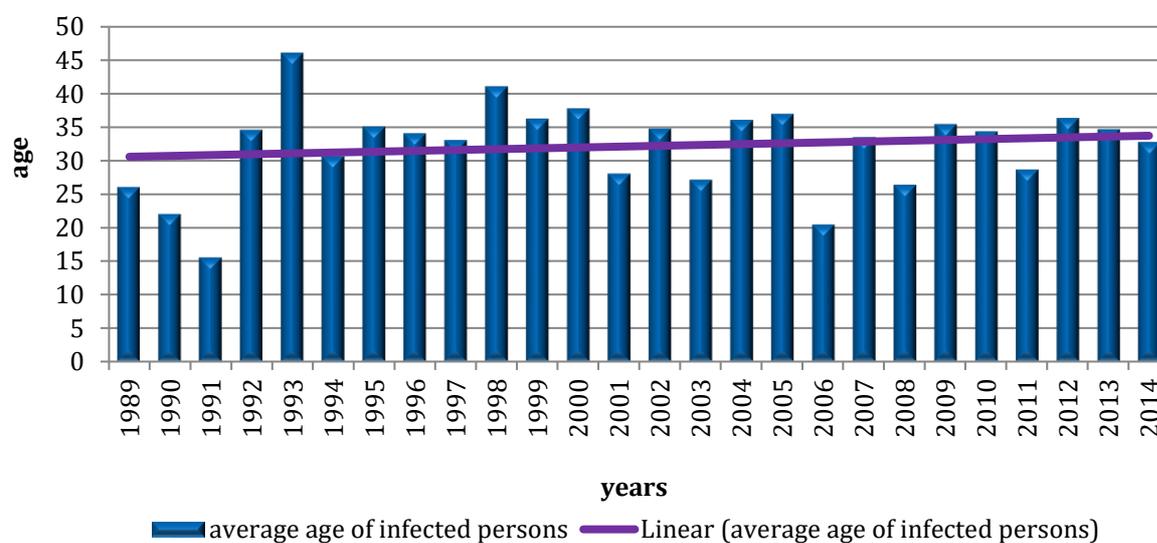
<sup>24</sup> Two HIV positive persons diagnosed in 2006 were registered in 2014; One HIV positive person diagnosed in 2013 was registered in 2014.

**Diagram 3. Age distribution of HIV infected persons at the moment of detection, period 1989 - 2014**



The trend of average age distribution during HIV infection detection shows a slight increase, but it is still maintained between 30 and 35 years of age (diagram 4).

**Diagram 4. Trend and average age distribution of PLHIV per years, period 1989 - 2014**

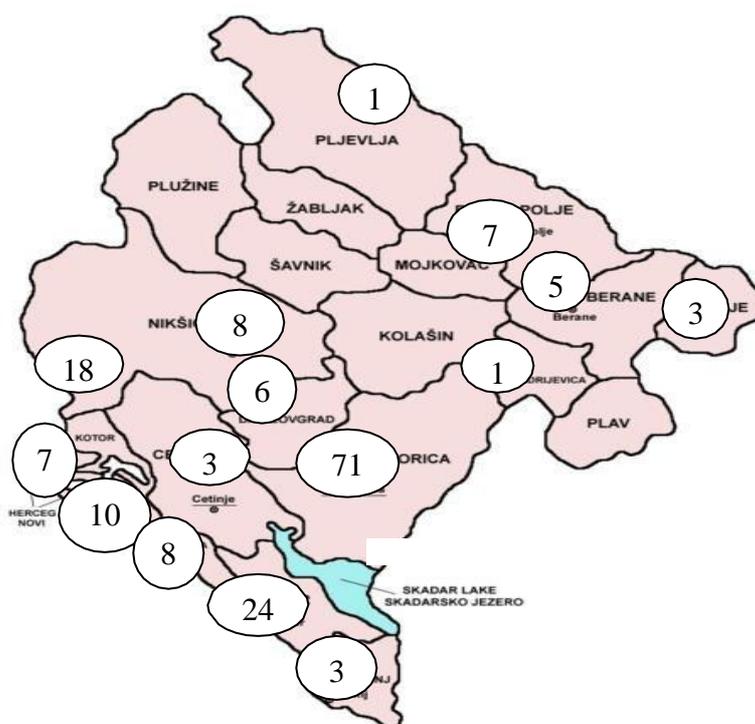


HIV/AIDS cases are registered in 5 out of 21 municipalities of Montenegro. Majority of cases are registered in coastal region (40%) and Podgorica (41%). Geographic distribution of HIV infected persons in Montenegro is shown in table 6 and image 1.

**Table 6. HIV/AIDS cases per municipality in Montenegro from 1989 to the end of 2014**

Municipality	Number of HIV/AIDS cases	%
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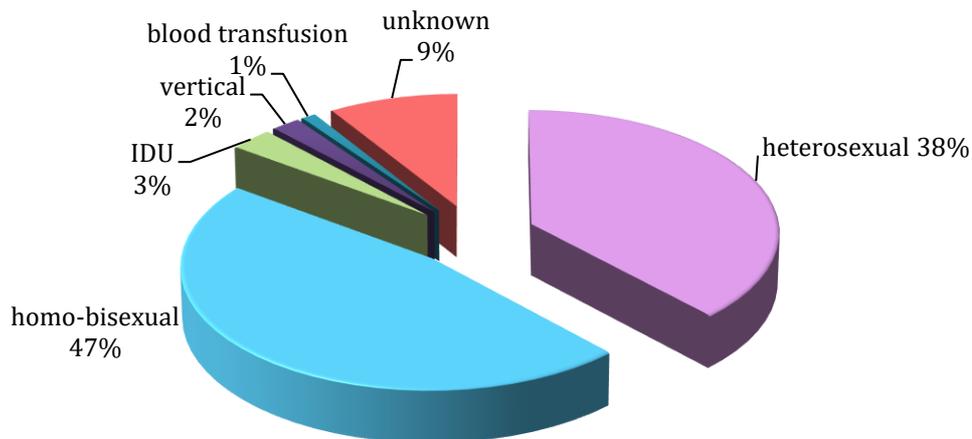
Andrijevica	1	0.6
Bar	24	13.7
Budva	8	4.6
Berane	5	2.8
Bijelo Polje	7	4.0
Danilovgrad	6	3.4
Kotor Nikšić	18	10.3
Pljevlja	8	4.6
Podgorica	1	0.6
Rožaje	71	40.6
Tivat	3	1.7
Ulcinj	10	5.7
Herceg Novi	3	1.7
Cetinje	7	4.0
	3	1.7
<b>TOTAL</b>	<b>175</b>	<b>100%</b>



Municipalities and largest cities and towns of Montenegro  
Opštine i veći gradovi Crne Gore

Leading way of HIV transmission in Montenegro is sexual transmission (85%). This transmission way is the most frequent one and since epidemic outburst it has maintained increasing trend. Contrary to sexual transmission, HIV infection transmitted via blood, either related to injecting drug users or persons who received infected blood via transfusion in health institutions, has remained rather rare (diagram 5).

