

**REPUBLIC OF ALBANIA**  
**MINISTRY OF HEALTH**

**LET'S KEEP ALBANIA A LOW HIV  
PREVALENCE COUNTRY**

**The National Strategy of Prevention and Control of  
HIV/AIDS in Albania**

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## **The need for a Strategy of Prevention and Control of HIV/AIDS in Albania**

The need for a Strategy of Prevention and Control of HIV/AIDS in Albania became evident after 2000 due to the following factors:

- Change of epidemiological situation, with an increase in the number of new cases every year. Out of 117 HIV/AIDS cases diagnosed and reported (as of end November 2003), 75 have been detected after 2000, with an average of 20 cases annually.
- Change of behavioral patterns among the general population. Although, more in-depth studies are needed, existing data shows an increasing trend of risky behaviors.
- The opportunities and the need to establish an active intersectorial and interagency collaboration and actions.
- The need to plan in a long-term approach and avoid spontaneous responses in potential emergency situations that might emerge, if appropriate measures are not taken in time.
- Building of necessary technical, scientific and management capacities able not only to develop strategic plans, but also to implement them.
- Strengthening the efforts and commitment of the Albanian Government and International Organizations present in our country, to achieve Millennium Development Goals where prevention and control of HIV/AIDS is included in Objective Nr.6.

Combination of these factors led to the development of a national project, implemented by the Ministry of Health and the Institute of Public Health within the framework of a regional project, which included 10 other countries of East and Central Europe funded by UNDP, UNAIDS and MoH. The goal of this project was the preparation of a Draft Strategy for Prevention and Control of the spread of HIV/AIDS in Albania, titled "Let's keep Albania a low HIV prevalence country".

A National Strategic Advisory Group of Experts representing different sectors, governmental, nongovernmental and international agencies was established near the Ministry of Health. A long process of consultations and round tables was finalized by the approval of the draft strategic paper in October 2003.

The Albanian HIV/AIDS National Inter-Ministerial Committee in its meeting in December 2003 adopted the proposed draft strategy with minor changes.

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## **1. Guiding principles of the strategy**

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

- NSPCHA will help in the management, coordination and orientation of the work of government, non-governmental and international organizations with activities in the area of prevention and control of HIV/AIDS in Albania.
- NSPCHA is a comprehensive document using a multifaceted approach to HIV prevention addressing the individual, community, societal and structural level prevention and control needs.
- The strategy will be reviewed and, eventually, modified bi-annually based on data provided from monitoring and evaluation process, changes in epidemiological situation, findings of research and scientific work, and possible organizational opportunities.
- NSPCHA will ensure the continuity of the work of all organizations and structures involved in the area of prevention, care, and control of HIV/AIDS in Albania. It will reflect recommendations of international organizations (UNAIDS and WHO, in particular) as well as previous National HIV/AIDS Conferences.
- NSPCHA creates a supportive environment and will guarantee the respect for human rights and places such value in the center of all HIV prevention, care and control activities.
- NSPCHA will ensure that HIV prevention and control programs do the utmost to prevent and control HIV/AIDS based on available resources.
- NSPCHA recognizes the importance of risky behaviors and the role of stigma and discrimination as a barrier to deliver highly effective programs of prevention, care and treatment. On the other hand, the NSPCHA views non-response to the specific needs of at-risk and vulnerable or marginalized groups as covert discrimination through neglect and will therefore focus on developing appropriate responses to their needs.

- NSPCH recognizes the importance of gender based HIV prevention and control programs stressing out gender equality and empowerment of women
- NSPCHA addresses HIV/AIDS prevention and control as multidimensional problem related not only to health and in conjunction with all partners at all levels in the public, private and non profit sector and in coherence with other existing country strategies.

## **2. Situation Analysis regarding HIV/AIDS in Albania**

### **2.1. Introduction**

#### **2.1.1. The geographical position and the economical and social development**

Albania is located in the Southeastern Europe (SEE) at western part of Balkan Peninsula. The country borders on UN Administered province of Kosova and Republic of Serbia and Montenegro to the north, the Former Yugoslav Republic of Macedonia to the east, Greece to the south and south east and Adriatic and Ionian Seas to the west. The terrain is mountainous except along the central coast. About 40% of the 3.1 million people of Albania live in urban areas. Approximately 20% of the population inhabits the capital of Tirana.

Albania has the youngest population in Europe with an average age of 29 years old and 40% of the population is under 18 years old. Seventeen percent of the total population belongs to young people of 15-24 years old where 20% are thought to have been migrating abroad (INSTAT, 2002).

Albania is a Parliamentary Republic, where the government is nominated by Albanian Parliament. The country is administratively divided into 36 districts and 12 prefectures, 309 communes, and 65 municipalities.

Since the collapse of communism in 1991-1992 the transition from centralized government to a more developed free market economy brought social, political and economic changes to the country. During the years 1992-93 there was a huge wave of emigration mainly to Italy and Greece, which proximity to Albania makes them a natural destination of economic migrants. During the period 1990-95 it is estimated that the number of emigrants ranged from 300,000 to 600,000, representing the total population in 1995.