**Diagram 5. Distribution of HIV/AIDS cases in relation to mode of transmission in the period 1989 - 2014**



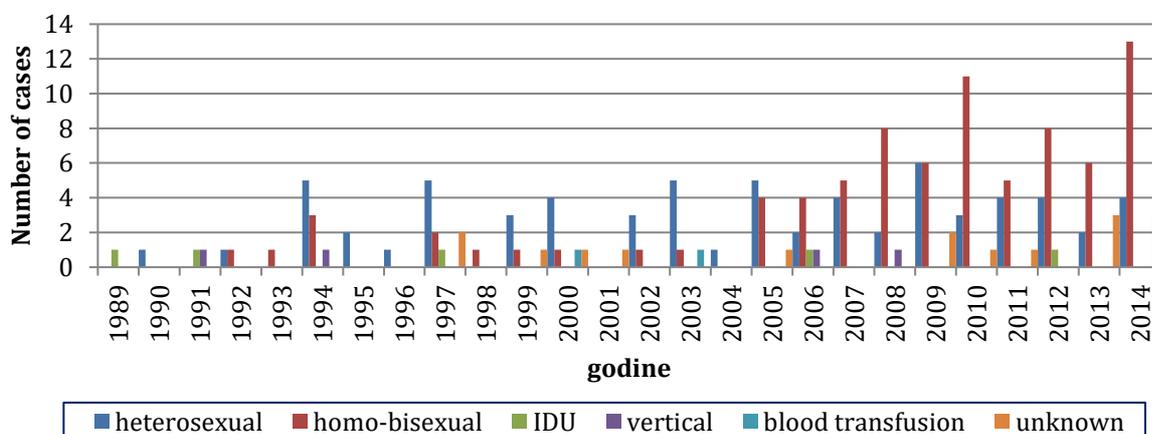
Probably among persons who declared as heterosexual, there is a certain percentage of those who are homosexual and bisexual, but who are afraid to declare so due to the existing discrimination and stigma in our society.

Also, it is assumed that the category with the unknown, or undefined transmission (9%) represented only by male persons, is in majority cases related to homosexuals or bisexuals who are unwilling to declare, so it is necessary to invest further effort to destigmatize and educate this risk group.

Out of 4% HIV registered persons infected by blood, 1% persons were infected by infected blood or its derivatives in health institutions (out of Montenegro) and 3% persons were infected by injected consumption of drugs.

Vertical HIV transmission was registered at 4 children i.e. in 2% cases. Distribution of HIV/AIDS cases per years, against the way of virus transmission, is shown in diagram 6. It can be shown from the diagram that since 2005, dominant way of HIV transmission is homo-bisexual. This may be explained by the fact that in recent years, persons more easily provide data on their sexual behaviour, which is the result of increased trust and great efforts invested by society (especially non-governmental sector) on the reduction of stigma and discrimination towards sexual minorities.

**Diagram 6. Distribution of HIV infected persons by years and transmission mode in the period 1989 - 2014**



Analysis of distribution of HIV infection against groups at risk indicates that in Montenegro the most exposed group to HIV infection are persons belonging to the population of men who have sex with men (47%), sailors (8%), while high percentage of tourism workers (10%) is probably the reflection of great population of these workers in Montenegro (over 13,000), rather than of their risky behaviour.

According to data from the Registry, at the end of 2014, 134 HIV infected persons lived in Montenegro (115 men and 19 women), making the prevalence of this infection in Montenegro 0.02% thus being one of the lowest in the region and Europe.

The survival of persons with AIDS was poor during the first ten years of epidemic, when the survival of over 50% persons after being diagnosed with AIDS was below 12 months. The situation was significantly improved and today there are over 70% persons living with AIDS affected after the year of 2000.

### **Mortality caused by AIDS**

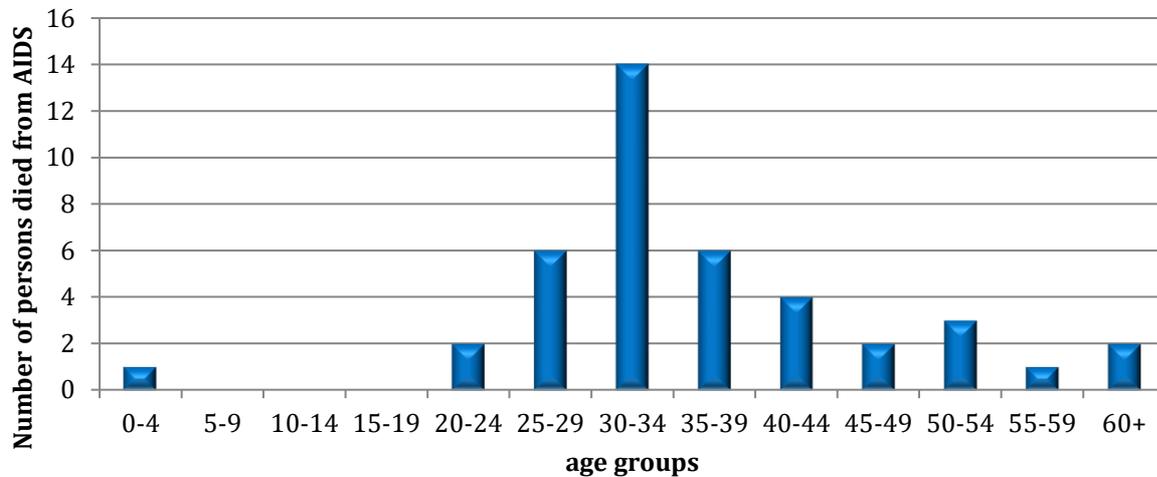
Data on mortality represent the greatest problem in monitoring the HIV infection trends in Montenegro due to inadequate registration of AIDS caused deaths. Several factors influence this phenomenon. The most important one is the fact that certain number of HIV/AIDS persons moved from Montenegro and cannot be monitored any more, then the fact that all persons with AIDS do not die in hospitals where the death and its cause can be registered, i.e. the deaths of persons with AIDS who died out of hospitals, usually due to the fact that their HIV status is unknown, are registered as caused by other disease or impact.

In Montenegro, from epidemic outburst to the end of 2014, 41 deaths caused by AIDS were registered (43% of all affected by AIDS), 32 men and 9 women. Majority of the dead (68%) were aged between 30 and 49 (table 7 and diagram 8).

**Table 7. Gender and age structure of persons died of AIDS in Montenegro from epidemic outburst to the end of 2014**

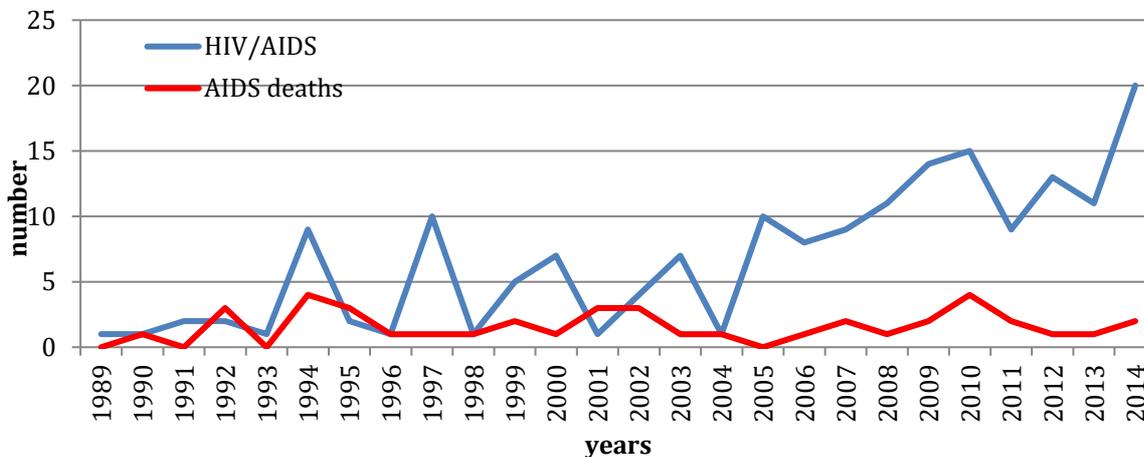
VARIABLE	CATEGORY	NUMBER
GENDER	MALE	32
	FEMALE	9
AGE	0 – 4	1
	5 – 9	-
	10 – 14	-
	15 – 19	2
	20 – 24	6
	25 – 29	14
	30 – 34	6
	35 – 39	4
	40 – 44	2
	45 – 49	3
	50 – 54	1
	55 – 59	2
60+	-	

**Diagram 7. Age distribution of persons who died of AIDS in Montenegro from the beginning of epidemics to the end of 2014**



Decreasing trend of deaths caused by AIDS is noticed in the regarded period against the rise of the number of HIV registered persons (diagram 9). Such trend may certainly be explained by the effects of HAART (High active antiretroviral therapy). The highest AIDS mortality rate in Montenegro was recorded in 1994 and amounted 0.64 on 100,000 citizens.

**Diagram 8. Distribution of HIV cases and death cases caused by AIDS from 1989 to the end of 2014**



**Assessment of prevalence of HIV infection**

On the basis of the number of registered HIV infections and the number of persons who died of AIDS, the prevalence of HIV infection was calculated by the end of 2014 and amounts 0.02%. If the calculation for prevalence is made on the population aged 15 – 49, according to the methodology and recommendations of WHO and UNAIDS, then the prevalence of HIV infection in Montenegro by the end of 2014 would be almost four times higher than registered (153 on 100,000 citizens aged 15 – 49, i.e. 74.7/100,000 in the whole population). According to this assessment, there are 20.4% infected women out of all infected citizens.

WHO methodology cannot be used with certainty for obtaining realistic assessment of HIV prevalence in Montenegrin population due to the lack of basic parameters related to the size of all groups at risk, the lack of data on HIV seroprevalence among certain groups, as well as the lack of data of HIV testing pregnant women. However, since the assessment of situation is needed for each serious analysis, and it is even more needed for strategic planning, this assessment was conducted with available data and assumptions.

### **Sexually transmitted infections**

In 2013, 30 cases of sexually transmitted infections were registered with incidence of 4.8/100,000. The incidence is approximately 15% lower than in the previous year. Registered rate of gonorrhoea, syphilis and genital chlamydia has not been drastically changed with regards to the previous year (Annual Report on Infectious Diseases 2013, Institute for Public Health). The number of registered infections is far below the actual number, primarily as the consequence of non-registration of these diseases by doctors. Probably, significant number of these infections is treated by doctors, without requiring and sending patients to additional microbiological examinations, which considerably influences official registration of persons affected by these diseases. Also, taking into account stigma which accompanies sexually transmitted infections and the lack of trust in terms of diagnosis, some persons treat themselves on their own by buying medicines in pharmacies.

The list of sexually transmitted infections and diseases required to be registered was extended ten years ago by introducing the obligation to register genital chlamydia, which is almost unregistered by health workers. The following sexually transmitted infections were registered 2013: hepatitis B (12 cases), syphilis (6 cases) and gonorrhoea (12 cases).

### **Hepatitis B**

As in 2003, immunization against hepatitis B was introduced into the programme of obligatory immunizations, it is expected that in the forthcoming period there will be a better control over this disease, although better diagnostic possibilities may lead to the increase of the number of registered cases in the next period (moving of certain number of cases from viral hepatitis whose causes could not have been differentiated these years).

All cases of this infection are registered among adult persons (persons aged above 20). In 2013, there were no registered cases of this disease at children of school age which is the consequence of vaccination of children introduced in 2003. With regards to gender distribution, it is noticed that infection is 83% more frequently registered among male persons.

Current problem is immunization of persons from most at-risk groups. Justification for this fact can be found at inaccessible risk groups (injecting drug users, sex workers, men who have sex with men, etc.), but it is difficult to find explanation for insufficient response of health workers.

Relevant data on HbsAg for the territory of Montenegro are insufficient, partially due to unbalanced diagnostic capacities on the territory of the country, as well as due to inefficiency in registration of such cases by health institutions. In 2013, 7 cases of HbsAg were registered.

### **Syphilis**

It is assumed that this infection, as well as other sexually transmitted infections, is not registered to the extent it really exists, so it is difficult to conduct adequate analysis. However, the very fact that the disease is registered indicates the need to improve supervision over sexually transmitted infections, especially among the populations with increased risky behaviour (sex workers, men who have sex with men, injecting drug users, etc.).

In 2013, with regards to age distribution, it was noticed that the infection was equally registered among genders.

## **Gonorrhoea**

Although the largest number of persons with this disease were registered in 2013, low value incidence is still recorded, primarily due to inadequate registration of persons affected by this disease.

### **National protocols on HIV prevention and treatment**

- Protocol on Antiretroviral Therapy
- Prevention of Mother to Child Transmission
- Safe Blood
- Sexually Transmitted Infections
- Universal Protection Measures in Health Institutions
- Voluntary Counseling and Testing.

### **Most relevant challenges**

Current assessments of the size of populations at risk need to be ensured in order to provide more precise assessments of intervention coverage.

Interventions aimed at the reduction of stigma and discrimination towards persons living with HIV and persons with increased risk of HIV infection need to be improved (Stigmatization by health workers, police, as well as general population result in low level of testing and counseling and more difficult access to populations at risk. The aforesaid, together with the lack of trust, has been identified as the main barrier for the implementation of AIDS Strategy.

Adequate programme of psychosocial support for PLHIV needs to be developed (Although the treatment is available to all HIV positive persons, the availability of services for care and support is inadequate).

High quality studies among PLHIV and MARP, especially MSM have to be conducted, so as to ensure that interventions correspond to their needs.

PLHV and MARP have to be involved in response to HIV. Criminalization of HIV risk behaviour also hampers the access to populations at risk and their access to information and services. Gender and sexual discrimination and violence, as well as poverty, lead to risky behaviour (selling sexual services).

## **6. STRATEGIC PROGRAMME AREAS**

National HIV/AIDS Strategy 2015-2020 is based on comprehensive approach and inter-sector cooperation and recognizes five strategic programme areas of priority for action: Stigma and discrimination; Prevention; Treatment, care and support; Supervision and monitoring; Coordination and partnership.

Programme areas are focused on the creation of safe and supporting environment, HIV prevention among most-at-risk persons, institutions and general population and provision of accessible and equal treatment, care and support for all persons living with HIV. At the same time, the Strategy, via its programme areas, tends to establish efficient supervision and monitoring to ensure the response to HIV/AIDS aligned with the existing situation and needs, as well as to the creation of sustainable mechanisms of coordination and partnership in response to HIV/AIDS as the prerequisite of success of the proposed activities.

### **6.1 Stigma and discrimination**

The main obstacle in the access to comprehensive interventions in the area of HIV prevention are stigma and discrimination towards the majority of most at HIV risk populations (especially MSM), as well as the lack of trust in health and other relevant services. However, experience of

persons with HIV related to stigma and discrimination were not examined by the research. There are only the reports on discriminations and stigma to Montenegrin HIV Foundation, CAZAS and Juventas by PLHIV and members of their families, but they are not adequately documented.<sup>25</sup>

The research: “Knowledge, attitudes and sexual behavior related to HIV of young people aged 15 to 24 in Montenegro”, conducted in 2012<sup>26</sup> by the Institute for Public Health, shows that the level of non-acceptance of persons with HIV is on concerning low level. In this research, contrary to the previous one conducted in 2009, participants from southern and northern region expressed equally stigmatizing attitudes. Half the examinees from southern region said that they would not eat together with a HIV infected person, while two thirds of young people would not buy food from an infected seller. One third of young people think that persons with HIV should be excluded from all working positions at which they might be in contact with other people, while half of them think that persons with HIV should be registered in police files.