During the past 12 years Albania has faced continuous political and social changes, and after a period of transition, interrupted many times by social crises such as those of the years 1991–1992 and 1997 (the collapse of pyramid schemes) and the Kosovo crisis in 1999, Albania is now a country under profound economic and structural reforms. The economy of the country is changing from a central economic planning system to a free-market system; many questions related to privatization, property ownership claims, and the appropriate regulation of business still remain unresolved.

The country has experienced slow but steady economic progress; however, about 30% of the population of approximately 3.1 million lives below the poverty line, with poverty greater in rural areas (UNICEF-Albania, 2000a).

The official unemployment rate is 16%, with two-thirds of all workers employed in agriculture, mostly at the subsistence level. Remittances from citizens working abroad remain extremely important, as does foreign assistance.

Albania is a lower middle income country with a Gross National Income (GNI) per capita of US\$ 1,380.

Nonetheless, the country faces considerable challenges as it remains one of the poorest countries in Europe. The country has good potential for growth in agriculture, livestock, fisheries, forestry, tourism, mining, and light industry and the Albanian government has recently prepared a new strategy for poverty eradication, and economic and social development. Albania started negotiations with the European Union for a Stabilization and Association Agreement (SAA) in January 2003. Negotiations have so far focused on political issues.

The policy of social welfare is highly conditioned from the economical situation. The programs of development and stimulation of the employment, social welfare, special social support of vulnerable groups are not sufficient. Also support on intervention programs for such groups of the population including health education, information and communication or behavioral change programs substantially lack funding although the attempts made by either governmental and non-governmental organizations or international agencies. The unemployment rate is higher among Roma group and it is the main cause of internal migration from rural areas to main cities or immigration outside the country.

The National Strategy for the Economical and Social Development which aims poverty reduction and social and economical development of the country and placing an important role on HIV/AIDS prevention efforts has been recently adopted. The Albanian Government has signed the Millennium Declaration and hereby is committed to achieve the Millennium Development Goals.

### **2.1.2. The important health indicators and organization of health system**

Albania's relatively high life expectancy estimated as 75 years old for average life expectancy at birth is a result of Mediterranean style of life even the incidence of accidents are increasing recently. Infant mortality still in decline since 1992 ranges from 12.2 to 20/1000 and compared with other EU member countries is higher. Maternal mortality with 15 deaths per 100,000 is one of the highest in Europe even the quality of women health services and antenatal care has been increasing. Family planning is offered in primary health care facilities and the number of abortions is decreasing but reproductive health services need to be improved.

Albania is experiencing an epidemiological transition, where cardiovascular diseases, chronic pulmonary diseases, cancers and accidents are the main causes of deaths. Mortality from the cardiovascular disease has been increasing from 36.6% in 1994 to 45% in 1998. Meanwhile communicable diseases are relatively significant.

The country inherited a Semashko similar health care system but after 90s the system was reorganized and more autonomy was given to the districts. Primary care is offering more services but still demands exceed the supply and hospitals carry the heavy burden. According to a questionnaire in 2000, only 45% of the rural population reported that had a family doctor, meanwhile 39% reported that they did not have any pharmacy in their nearest area.

Health care reform starting from 1993 made possible the establishment of health insurance system. General practitioners are paid by Institute of Health Insurance where many public health duties are included. Recently efforts are in process to include hospitals within health insurance scheme. Classical public health services are included within primary health care and a new system of Regional Authority has been implemented in Tirana.

The National Institute of Public Health is undergoing changes towards strengthening prevention programmes giving importance to health promotion and education and training activities. A Strategy of Health Promotion and Public Health is in place stressing the importance of equity, solidarity and multisectoral responsibility for improving public health.

During 2003 a strategic document about health care system reforms was published. It foresees strengthening the coordination role of the MoH and revisions of institutional health sector chart as well as increase of the autonomy of resource use and strengthening human management capacities underlining primary health services capacities and increasing the quality of care and access to health services. Decentralization of power towards the local governments in certain areas including some health services is undergoing.

## **2.2. The epidemiological situation of HIV infection in Albania**

### **2.2.1. Past and current status of the HIV/AIDS in Albania**

As of end of 2003, Albania is still considered a low HIV prevalence country. However, there are major concerns that since the early 1990s, when Albania ended decades of self-enforced isolation, that HIV risk behaviors--especially among youths and the large mobile populations in Albania--have been steadily increasing and that there may now be a high potential risk for extensive HIV transmission in injecting drug users (IDU) who share their injecting equipment with others and in persons who have unprotected sex with multiple and concurrent sex partners. The first case of an infected person with HIV in Albania was diagnosed in May 1993 through routine HIV screening of the blood bank. Since then, up through the year 2000, about 5-10 HIV-infected persons and from 1-4 AIDS cases have been detected annually via a variety of different passive clinical and laboratory testing programs. Until end of November 2003, in Albania are reported 117 cases of persons infected with HIV/AIDS. From these persons, 42 have manifested AIDS and 37 deaths are counted among them. Although, based on the low numbers of the persons diagnosed with HIV/AIDS Albania can be considered a country with a low prevalence of HIV/AIDS, there is an increasing trend evident during the last three years.

Starting from 2000, 75 new cases of the persons infected with HIV/AIDS were diagnosed, a number, which consists two third of all, the cases diagnosed and reported until November 2003.