The research related to stigma and discrimination among health workers (private dentists refused to take part and pharmacists were not covered by this research) did not provide expected results, but the examinees still show low level of knowledge on HIV, and the attitudes of health workers show that there is still high level of stigma towards the persons living with HIV. Only 11% examinees health workers did not express any type of judgment or blame for PLHIV. One fourth of examinees think that HIV infected persons by sex or drug abuse have deserved this disease, and there is a similar number of those who think that the name of persons living with HIV should be published. Almost one third of health workers are afraid when working with PLHIV.<sup>27</sup>

During the implementation of previous strategy, numerous activities were implemented aimed at the reduction of stigma and discrimination of persons living with HIV and persons with risky behaviour with regards to HIV and elimination of gender violence. These activities were mostly implemented by partners from NGO sector: CAZAS, Juventas, Montenegrin HIV Foundation, Monte Vita, SOS Line for Women and Children Victims of Violence Podgorica.

Within the period 2010 – 2014, 86 health workers were covered by some training, directly or indirectly related to HIV. At the same period, training covered 931 persons from other institutions such as social and police services, judiciary authorities, media and NGO. Training on gender equality, organized by NGO, in the context of HIV/AIDS, stigma and discrimination, principles of harm reduction, the rights of MSM, drug users, sex workers, prisoners, communication with patients/clients and relevant national and international regulations and laws related to HIV, for: a) health workers and associates; b) judges, prosecutors, attorneys, police, prison staff, social workers and other civil servants; c) students of medicine, stomatology and social work. Training organized by Juventas, Monte Vita, PHCC Podgorica and SOS line Podgorica targeted 93 judges, attorneys and public prosecutors in the period 2010 – 2014.

Numerous publications were printed, as well as brochures and other informative and educational material related to stigma and discrimination, publication: “HIV and AIDS Guide for media – advice for editors and journalists reporting on HIV in Montenegro” was created<sup>28</sup>, many workshops were organized for young people along with informative educational campaigns followed by programme activities<sup>29</sup>. Campaigns were organized on World AIDS Day (1<sup>st</sup> December 2010), St. Valentines Day (14<sup>th</sup> February 2011), World Health Day (7<sup>th</sup> April 2011), Candle Light Memorial (15<sup>th</sup> May 2011). Street performances were organized, as well as distribution of

<sup>25</sup> Statements from NGO MHF, NGO CAZAS and Services for VCT of the Institute for Public Health

<sup>26</sup> Research on knowledge, attitudes and behaviour related to HIV/AIDS in the population of young Roma and Egyptians in Montenegro: A.Ljaljević, B.Mugoša, N.Terzić, I.Labović, Institute for Public Health, 2012

<sup>27</sup> Study of knowledge, attitudes and behaviour related to HIV/AIDS among health workers in Montenegro: A.Ljaljević, B.Mugoša, N.Terzić, I.Labović, Institute for Public Health, September 2012

<sup>28</sup> HIV and AIDS Guide for media – advice for editors and journalists reporting on HIV in Montenegro, July 2012

<sup>29</sup> Project “Anti-Stigma” implemented with the support of GFATM

informative educational material, condoms, T-shirts, etc. Stop AIDS caravan visited Nikšić, Danilovgrad, Žabljak, Kolašin, Mojkovac, Podgorica, Cetinje, Bijelo Polje, Berane, Rožaje and Bečići.

The work of the Protector of the rights of patients was monitored and informative educational campaign was conducted for patients by the placement of info corner in primary health care centres in Montenegro<sup>30</sup>. Within these project activities, monitoring of certain media reports was conducted, but without accompanying assessments, conclusions and recommendations. Only the frequency of the mentioned terms was monitored without detailed analysis, and only for three dailies. Continuous monitoring of media presentation on HIV and AIDS does not exist. Periodical analyses of compliance of laws and public policies with ratified international documents are also missing. In 2012, with professional support of NGO Human Rights Action (HRA), Montenegrin HIV Foundation created summary and analysis of Montenegrin laws together with proposals for the improvement of solutions related to the protection of persons living with HIV, with reflections on international regulations and practice.

Summary and assessment of legislation related to juveniles were not created. Article 64 of the Family Code is related to the right of a child to the provision of best possible life and health conditions for appropriate and complete development.<sup>31</sup> Child aged 15, able to judge, may provide consent for taking over medical intervention. However, in Protocol for VCT<sup>32</sup> despite this Article, a juvenile may be counseled or tested only with the presence of a parent and/or custodian.

#### *Conclusions:*

Activities have to be continued so as to lead to the improvement of institutional mechanisms necessary for elimination of stigma and discrimination of persons living with HIV and persons at HIV risk. For such purpose, the assessment of compliance of national legislation, public policies and international standards should be continuously conducted and initiatives for improvement should be launched based on research recommendations. At the same time, the analysis of curricula for secondary vocational, post-secondary and higher education of health profession should be done with regards to HIV and stigma and discrimination of persons living with HIV. Continuous assessment of media presentation of topics on HIV and AIDS in Montenegro is essential in order to examine the accuracy of information, terminology, attitudes and identify examples of discrimination.

Research in potential discrimination of persons living with HIV which also includes stigma index research is of paramount importance for consideration of situation in this area. Also, activities contributing to the reduction of stigma and discrimination should be continued through education of staff in health, social, police and other services and competent authorities on discrimination related to sex, gender, rights of persons living with HIV and most-at risk of HIV persons prescribed both by national legislation and international documents. The results of previous project also indicated the necessity of promotion of rights of patients within general population.

## **6.2. Prevention**

In the last five years, Government of Montenegro and NGO, supported by GFATM and UNDP Montenegro, have intensified the efforts in the area of prevention of most at-risk populations. Key target groups within prevention programmes implied drug users, sex workers and men having sex with men, prisoners, sailors, hospitality workers, RE population, youth, including MARA.

In prevention area, the focus has recently been mostly given to programmes of harm reduction

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<sup>30</sup> Project "Rights of Patients" (Dutch Embassy – MATRA programme)

<sup>31</sup> <http://www.sluzbenilist.me/PravniAktDetalji.aspx?tag=%7B79054F65-3C37-4FC8-912B-49704386C652%7D>

<sup>32</sup> Protocol for Work of Counseling Service for HIV/AIDS Prevention, Institute for Public Health, 2007

among IDU, prevention of HIV and STI among MSM, sex workers, youth and general population, prevention among persons in institutions in which HIV risky behaviour is more present (such as prisons, hotels), army and uniformed officers including sailors, and socially excluded young people. The implemented programmes were aimed at decreasing the risk of HIV transmission and other sexually transmitted infections, improving the quality of life of people in high risk of HIV and their families, improving the access to health and social welfare services, and creating better policies and interventions in the area.

The prevention area also implied services for categories of population which are in high risk of HIV infection and those who already live with this infection. Four trainings have been held in this period for people who live with HIV and members of their families, for a total of 30 persons. Trainings implied building personal capacities to accept the disease, literacy when it comes to therapy and training on healthy lifestyle. Just one organization, i.e. an association of patients was established between 2010 and 2014.<sup>33</sup>

Involvement of the members from target population facilitated the access to most populations at high risk, especially IDU and MSM. Many trainings on the rights and HIV/AIDS were conducted among health workers, policemen, officers in the Institution for Execution of Criminal Sanctions, and social workers. A rulebook for operations of the counselling office for LGBT population and basic job description for field workers was drafted, as well as for social workers, doctors, psychologists who work on the field and drop – in centres for sex workers, MSM, IDU. Drafting a strategy for LGBT has been initiated, amendments to the legislation as well, with many implemented campaigns and strengthening LGBT community. Several informal LGBT groups were established, including a formal NGO, known for its results achieved – Queer Montenegro.

The coverage of target groups was excellent. A programme for decreasing the risk of HIV transmission with prisoners maintaining a criminal sanction solely covers around 300 prisoners annually, whereas around 800 contacts are made.<sup>34</sup> A programme for harm reduction among IDU, just in CAZAS in the period from 2010 to 2014, through field work in 9 towns and two drop in centers in Bar and Podgorica, covered 24023<sup>35</sup> clients, distributed more than 400 000 sterile needle and syringes, and trained more than 20 field workers. During one year, a programme in Juventas' Drop in Centre is used by 650 to 700 persons, whereas more than 3000 contacts are made. This programme distributes around 12000 syringes and the same amount of needles. A programme of providing the service to sex workers is used by cca. 200 person annually, mainly females, whereas more than 2000 contacts are made, and around 15 000 condoms are distributed, and over 3000 needles.<sup>36</sup>

Through peer learning programme, implemented from 2003 onwards in different intensity, more than 50 peer educators for HIV and STI have been trained, and more than 390 workshops have been organized for youth in Montenegro. The activities of the Youth Club, as a holder of peer learning programme in CAZAS, included more than 11000 young persons<sup>37</sup>. Four raising awareness campaigns have been carried out, emphasizing the importance of using condoms, and distributing condoms and IEC materials at different manifestations<sup>38</sup>.

During 2014/15 a subject Healthy Lifestyle (including the topics of HIV and STI) was introduced in 13 additional schools. It was elected by around 3500 students from 89 elementary schools in

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<sup>33</sup> Montenegrin HIV Foundation – activities financed from GF project

<sup>34</sup> Juventas report

<sup>35</sup> Clients undergoing such services are being recorded on a half-year basis. Total sum of 24203 clients represents a simple sum of the unique ones on a half year basis between 2010 – 2014. Average number of clients on a monthly basis is 450!

<sup>36</sup> Juventas report

<sup>37</sup> Programme “Mladi mladima bez straha“(ENG: Young persons to young persons without fear) supported through GFATM

<sup>38</sup> Project „Condom usage promotion“ implemented with a support of GFATM

161 classes (around 45%). In high school, the subject was elected by 700 students from 13 schools in 32 classes (around 30%).

A lot of informative material on HIV and STI was prepared and distributed to sailors, prisoners and RAE population. The fact that seaside area accounts for 39.3% of HIV/AIDS cases in Montenegro, out of which one third is registered in Bar, urges the need for further implementation of HIV/AIDS prevention projects among sailors in this town. It is also supported by the fact that thanks to present activities on HIV/AIDS prevention among sailors, the representation of sailors in National Registry of HIV is obviously decreasing (in 2009 – 13%; in 2013 – 9%).<sup>39</sup>

There has been no survey on risky behaviour related to HIV among military and uniformed services or prisoners. Since Montenegro is about to join North Atlantic Treaty Organization (NATO), it is necessary to involve members of Army and peace – keeping forces in HIV prevention and treatment programmes.

Methadone maintenance treatment programme is implemented in Primary Health Care Centre in Podgorica, however, buprenorphine therapy has not still been included in primary health care and Institution for Execution of Criminal Sanctions.

*Safe blood* – In the recent five years, the Government emphasized the maintenance of quality standards, increase in voluntary blood donation, especially among students and young people, and the establishment of data base on voluntary blood donors. The equipment and new premises of the Institute for Blood Transfusion of Montenegro were provided, where total processing of all blood units collected on the territory of Montenegro will be performed, in line with quality system standards, being in its final phase. Harmonization of legislation with EU regulations has been completed. Voluntary blood donation is being carried out, whereas the implementation of quality system is ongoing. A Rulebook on Quality for prescribed documentation<sup>40</sup> has been drafted, and education for transfusion staff was carried out (doctors and medical technicians), clinic doctors who prescribe blood in treatment and nurses at departments where blood is applied in treatment.

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*Universal protection measures* are applied, even though there is a need for further capacity development of people employed in health system, training of dentists, police and staff in prisons and establishing measures to prevent HIV transmissions at a workplace.

### *Conclusions:*

In terms of prevention activities, it is necessary to draft guidelines for programme of harm reduction in relation to HIV with drug users and continue with provision of basic package of interventions for prevention of HIV and STI for most at - risk populations. Drafting of an Expert Methodological Instructions for substitution therapy for drug users is required, including guidelines for pregnant women drug users, new-borns and postpartal women. The availability of methadone therapy has to be ensured within primary health care system, buprenorphine has to be included as a therapy in primary health care and the Institute for Execution of Criminal Sanctions, and methadone therapy established within the Institute for Execution of Criminal Sanctions.

Special attention has to be paid to ensuring sustainable, easily accessible service to persons living with HIV and persons in risk in relation to HIV, based on confidentiality and friendly approach. To this end, it is necessary to design a programme and train the staff for field work, as well as find a systemic solution for implementation of services on the field and in drop – in centres (testing, medical checks, mobile units, etc.) Special efforts should be invested to create conditions for

<sup>39</sup> Report of NGO 'Protection' (Zaštita) from Bar

<sup>40</sup> (SOPs, EOPs, Flow Charts, process mapping, regular controls of blood components, in line with recommendations within the Guide for preparation, usage and quality assurance of blood components EDQM, Council of Europe, etc.).<sup>[1][2]</sup>

<sup>41</sup> Report of the Institute for Blood Transfusion

licensing professional and field workers, for accreditation of the programme and ensuring institutional support to existing drop – in centres for MSM, IDU and SW.

In order to align existing services with the needs of users, it is important to implement trainings on HIV/AIDS and STI for representatives of government and non–governmental sector working with persons in higher risk of HIV, but it is also important to implement specific trainings which will enhance the prevention among target groups in risk themselves. Special focus shall further be given to education in any sense of young persons in educational institutions and general population. Greater availability of free of charge condoms should be ensured, followed by making condom machines more popular, distributing condoms in hospitality facilities, and networking in the area of condom promotion through involvement of institutions, NGOs and private sector (pharmacies, hospitality facilities, hotels, etc.).

Aiming at preventing occupational exposure to HIV in health system and other professions, materials and training on applying universal protection measures should be ensured. However, general population, especially young people, should also be motivated for voluntary blood donation.

### **6.3. Treatment, care and support**

The application of antiretroviral therapy in Montenegro started back in 1995, when zidovudine emerged as a first nucleoside reverse transcriptase inhibitor (NIRT) of HIV. From 1998, clinical practice introduced a combined antiretroviral therapy, since several medicines belonging to NRTI were registered, followed by non – nucleoside RT inhibitors (NNRTI) as well as inhibitors of viral proteases (PI). From 2000 to 2010, additional 14 medicines were registered, with Montenegro registering significantly lower number, and the strategy for their application changed in time.

Nowadays, around twenty medicines are being used in Europe according to recommendations made by EACS<sup>42</sup> and other (Americans, WHO, etc.), however our country exhibits significantly lower range of medicines. HAART therapy should be taken until end of life, estimations saying it is around 50 years in total in developed countries, i.e. 30 years in developing countries. Having in mind that HAART is being taken for decades, similar to treatment of some chronic diseases, in order to improve adherence, two co – formulations are used of two, even three medicines, simplifying the manner of taking them. Inevitable toxic influence of medicines, developing resistance of HIV to medicines and adherence problems had a crucial impact on the strategy for antiretroviral therapy. In order to achieve optimal and limited usage of the number of medicines throughout decades, it is necessary to introduce new ones rationally, which are less toxic and with good resistance profile. HAART mainly consists of combination of three medicines, sometimes even four.

#### *Conclusions:*

Easy procurement of antiretroviral medicines has to be ensured, both for the existing patients whose condition is stable, and for potential extraordinary procurement for newly discovered cases and/or cases in which the therapy needs to be changed (due to developing virus resistance to medicines and occurrences of side effects). Simultaneously, it is necessary to provide for the therapy for prevention of infection following a risky contact and tests used to monitor therapy effects. Monitoring the safety of the therapy (in terms of side effects, allergic reactions) is of key importance for efficient treatment and care. The analysis of current condition indicates deficiencies in technical capacities for effective implementation of treatment, therefore the construction of a new one, or adaptations of the existing Clinic for Infectious Diseases is absolutely necessary.