Sexual transmission continues to dominate the modes of HIV infection with approximately 90% of all cases. Another characteristic for Albania is that approximately 70% of HIV infections and AIDS cases (HIV/AIDS) are believed to have acquired their HIV infection outside of Albania.

There is a trend towards the feminization of epidemic during the last years where the number of females is progressively increasing.

The annual number of reported HIV/AIDS is small and even though the actual number of prevalent HIV/AIDS currently in Albania has to be much larger than the few reported, the estimated number and the estimated prevalence rate for all persons in Albania living with HIV are all still relatively low. Based on HIV data from blood donors and emigrant populations that together have totaled from 10,000 to 40,000 persons annually since 1993, it can be concluded that HIV prevalence in Albania is less than 1 per 1,000 of the 15-49 year old population in Albania. The total number of Albanians in the 15-49 year age group is about 1.5 million and a prevalence rate of 0.1% (1 per 1,000) would mean a total of about 1,500 HIV infections. Although estimation of the actual prevalent number of persons living with HIV in Albania cannot be precise because of the limited data, a good working estimate that is consistent with the available data would be at least a few hundred but probably less than a thousand. Based on the lower range of this estimate, the number of clinical AIDS cases and deaths that can be expected annually in Albania over the next five years will be about 20-30.

As of end-2003, even HIV infection is appearing among injecting drug users and victims of trafficking still there are no indications that any epidemic (sustained or extensive) transmission of HIV has or is occurring in Albania. Extensive or epidemic heterosexual HIV transmission has not yet occurred but however, detailed information on the rapidly changing patterns and prevalence of high heterosexual risk behaviors still need to be collected to better assess the potential risk for extensive heterosexual HIV transmission all over the country. The non-epidemic type of heterosexual transmission pattern from HIV-infected persons, who acquired their infection by engaging in high HIV-risk behaviors (unprotected sex with many sex partners and/or sharing drug injecting equipment) to his or her regular sex partner, aside from those HIV infections acquired abroad, appears to be the primary mode of sexual transmission of HIV in Albania.

There are insufficient data on HIV transmission in MSM in Albania but limited evidence indicates that a few MSM in Albania acquired their HIV infection outside of Albania.

Routine HIV screening of paid and volunteer donor blood started in Albania during the early 1990s. However, a few donors in the "window" period of their HIV infection may have infected several transfusion recipients in Albania during the past decade. As a result of the self-enforced isolation of Albania by the former communist regime up to the early 1990s, HIV-infected blood products that were distributed worldwide in the early-to-mid 1980s did not enter the country.

## **2. 2 .2 Vulnerability to HIV/AIDS of specific groups of population**

### **2.2.2.1. The General Population**

Different factors contributed towards Albania as a low prevalence country where among them are mentioned:

- Due to total isolation, HIV entered the country relatively late, only after 1990 (as it is documented in a serial epidemiological studies)
- Commercial sex work and drug use were very limited almost unknown before 1990.
- Social and cultural factors that do not encourage premarital and sex at a young age (stressing the importance of virginity by females) as well as sexual relations with many partners (especially in the more traditional and rural areas of the country).
- The establishment of the National Programme, National Committee and the Executive Office for Preventing and Controlling of HIV/AIDS before that Albania reported the first case of HIV/AIDS
- Compiling of national policies in full compliance with epidemiological situation as well as the recommendations of international organizations like WHO/GPA and UNAIDS
- Introduction of blood safety measures and universal blood screening for HIV/AIDS all over the country in the beginning of 90s
- Introduction of single use and AD syringes all over the country in the beginning of 90s
- Introduction of a harm reduction programme in Tirana

Nevertheless, the increasing trend is in accordance with social and cultural factors that have dramatically changed after 1990, and are described in details in connection with vulnerability of special groups of the population to HIV/AIDS.

#### ***2.2.2.2. Young people***

With the youngest population in Europe the risk of the country towards HIV/AIDS especially when there are many social, economic and cultural factors that make young people vulnerable to HIV/AIDS, is very high. Amongst them there are lack of access to adequate information, lack of access to proper sexual education including health knowledge in relation to sex and lack of various services for youth especially in rural areas. The increasing number of youngsters at critical ages (16-24) dropping out of schools, young migrant workers and changing sexual norms in urban areas are added to other causes that increase the vulnerability of young people in Albania. According to the epidemiological data of the reported HIV/AIDS cases 70% of infected cases with HIV belong to age-groups up to 34 years. Also there is increasing trend of increasing the numbers of HIV cases from 15 to 24 during the last year. The recent RAR survey reported that the majority of youngsters receive information about HIV/AIDS and STI mainly from media and less information is provided by schools or other responsible institutions or parents. High levels of risky sexual behaviors such as sex without condom and relations with multiple partners was found as common during the survey and it was more evident among sub-groups of youth with higher vulnerability such as: young immigrants, or migrant workers especially seasonal ones, youth out of school as well as the youth pattern of drug users. Data from a survey show that around 59% have seen violence at home and 50% report that they have little information about HIV/AIDS. Out of 600,000 people who left Albania, 70% were males of 16 to 30 years old. A National Strategy about youth is addressing specific problems the country is facing and it is proposing interventions where young people will be involved on designing and implementing.