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<sup>42</sup> European AIDS Clinical Society

Serious limitations are still: stigma and discriminations towards HIV – positive persons that causes delays in HIV testing, late diagnosis and late care, and underdeveloped system for psycho – social assistance, palliative care and home care. Establishing a counseling service at the Clinic for Infectious Diseases (premises, staff and equipment) which would ensure a psycho – social support and therapeutic counseling (therapeutic literacy, planning healthy offsprings, PeP, PreP) would be of crucial importance for persons living with HIV and their families.

The key instruments needed for implementation of a successful treatment and support would be a drafting of a National Guide for HIV/AIDS consisting of both the therapy guide and the guide for paediatric HIV/AIDS, establishing a database on the disease's history with retroactive and current medical data, drafting a professional – methodological instructions for post – exposure prophylaxis (PEP), as well as education of health-care workers and associates (clinical picture, diagnosis, therapy, standardized protection measures, post – exposure prophylaxis) and professional training of health services providers on new achievements in prevention, treatment and care. Additional efforts should be made into testing the pregnant women for HIV, aiming at early detection of HIV infection, with prior counseling.

### **6.3.1. Capacities of service providers**

Holder of Montenegrin health policy is the Ministry of Health, whereas the leading institution when it comes to public health in Montenegro is the Institute for Public Health, whose establishment and activities are provided within the Law on Health Care. The network of public institutions in health system in Montenegro consists of: 18 primary health care centres, Emergency Care Unit, 7 general hospitals, 3 specialized hospitals, Clinical Centre of Montenegro, Institute for Public Health and Pharmacy Institution of Montenegro. Dentistry, as a primary health care, was outsourced as of 1 January 2008 from primary health care centres, and organized as a private activity.

Health – care activity is performed at a primary, secondary and tertiary level, with primary health care being the first level and the basis of health care system. The holder of the primary health care is a chosen general practitioner in outpatient clinic, i.e. teams of chosen GPs. Second level, the level of secondary health care, is provided through specialized clinics and hospital beds. Tertiary level of health care is provided through sub – specialized clinics, diagnostic centres and hospital departments.

#### *Set of services for HIV/AIDS in public health*

At the level of prevention: Counseling for voluntary confidential counseling with testing is located at the Institute for Public Health of Montenegro, Primary Health Care Centre Herceg Novi, Bar, Kotor, Nikšić, Berane, Bijelo Polje, Pljevlja. Counseling services are within population counseling in primary health care centres, and within the Centre for control and prevention of diseases at the Institute for Public Health. They conduct counseling prior to testing, testing with fast and ELISA tests, and counseling following testing procedure. Counseling may be conducted with family members and sexual partners. Both testing and counseling are carried out in counseling centres, without chosen doctor's referral. Confirmation of the infection can exclusively be done in the Institute for Public Health laboratory, based on a positive WB test. The counseling centre for voluntary counseling and testing, within the Institute for Public Health, can also take samples for analysis of PCR and CD4Ly that monitor the efficiency of ART therapy as a part of HIV infection treatment.

Besides these counseling centres, HIV testing can be carried out in transfusion centres of general hospitals (which is not recommendable since proper counseling cannot be given, and blood should be donated out of humane reasons, and not for the purpose of finding out the status of HBV, HCV and HIV). This kind of testing can be done without a referral. Also, the testing can be done in the admission lab of the Institute for Public Health, however only with a proper referral by a chosen

GP.

All HIV patients (provided that they hold Montenegrin health insurance, i.e. that they are Montenegrin citizens) have got a chosen GP, who, if required, refers patients to other interventions to secondary or tertiary level of health care.

*HIV infection treatment* is carried out at the Clinic for Infectious Diseases of the Clinical Centre of Montenegro. Only two doctors are designated for treatment who perform medical checks and who are entitled to write referrals for ART, based on the referral of chosen GP. Prescriptions may be taken exclusively in one pharmacy AU Montefarm, located in Podgorica. These are the medicines that cannot be found traded freely at the market, and they are procured exclusively based on requisition from the Clinic for Infectious Diseases. The procurement of these medicines is allowed by Health Insurance Fund. There are certain interventions that are not carried out in Montenegro, therefore the patients are sent to regional countries, one of these being family planning. So far, not a single couple nor HIV infection patient has had a planned reproductive intervention in Montenegro (two married couples had their children at the Department for Gynaecology and Obstetrics in Belgrade, and preparations for reproductive planning are ongoing for three additional married couples). These reproductions are also planned to be carried out in Serbia.

Rehabilitation and care: psycho-social support and a psychologist who would provide this kind of assistance exist only through project activities of certain NGOs, and exclusively depend on grant's financial structure. Clinical Centre of Montenegro and primary health care centres have clinical psychologists, however they lack proper education (and sensibility) to work with populations struck by HIV and rarely did any of the HIV patients or members of their families receive this kind of service.

There is no possibility for infected persons to obtain regular dental health care. Exercising the right to this service is always dependent on the sensibility of the dentist (mostly private ones), since there are no regulations providing for free and mandatory treatment of HIV positive persons as especially vulnerable population in terms of health, as is the case with some other chronic diseases.

HIV patients receive lab services in primary health care centres labs and at Clinical Centre of Montenegro, based on chosen GP's referral.

Testing may be conducted in private labs, however there is still no efficient manner of data collection on the number of newly discovered cases with them. This still does not create a considerable problem, since the register is kept only on confirmed tests (and a confirmation is done only at the Institute for Public Health, therefore the information on positive test results goes directly to the registry of the Institute for Public Health). However, the problem arises with patients who discover that they are HIV positive, how many of them seek confirmation of the infection, move to other countries and become unknown for any type of monitoring, or simply ignore the fact.

HIV/AIDS registry is kept at the Institute for Public Health within a Centre for Diseases Prevention and Control, HIV department. This department is accountable for drafting annual epidemiological report on HIV, media information on epidemiological significance of HIV infection, preparing reports for UNGASS, ECDC, WHO, and other international partners and health care officials.

Programmes and services at NGO

Services provided at the NGO level are of considerable significance, primarily because they guarantee direct communication with target group. These organizations employ trained professionals with many years' experience. Programmes focus on prevention and harm reduction among populations at risk of HIV.

*Programmes for harm reduction among drug users are implemented through field work and the work of Drop in centres. Services implied are:*

- field work
- prevention education and informing
- basic medical assistance
- exchanging sterile equipment for injecting drugs
- distribution of free condoms
- psycho – social support
- promotion and referral to health care and social services, emphasizing institutions for treatment and rehabilitation

Drop in centres for injecting drug users are managed by NGO CAZAS (in Podgorica and Bar) and JUVENTAS (in Podgorica). These organizations conduct field work as well. Programme beneficiaries are provided with counseling for different topics: STI, HIV/AIDS, Hepatitis B and C, condom usage, drug usage, addiction disease treatment, safe injections, methadone maintenance, overdose, stigma, social assistance. The counseling is provided by field workers, social workers, doctors and psychologists.