#### ***2.2.2.3 Women and gender related issues***

Women are especially vulnerable towards HIV for biological, social-cultural and economic reasons. According to a study conveyed by UNDP in 2001, Albania presented the lowest index of gender development among East European countries.

Albanian women present a lower level of participation in decision-making processes. During transition years, the phenomenon of family violence has been increased, especially in rural areas. The issue is characterized by "silence" and it remains within closed doors and is rarely denounced. Most of employed women work in agriculture and public sector, both sector characterized by low wages and prestige (UN/ACER, 2002). Women, particularly are often economically dependent on males since in most of the cases are unemployed and uncovered by social security. The privatization process greatly helped men over females and credit for women is difficult to obtain in rural or in some urban areas (UN/ACER, 2002).

Gender barriers and the women lack of power to negotiate, limits the use of the condoms. Prostitution, as one of the forms of human beings trafficking, also represents, in combination with the low use of condoms among sex workers, a potential threat for the spreading of HIV/AIDS. The most vulnerable categories, aside from women trafficked for sex work, are: the wives or migrant workers, and girls and women who live in rural and urban surrounding areas.

The tradition of male dominance within the family has been revived and has placed women at risk of abuse and limits their power to control their reproductive lives through the use of contraceptive methods (UN/ACER, 2002).

Services that only focus on STI treatment carry stigma, which creates a barrier for access to women. Norms that prescribe the preservation of female virginity discourage STI treatment and information seeking in order to avoid being identified as sexually active. The burden of care for HIV affected family members, often falls on females. Moreover, orphaned girls are more likely to be withdrawn from school than their brothers.

In Albania as in many other countries, HIV is seen as a sign of sexual promiscuity. Therefore gender norms shape the way men and women infected by HIV are perceived and positive women face greater stigma and rejection than men (UNAIDS, 1998).

Women present a low level of knowledge in HIV/AIDS and IST, and also a poor health care culture in general and poor reproductive health in particular. The level of awareness on how to prevent HIV/AIDS is low. According to MICS in 2000, 40% of women did not know a single effective way to prevent infection and 77% did not know where to get tested. Knowledge about sexually transmitted diseases is still very low.

#### **2.2.2.4. Mobile population**

Albania is considered to have one of the highest levels of population mobility in the region out of, within and into the country. Albanian illegal immigrants, who are often seasonal, prefer not to seek health care as many fear expulsion or other legal actions if their status were to be discovered.

The data existing for Albanian migrants are not complete and realistic, due to the irregular nature of their movements and the lack of possibilities to reach them. According to the statistics of the Ministry of Labor and Social Affairs, around 800,000 Albanians live outside the country.

Being mobile is not a risk factor for HIV/AIDS; there are the encountered situations and the risky behaviors possibly engaged in during mobility or migration that increases vulnerability and risk regarding HIV/AIDS.

Around 70% of the reported cases with HIV in Albania are reported as being infected outside Albania. The majority of them are young males of 20-40 years old that have worked or lived for some time in countries like Italy or Greece.

Urban population is growing rapidly due to internal migration while social and health services have to carry the burden of such increase. Most of the internal migrants set up temporary dwellings on the outskirts where the overall quality of life is poor.

Some of them immigrate abroad where sometimes enter the sex trade.

Albanian immigrants are often subject of discrimination, xenophobia, exploitation, and harassment and have little or no legal or social protection. According to RAR they have little or no access to information about HIV prevention and many of them separated from families, spouses or partners report unprotected sex with different partners. The level of condom use is quite low and one third had sex under the influence of drugs. Most of the young mobile interviewed had a wide use of drugs mainly alcohol and marijuana but also reporting of injecting drug use among them is increasing.

#### ***2.2.2.5. Injecting drug users***

IDUs seem to be at risk group which puts them in an urgent category. The phenomenon of drug use has obviously increased in Albania during transition years. The number of drug users mainly in Shkodra is increasing specially among the young people, which in most cases come from families with low incomes. Also an increase has been noted in the drug use among young people from Roma community. In a national wide scale there are 30.000 drug users, including also those who use the so-called "light drugs". The Toxicology Center in the Central University Hospital refers that

during 2002, has treated 1260 cases of the persons that are IDU, which consist of 68 % of all cases in this center. 65% of these persons were between 20-30 years old and 90 % use heroin. Different studies have shown that the heroin use and drug injection has been recently increasing. According to RAR study, injecting of drugs is increasing both in Tirana and Shkodra and 64 % of the drug users use drug injections. Needle and syringe sharing is very high in almost two thirds of IDU. Bleaching is not known and they do not perceive as a risk sharing of syringes. High prevalence of Hepatitis C was seen among drug users according to data provided IPH. They report several sexual partners and level of condom use is very low. Level of knowledge about HIV, STI etc is very low especially in Shkodra and shows the need for harm reduction programs outside Tirana.

#### **2.2.2.6. Commercial sex workers**

Sex Work is illegal in Albania. The Penal Code anticipates a punishment varying from a simple fine up to three years of detention for persons practicing commercial sex. Before 1990s this law was strictly enforced and it can be said that commercial sex work did apparently disappear during that time. After 1990s, several events took place such as:

- a. Sharp socio-economical changes took place in Albania following the collapse of the communist regime. A large number of families remained without the necessary economical means (in some cases suffering from extreme economic deprivation). The most affected strata were the population living in the rural area, the families that migrated from rural to the urban area and some ethnical minorities (Roma people and *Evgjite* community). Many young girls from these population groups either become the target of human trafficking (see below) or practiced sex work in or outside the country as the sole way to obtain economic support.
- b. A large number of Albanian girls were trafficked to foreign countries (initially to Greece and Italy and latter to Benelux and UK) and were exploited there as commercial sex workers. There are no accurate estimations for their number, but governmental sources give a figure of 5,000 Albanian girls being exploited as CSW as opposed to NGO sources that give this figure up to 30,000.

- c. Girls from other Eastern European Countries (such as Romania, Moldova, Ukraine, Bulgaria, etc) were first trafficked in the country and then out of the country with destination countries those one mentioned also in the case of the Albanian girls that were trafficked.

The commercial sex started thus to be practiced in the country and to become visible. There are no scientific studies performed to estimate the number of CSW in the country, but according to anecdotic and press reports they can be divided as follows:

- d. Albanian and foreign girls who shall be trafficked into foreign countries are first exploited as CSW in Albania – there have never been attempts to estimate their number. Usually the first exploitation is through sexual rape and there are press articles reporting abuse and inhuman treatment of this category of CSWs.
- e. Commercial sex workers coming from low SES (mostly Roma population or *Evgjite* community) otherwise known as “street prostitutes” – one can observe in the streets on Tirana up to some tens of “street prostitutes” offering their service near the center of the city, in the main roads and in the area of the National Park. The price for one sexual service varies from 500 to 1,500 leke (€3 - €12). Based on the information of the Albanian Lesbian and Gay Association there are also male sex workers who belong to the Roma population or *Evgjite* community who practice sex work.
- f. *De-luxe* commercial sex workers who offer their service in hotels and motels of Tirana and other big cities of Albania. According to press reports these CSWs are students (based on a newspaper article up to 300 female students in Tirana alone practice sex work), girls from rural areas and other districts recently settled in Tirana and other big cities and CSWs who return from foreign countries. The prices for a sexual service from these CSWs vary from €30 to several hundreds Euro.
- g. CSWs in public houses – these are more often private apartments that are used for commercial sex work. The public houses operate in illegality and there are frequent press articles reporting police detecting public houses and arresting the CSWs. Press articles from 2002-2003 report public houses found

in Tirana and Korca. The price for a sexual service from this CSW was reported from 1,500 (€12) to a few thousands leke.

RAR indicated a very low level of condom use among sex workers. Also their level of knowledge and awareness is very low. This is alarming when it is face with the high numbers of sexual partners they have. Only 4 cases of HIV are identified among them. The same study shows a good level of risk perception but a low level of the health seeking behavior from commercial sex workers.

The living conditions of Albanian sex workers are commented by observers among the worst of all sex workers, and they are unable to negotiate with the pimps and/or their clients. Of all sex workers in Italy and Greece, it is widely held that Albanian women have the lowest status.

A National Strategy on Trafficking and other governmental and nongovernmental policies address the abovementioned problems through some already established interventions.

#### **2.2.2.7. Men who have sex with men**

There is little knowledge regarding man having sex with man, including the sexual practices in Albania. Although stigmatised, a homosexual community does exist in Albania and is trying to become organised. Their risk behaviour in general is reflected in the number of HIV/AIDS cases where 25 % of the males infected with HIV are gay or bisexual. Anecdotic data show a lower level of condom use among males that have sex with men. The lack of the knowledge and practicing of safe sexual practices are accompanied with a lack of friendly services for men who have sex with men. Also MSM have difficulties to find proper condoms for anal sex and lubricants. The stigma and often discrimination of the society make very difficult for this community to make use of the existing services or to be organized. Silence, stigma, denial and taboo are key concept to understand why too little is known and why current interventions are insufficient.

Sex work has emerged as a strategy of survival for much Albanian man who immigrates and many of them refer of having learnt about homosexuality when they were abroad. The unclearness on sex between men is also connected to the fact that this happens often in the context of the illegal emigration in west countries. The low risk perception towards HIV/AIDS is very common among Albanian homosexuals. Active partners consider themselves not at risk for HIV/AIDS or other STIs.

As stated by UNAIDS, in Mediterranean societies like Albania, where marriage is strongly urged by family and society, sex between males is much more hidden. There are 2 gay NGOs in Albania, which deal with the education-information and distribution of condoms and lubricants but their activity is still scarce.

In 1999 the distribution of leaflets and condoms in Vlora encountered some opposition as some people rejected the initiative. Distribution of IEC materials containing HIV prevention information for homosexuals is very difficult to be accepted and reach the target because even MSM are part of Albanian society most of them do not consider themselves being gay. Those men who have active sexual relations with other men are not considered homosexuals but rather "more men" and have also sexual relations with women. Being found with a MSM leaflet might expose people to scandal and discrimination and therefore prevent them from taking/keeping/reading the material. According to experts, a general brochure accessible to everybody could be more convenient than addressing MSM with specific publications. Being homosexual in Albania is an acute drama, both for the individual involved and for the families.