*Prevention programme for sex workers coordinated by NGO Juventas consists of field work and Drop – in Centre work. Basic services provided to the beneficiaries are:*

- Field work and work in drop – in centre with distribution of free of charge condoms and lubricants, and changing sterile equipment for injecting;
- Doctor's advice and treatment of injuries inflicted by injecting (abscess, miss-shots, wounds...);
- Referrals to health care and social services in the community;
- Assistance in treatment of addiction diseases, communicable or sexually transmitted infections;
- Individual, group and family counseling with a psychologist / psychiatrist;
- Counseling with a social worker;
- Legal assistance;
- Education and informing;
- Free of charge treatment at hairdressers' (cutting, hair – drying, hair – dyeing)
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*Prevention programme for MSM (men having sex with men) coordinated by NGO Juventas is implemented through provision of services on the field and at Counseling centre for LGBT. Services imply: individual conversations/counseling on STI, protection, HIV testing and other STI; promoting the work and services of counseling centre for LGBT; distribution of condoms; distribution of informative materials; referrals to health-care services; field survey/ motivating the users to participate; distribution of surveys and questionnaires; counseling, consultancy and educational services provided by doctors/psychologists/peers. Counseling for LGBT is the area in which capacities of LGBT community are built, and the area from which recognized and informal LGBT groups emerged.*

*Programme of prevention of blood borne infections and harm reduction among prisoners and young population in conflict with law is implemented by JUVENTAS, continually as of 2004. The programme is on a voluntary basis, and consists of intensive group trainings and individual counseling being held at least once a week, and even more frequently if required. Counseling is provided for the following topics: HIV/AIDS; Hepatitis A, B and C; usage of condoms; drug usage; addiction treatment; safe injection of drugs; overdose; discrimination and stigma; social aid.*

*AIDS info service – exists as of 2004, by introducing AIDS info phones, which was a first counseling service of that type in the area of HIV in Montenegro. Recommendations: greater networking of all services for prevention counseling, strengthening capacities for young persons*

and their networking with VCT.

*Psycho – social support programme to persons living with HIV* and members of their families is implemented within NGO Montenegrin HIV Foundation.

*Programme for prevention of HIV/AIDS and other sexually transmitted infections among sailors* in Montenegro is implemented by NGO Protection (Zaštita) from Bar, as of 2003, when the counseling centre for sailors opened. Activities implying provision of information on HIV/AIDS and other sexually transmitted diseases, distribution of educational and informative materials and condoms are carried out on the field and in the counseling centre itself. Contacts with target groups are made in educational institutions for sailors, centres for sailors' training, cafés in which sailors usually gather, outpatient clinics for vaccination and medical checks for sailors, as well as in cooperation with agencies for sailors' boarding.

#### **6.4. Supervision and monitoring**

Supervision and monitoring of HIV in Montenegro is a practice exercised for more than two decades, however it has considerably been improved by the adoption of the HIV/AIDS Strategy and by introduction of a second generation monitoring, which created basic reconditions for more efficient and comprehensive response to HIV epidemic.

Second generation monitoring:

- Registration in accordance with law<sup>43</sup>
- Data on the number of tested persons
- Data on counseling and testing
- Data on treatment
- Survey:
  - o Sex workers (knowledge, attitude, behaviour and biological)
  - o IDU (knowledge, attitude, behaviour and biological)
  - o MSM (knowledge, attitude, behaviour and biological)
  - o Young population aged 18 – 24 (knowledge, attitude, behaviour)
  - o General population 18 – 65
  - o Sailors (knowledge, attitude, behaviour and biological)
  - o Young Roma populations living in camps (knowledge, attitude, behaviour)
  - o Prisoners (knowledge, attitude, behaviour and biological)
  - o Tourism workers (knowledge, attitude, behaviour)

Several agents affect the number of reported cases of HIV infection or associated diseases: actual epidemic situation in the field, voluntary testing practice, level of development of the health – care system, possibility of usage of laboratory diagnostics for the purpose of diagnosis confirmation, health care being up-to-date regarding the record on getting sick, as well as death records caused by this infection, population awareness on health issues i.e. the habit of reporting to doctor and asking for counselling and testing in case of existing risk, strict law implementation regarding mandatory HIV testing of all voluntary blood and organ donors, implementation of behavioural and biological survey within more HIV exposed population.

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<sup>43</sup> *Law on Protection of Population against Communicable Diseases* (Official Gazette 32/2005, Official Gazette 30/12) - This law defines the communicable diseases that threaten the health of the population of Montenegro, and infections that occur as a consequence of carrying out health activities; measures for their prevention and control; competent authorities for their implementation, the method of securing funds for their implementation, as well as overseeing the enforcement of this Law.

*Rulebook on registration of communicable diseases and hospital infections* (Official Gazette 45/07) – This Rulebook provides for the manner and deadlines for registration of communicable diseases, as well as forms for their registration.

Registry for HIV/AIDS:

- First step in HIV monitoring system
- Registration in accordance with law
- Registration in accordance with international rulebooks
- Data collection, analysis and interpretation
- Analysis of frequency, spreading, flow and prognosis of the disease (incidence data, prevalence, duration and outcome; identifying special risk groups)
- Creating prevention programme
- Trend monitoring
- Comparison to world data.

Strategic response to HIV/AIDS in Montenegro and accompanying Action plan envisage, among other things, implementation of biological and behavioural survey among populations difficult to approach, who are exposed to higher risk of HIV. The said survey is implemented under second generation monitoring of HIV and are required to understand total epidemiological situation in the country. In recent years, several biological and behavioural survey have been carried out among sailors, sex workers, injecting drug users and men having sex with men, that contributed to much better understanding of proliferation of HIV among these populations. Additionally, the survey helped gain information required for designing proper HIV prevention and control programmes.

In 2014, a third bio – behavioural survey was carried out among injecting drug users, and second survey among men having sex with men.

Bio – behavioural survey among **injecting drug users** (carried out in 2008, 2011 and 2014) provided for possibility to determine the behaviour of adult intravenous drug users in Montenegro, monitor the changes in risky behaviour and monitor the outspread of HIV, HBV and HCV among members of this population. Prevalence of HIV in survey sample of intravenous drug users in the survey conducted in 2014 is 1.1 % (2011 it was 0.3%, and 2008 0.4%). Prevalence of HBV, i.e. HbsAg is rather low (1.4%) the same as in prior survey, whereas the prevalence of HCV is high (53%) and insignificantly changed in comparison to 2011 and 2008, when it was 53.6% and 55% respectively. High prevalence of HCV infection indicates that a considerable degree of risky behaviour existed among intravenous drug users, at least in the past. The level of knowledge that IDU have on manners to transmit HIV and ways to prevent HIV is improved, however still insufficient, and together with identified risky behaviour inherent to intravenous drug users, make this group sensitive to HIV spreading. The survey confirmed that targeted prevention programmes have certain favourable impact to prevent the proliferation of blood borne diseases with intravenous drug users, however more investment is required for further progress in the area.

In 2014, second survey was conducted among **men having sex with men**. Within this survey, HIV infection was found with 12.5% of examinees (the survey conducted in 2011 showed HIV infection with 4.5% examinees). Prevalence of HIV of such kind is in accordance with the fact that most HIV positive persons registered in recent years belong to this group, and it has passed the line of concentrated epidemic. However, the results of this study which is based on sampling the examinees by snowball sampling method, has to be taken into consideration with a bit of reserve, since this method cannot provide for total representative sample of examinees based on which data could be obtained and which could be representative for total population of men having sex with men. Still, this survey gave initial informative basis for understanding the situation of HIV infection in MSM population (it has been confirmed that knowledge on the manners of transmission and prevention of HIV was insufficient, that prevalence of a risky sexual behaviour is considerable and that there is a need for increased usage of anonymous testing and counseling related to HIV and other STI).

The results of 2013 study carried out among **sailors** indicate that prevalence of HIV in this group

is low and is around 0.6% (the survey carried out in 2008 showed the prevalence of HIV among sailors at 1.5%).

In 2013, first bio – behavioural survey among young **Roma and Ashkali (RA)** population was carried out. The survey indicated socio – demographic and behavioural characteristics, based on which targeted prevention and control programmes may be developed in said population. Not a single HIV infection case was found among examinees.