#### ***2.2.2.8. Patients with Sexually Transmitted Infections***

The data from different studies have shown an increase of the cases with STIs in Albania even underreporting is very obvious. After the eradication of syphilis from 1972 to 1995, 132 cases with primary and secondary syphilis were diagnosed and reported, in Albania, from 1995 to 2002. Other sexually transmitted diseases were present in different surveys performed recently by IPH. Gonorrhoea, chlamydia infections and trichomonas vaginalis infections were seen in almost all studies with a considerable percentage always over 10%. It is important to mention the increasing trend of HSV2 infections over the time.

Around 13.2 % out of 369 young interviewees for Hepatitis B (19-21 years old) resulted positive for HbsAg. Also during 2002, 6.78 % of the blood donors resulted positive for HbsAg.

In a blind study done by IPH 4.5 % of the patients with syphilis resulted positive for HIV and vice versa 11% of PLWHA were positive for syphilis. Also Syphilis or other STIs were seen in 20% of HIV/AIDS cases. This fact shows the important role that IST has in spreading HIV/AIDS and the need of the preventive measures for the spreading of these infections.

Almost all FSWs during RAR reported syndromes of sexually transmitted diseases but they did not ask for treatment. Stigma related to STIs does often not allow women, youngsters or men to seek treatment or help. Before 90s STIs were a taboo and programs of eradicating syphilis and control gonorrhoea presented serious human rights violations and often carried the burden of underreporting due to fear, discrimination etc. A countrywide syphilis control program was implemented in Albania after 1949 that included mass screening (over 100,000 persons screened annually), partner(s) tracing and obligatory treatment for the diagnosed patients. This reduced the annual incidence of syphilis from over 1,000 (in the period 1949-55) to 0 in 1972, maintaining the "zero incidence" until 1995.

From the other side the actual system of the management of STIs through STI dispensaries was found non effective. There are efforts going on to integrate reporting and management of STIs in the system of primary health care.

#### **2.2.2.9. The prisoners**

The health care in the prisons in Albania is presented through medical care offered by doctors, nurses and dentists and the prison hospital. In parallel with health care, an educational service through individual and group work is offered by sociologists and teachers. The epidemiological situation of HIV and STIs in prisons is not clear. Till now, none of the HIV reported cases in Albania have come from prisons. According to the KABP study made in 3 prisons of Albania, the prisoners have little and incorrect knowledge on HIV/AIDS, its transmitting ways and preventive measures.

A program of HARM reduction has been implemented in 4 Albanian prisons by an NGO in collaboration with prison staff. This program had these components: staff awareness and training, education and information for prisoners, distribution of condoms.

#### **2.2.2.10. Roma community**

Low level of knowledge and perception of risk about HIV/AIDS is common among Roma community. This is linked with their high rate of dropping out of school and other reasons common for all population groups. Low level of protective sexual behaviors would be related with knowledge and attitudes. Like other risk groups, the main sources of information regarding HIV/AIDS/STI remain media and friends, whereas school and family are regarded as less important sources of information.

Young roma people represent a relatively sexually active group (around two third of respondents during RAR have had sexual intercourse). Even the relatively young age at the first sexual intercourse (16 years of age) is a fact that supports those results adding the fact that around half of those having had sexual intercourse, have had two or more sexual partners during the last year.

Their relatively high level of sexual risk behaviors is in contrast with low level of protective sexual behaviors, such as very low level of condom use. According to RAR in Roma community, almost half of those who had sex in the past have had sexual intercourse in change for money, drug or other favors, which indicates how their low socio-economic level can influence their risk behaviors. This is also supported by the fact that almost two thirds of the respondents were illiterate, data that should be considered while designing interventions for HIV prevention with this community

Young Roma people start using drugs at a relatively early young age (16 years of age) with cannabis sativa as the main used drug. None of the respondents have been using intravenous drugs. However we have to be careful to generalize this result to all Roma young community, considering the small sample size of RAR study and difficulties of reaching injecting drug users among Roma community. Around one fourth of Roma drug users have experienced intercourse under the effect of drugs, which increases the risk behaviors of this sub-group.

### ***2.2.3. Current Estimates of HIV/AIDS in Albania and Projections***

As of end of 2003, there may be from a few hundred to less than a thousand HIV-infected persons in Albania. A good working estimate is probably closer to a few hundred than a thousand. The best-case scenario will be that HIV prevalence will continue to increase slowly--mostly imported infections and some limited transmission from HIV-infected persons in Albania to their regular sex partner(s). The national HIV prevalence rate will continue to be less than 0.1% (less than 1 per 1,000, or less than 1,500 prevalent HIV infections) by the end of this decade. The worst-case scenario will be a prevalence rate of slightly less than 1% - about 10,000-15,000 prevalent HIV-infected persons in Albania by 2010.

In the projected "most likely" scenario, Albania will remain a low HIV prevalence country, but some HIV transmission will probably occur in the IDU population. However, because of the estimated relatively small number (3,000-5,000) of IDU who routinely share their

injecting equipment and the relatively small size of injecting networks (usually no larger than 2-5 persons), the number of IDU in Albania who may become HIV-infected will probably total no more than about 1,000-2,000 by the end of this decade. These projected HIV-infected IDU can be expected to transmit HIV to some of their regular sex partner(s), i.e., via the non-epidemic pattern of heterosexual transmission. A total of perhaps 500 to 1,000 additional HIV infections via such heterosexual transmission can be expected to occur by the end of this decade. Thus, according to this "most likely" scenario--by the end of this decade, there may be a total of about 3,000-4,000 prevalent HIV-infected persons or a prevalence rate of 0.2%-0.25%. No significant epidemic or extensive heterosexual HIV transmission is projected in this scenario. To put all of these scenarios in perspective, the following are some other scenarios based on what has actually happened in other countries.

sub-Saharan African HIV/AIDS scenario – In this scenario, epidemic HIV transmission occurs in the heterosexual population – HIV prevalence will be 20% of the 15-49 year old population of Albania (1.5 million) resulting in a total of 300,000 prevalent HIV infections in Albania by the end of this decade. This scenario seems not very realistic because the general patterns and prevalence of heterosexual risk behaviors, as well as the high prevalence of known facilitating factors for HIV transmission that are present in sub-Saharan African countries are not present (at least not to the extent that they are in Africa) in Albania.

Thailand HIV/AIDS scenario – In this scenario, explosive HIV epidemics in Albanian IDU reach levels of 30-40% by 2005 and HIV prevalence in Albanian FSW reach levels of 20-40% by the end of this decade. In addition there will be slow and steady HIV transmission from infected IDU and infected male clients of FSW to their regular sex partners during this decade. This will result in a total national HIV prevalence of about 2% or a total of about 30,000 HIV-infected persons in Albania by the end of this decade. This scenario is also unlikely because the size of the IDU population and their injecting networks in Albania are much smaller than in Thailand and the sex industry in Albania is not nearly as large or as highly organized as it is in Thailand. In addition, more than 50% of young Thai males visited FSW on a regular basis in the 1970s and 1980s and this level of high-risk sex behavior is clearly not present in Albania. Anyway more in depth studies related to IDUs and FSW and their behaviors in Albania are needed to follow the supposed scenarios.

Portugal HIV/AIDS scenario - Portugal currently has the highest HIV prevalence of all European countries - In this scenario, relatively extensive HIV transmission occurs in MSM and IDU populations in Albania during this decade and some limited HIV spread to their regular sex partners occurs, but there is no significant further penetration into the "general" heterosexual population. The national HIV prevalence in Albania will, by the end of this decade, be close to 1% for a total of about 10-15,000 prevalent HIV infections. This scenario is possible but still the general level of HIV risk behaviors in MSM and IDU in Albania are probably not as high as those in Portugal.

An HIV/AIDS scenario that is in-between Italy (0.35%) and Greece (0.16%) - In this scenario, some extensive HIV transmission, concentrated in MSM and IDU occurs and then some limited spread from these infected MSM and IDU to their regular sex partners occurs, but no significant further spread or penetration into the "general" population will occur. National HIV prevalence in Albania by the end of this decade will be about 0.2%-0.25% or about 3,000-4,000 HIV infections. This would be a likely scenario for Albania if aggressive or intense risk reduction and harm reduction programs are not implemented and/or are not effective.

Using the SPECTRUM programme (WHO/UNAIDS), existing data about vulnerable groups in July 2003 have been evaluated and reached the conclusion that the numbers of HIV/AIDS infected persons in Albania, fluctuate from 400 to 700. Based on the same figures, if there is no any efficient intervention then the predicted number of HIV/AIDS cases may reach 4000 cases in 2010 and 7000 cases in 2015.

### **3. Response analysis**

#### **3.1. Government**

##### **3.1.1. National HIV/AIDS/STI Programme (Institute of Public Health)**

The National Programme for Prevention and Control of HIV/AIDS was established in August 1987, near the MoH, with the direct support of WHO. The programme aimed at having a comprehensive, organized and scientific evidence-based policy of prevention and control of HIV/AIDS. Even the programme consisted of very few human capacities, another Inter-ministerial and Inter-sectorial National Committee was held responsible to lead the efforts at national level. This Committee was defined as a decision making body in charge of analyzing and deciding to present to the Government health, financial, social, ethical and legal problems related to HIV/AIDS encountered during the years and according to the epidemiological situation.

Further on the National HIV/AIDS Programme was transferred near the Center of Health Promotion and Education and thereafter till now near the Institute of Public Health. During the first years and later, staffed by only one or two people, the NAP has difficulty co-ordinating effectively with other government institutions and ministries because of rigid hierarchal and reporting structures.

Two National Conferences on prevention and control of HIV/AIDS were held in Albania. In September 1992 the First Conference called on "AIDS – will it forget to come to Albania", and in July 1998 the second one "National Policies for Prevention and Control of HIV/AIDS/STI epidemics in Albania". Both conferences had the goal of analyzing the situation, setting the priorities, national policies to address related problems and identify actors in implementation of these policies.

A strategy paper was produced by the second Conference, but the NAP still did not have clear priorities with regard to the targeting of preventive and harm reduction activities among vulnerable groups. The scarce resources (both financial and human) were focussed on setting up safe blood supply and surveillance systems.