Survey carried out among **prisoners** showed data on prevalence of HIV, HBV and HCV, as well as socio – demographic and behavioural characteristics of this population. It was confirmed that HIV epidemic among prisoners in Montenegro was at a low level (not a single HIV infection case was found), HBV infection was detected with 3 examinees, whereas HCV infection was detected with one fifth of examinees (determined prevalence of HCV is 20.1%). The survey also indicated that prisoners demonstrated a considerable degree of conduct which is connected to risks of HIV, HBV and HCV, as well as the insufficient knowledge on HIV.

Low prevalence of HIV was registered among **sex workers** (prevalence of HIV was 0,8% in the survey carried out in 2008, 1.1% in survey carried out in 2010, and 0% in survey carried out in 2012), therefore HIV epidemic among sex workers in Montenegro is of low intensity. The survey determined that prevalence of drug usage, as well as prevalence of risky sexual behaviour in said population are still high.

Good cooperation between NGO and the Institute for Public Health in implementation of this survey resulted in NGOs being recognized as significant actors in carrying out behavioural surveys and providing the access to target population. Revised forms for reporting from the field have been prepared for non – government organizations for their work with IDU, used for monitoring the services and number of persons belonging to this population group.

There are weaknesses, due to the lack of estimation on the size of population and lack of data on HIV prevalence with commercial sex workers , IDU and MSM, accompanied by improper registration of STI. Simultaneously, monitoring and evaluation mechanisms have not been sufficiently strengthened, whereas the sustainability of M&E positions, with the exception of those in the Institute for Public Health and other health institutions, is questionable upon completion of GF financing. M&E plans on the level of institutions/organizations do lack, as well as national guides for routine programme monitoring and data quality control for services provided by NGO, as well as services provided in health institutions. Simultaneously, dissemination of data and usage of the data is not adequate – there is no web site of the NAC/CCM, which would make all relevant information on the national response to HIV available. Based on identified weaknesses, M&E action plan for April 2013 – December 2014 was defined, however funds are lacking for its implementation.

#### *Conclusions:*

Key recommendations given with a view to improving strategic response to HIV are directed towards developing a unique data base for monitoring second generation with data from bio – behavioural surveys, arranged according to age, gender and differences, and towards revision of forms for collection of data on blood borne infections. Also, it is necessary to make an estimation on the size of population for: P HIV, intravenous drug users, commercial sex workers and men having sex with men, and implement additional trainings of personnel in health care sector on different aspects of second generation monitoring. At the same time, additional effort should be exerted to create sustainable mechanisms for monitoring and evaluation and transparency of information related to national response to HIV.

### **6.5. Coordination and partnership**

National Commission for AIDS has a legal mandate to coordinate all the activities related to AIDS in Montenegro. The Commission has 15 members and includes members from key ministries, four NGO representatives and persons living with HVI, and is convened at the invitation of the

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Ministry of Health as a responsible executive body. Within the Ministry, it is the Institute for Public Health which is designated as a responsible technical department.

National coordinating body has more representatives, around 25 voluntary members, including the representatives of five different ministries (besides the Ministry of Health it includes the representatives from the Ministry of Education, Ministry of Interior, Ministry of Justice and Ministry of Tourism), and it also includes representatives of PLHIV, NGO, representatives of the National Fund for Health Insurance and members of UN Thematic Group of AIDS.

Several working groups are established within state coordinating body: working group for monitoring the implementation of project activities, working group for gender equality, working group for estimating the educators' competences, working group for selection of NGO representatives for membership in commission and CCM. Technical working group for M&E has not still been established.<sup>44</sup> In the last four years, State Coordination Body held 24 regular meetings (the average attendance of members 14 out of 27) and 5 annual meetings for annual overview of national response to HIV. Reports are provided within the minutes of meetings of CCM.<sup>45</sup>

Coordination between the Government and NGO is improved, and a significant role of organizations within the community has been recognized, when it comes to responses to AIDS. Existence of formal organizations who represent the populations of IDU, MSM shall facilitate their inclusion into planning and implementation of interventions that meet their needs. NGOs involved in implementation of the strategy are: Juventas, CAZAS, MHF (CHF), SOS phone PG, Zaštita (Protection), Montevita, LGBT Progress Forum. First four are also members of the National Commission for HIV, and remaining ones are part of CCM, i.e. at some point from 2010 to 2014 they were SE or sub-beneficiaries of the funds.<sup>46</sup>

It is believed that doctors having private practice play an important role in providing confidential services related to HIV/STI to those who can afford those services. Recently, private sector has been recognized as a full participant in health care, therefore cooperation needs to be strengthened in this area as well.

#### *Conclusions:*

In order to create sustainable mechanisms of coordination and partnership in response to HIV/AIDS, it is recommendable to establish a national office or coordinator for HIV, to hold regular quarterly meetings of National Commission for AIDS and to establish operational team for monitoring the implementation of HIV strategy within National Commission, which would be in charge of drafting annual reports on implementation of the action plan. Already established practice of organizing annual national conferences, aiming at presenting the achievements in implementation of the strategy and next steps, shall be continued, however efforts should be continually made to enhance regional cooperation in the area of treatment and support. Action plan for implementation of the strategy for 2017 – 2019 period should be drafted.

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<sup>44</sup> Monitoring and evaluation

<sup>45</sup> Reports and minutes on the work of CCM and NCA from 2010 to 2014, HIV Secretariat in the Institute for Public Health

<sup>46</sup> Decision on Establishment of a National Commission for HIV, 2013

## STRATEGIC DIRECTIONS AND GOALS

### 1. Stigma and discrimination

**Strategic goal 1.** Creating a safe and supportive environment for people living with HIV and people in increased risk, and reduced gender inequality in response to HIV.

**Operational objectives:**

- 1.1. Conditions provided for improvement of institutional mechanisms required for elimination of stigma and discrimination of persons living with HIV and persons at risk of HIV
- 1.2. Decreased level of stigma and discrimination of persons living with HIV and persons in risk of HIV, and decreased gender inequality in response to HIV

### 2. Prevention

**Strategic goal 2:** Establish an effective HIV and PPI prevention system among people in an increased risk, institutions and general population

**Operational objectives:**

- 2.1. Conditions ensured for provision of a basic prevention package services related to HIV and STI which are available to most – at – risk HIV groups
- 2.2. Easily accessible and sustainable services provided to persons living with HIV and persons at HIV risk, based on confidentiality and friendly approach
- 2.3. Increased government and NGO capacities for preventive operations related to HIV and STI
- 2.4. Enhanced prevention with regards to HIV and STI among prisoners, tourism – hospitality workers, sailors, military and other uniformed persons and socially excluded youth
- 2.5. Increased degree of knowledge on prevention of HIV and STI among young persons in educational institutions and general population
- 2.6. Professional exposure to HIV in health care system and other vocations prevented

### 3. Treatment, care and support

**Strategic goal 3.** Ensure affordable and equal treatment, care and assistance for all persons living with HIV.

**Operational objectives:**

- 3.1. Adequate antiretroviral treatment and monitoring of effects and safety of the therapy
- 3.2. Strengthened capacities for treatment, care and support to all persons living with HIV
- 3.3. Secured sustainable universal approach to HIV prevention and treatment within health care sector
- 3.4. Ensured efficient prevention of HIV mother – to – child transmission (PMTCT)

### 4. Monitoring and monitoring

**Strategic goal 4.** Establish effective monitoring and monitoring that will enable the response to HIV/AIDS in line with current situation and needs

**Operational objective:**

- 4.1. Improved supervision, monitoring, and estimation of the impact of activities related to HIV/AIDS and further planning based on received data

### 5. Coordination and partnership

**Strategic goal 5.** Creating sustainable coordination and partnership mechanisms in response to HIV/AIDS

**Operational objective:**

- 5.1. Strengthened capacities, coordination and partnership within the national response to HIV/AIDS