**Since 2001 NAP is a multidisciplinary team of doctors, epidemiologists, psychologists and social workers that coordinates and develops HIV/AIDS**

**prevention activities as well as monitors and evaluates the epidemiological situation in Albania.**

**A network of strategic partners has been established in 2003 including governmental, nongovernmental and international or national agencies. This will strengthen the multidisciplinary approach towards prevention and care of HIV/AIDS in Albania. The agencies are listed below in Annex 3.**

**In 2001 an Inter-ministerial HIV/AIDS committee chaired by Vice Prime Minister was established to strengthen the political efforts against HIV/AIDS.**

### ***3.1.2. Diagnostic capacities***

The first diagnostic center of HIV/AIDS was established near IPH followed by the other one in TUHC "Mother Theresa". The diagnostic capacities of IPH lab have been increasing and activities to establish PCR techniques are ongoing. Meanwhile the hospital diagnostic center often suffers lack of kits and reagents. Outside Tirana, only blood banks in district centres and very few public health labs can provide rapid tests for blood donors and volunteers. HIV testing is carried out on a voluntary basis and offered anonymously and free of charge.

Simple techniques of measuring CD4 and CD8 were established in Tirana in the beginning of 90s but failed to develop further and such activity was interrupted in 1997. Only recently TUHC has ordered the purchase of more advanced techniques such FACs etc.

Still the diagnosis of opportunistic infections needs to be strengthened.

### ***3.1.3. Surveillance of HIV/AIDS***

The general methods used for public health surveillance of HIV/AIDS are, in general; no different from those used for other diseases and infections. However, the methods used must be adapted to the unique epidemiology, wide variation in prevalence levels, and the very long incubation period of HIV infection prior to the development of AIDS. In addition, the severity of AIDS and the extreme social and personal implications of identifying HIV-infected persons make surveillance of HIV/AIDS much more difficult and make issues such as anonymity and confidentiality of paramount importance.

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

A surveillance system of reporting HIV and AIDS cases was established since the early 90s but recognition, diagnosis and reporting of HIV/AIDS is generally very incomplete so HIV infections and AIDS cases reported to health authorities throughout the world constitute a variable and usually only a small fraction of the estimated total. The estimated completeness of AIDS case reporting varies from highs of 50% or more in the more developed countries to less than 5% in most developing countries. Therefore reported AIDS cases and HIV infections should serve only as a starting point for estimation of actual HIV infections and AIDS cases that have occurred.

Four sentinel groups were established in Tirana in 1995 to measure the trends of the epidemic: pregnant women, new military recruits, women attending the Gynaecological Hospital for abortion and women attending the Gynaecological Hospital for gynaecological complications. Although no cases of HIV infection were identified, the establishment of such sentinel surveillance system was a success.

According to the UNAIDS/WHO Guidelines for Second Generation HIV Surveillance distributed in 2000, the WHO HSS guidelines must be adapted to different HIV patterns and prevalence in low HIV prevalence countries.

In 2002-2003 four sentinel sites for drug users were established in Tirana in collaboration with governmental and nongovernmental structures such as National Substance Abuse Facility, Action Plus, APRAD and Emmanuel Center. Efforts are in place to establish such sites in Shkodra, Vlora, Korca and Gjirokastra.

Sentinel surveillance of victims of trafficking and FSWs were established in Tirana and expanding in Vlora. The high HIV risk behavior of MSM in Albania is reflected in the finding that as of 2002 they constitute up to a quarter of the total reported HIV/AIDS in Albania. MSM should be included as an HIV sentinel group, regardless of small numbers. More MSM might be accessed by an NGO such as ALGA (Albanian lesbians and gay association) working with public health staff.

Surveillance of STIs lack resources but laboratory Syphilis surveillance is in place and efforts to establish a syndromic surveillance and Gonococcal and Chlamydia lab surveillance are ongoing.

The current HIV surveillance system appears to be sufficient to be able to detect increases of HIV prevalence to about 1-2% in IDU and STD patients, but the numbers of

samples collected for these HIV RBGs should be increased (doubled if possible) to increase the reliability and sensitivity of the current HIV surveillance system.

What has been lacking with the current HIV surveillance system is a regular and systematic review and evaluation of the accumulating HIV data from the many different and diverse population groups.

Large scale population surveys of HIV risk behaviors (KABP surveys, RAR, MICS and RHS) were developed and supported by MoH and IPH in collaboration with international or national agencies such as UNICEF, UNFPA, USAID, CDC, UNDP etc. A risky behavior survey of youngsters' 14-18 years old is ongoing and will serve as a baseline for evaluating regularly risky behaviors of such age all over the country. A Behavioral Surveillance System in Albania to monitor behavior change in the highest HIV risk behavior groups should be established.

#### **3.1.4. Blood safety and blood donors**

HIV blood screening started in Albania before the first case of HIV/AIDS was diagnosed in the country. Since 1992, 60% of blood donors countrywide were screened for HIV. In May 1993 the first case of a HIV case was detected among blood donors and in October 1993, 26 Blood Banks all over the country introduced HIV blood screening for every single unit. Blood screening for HIV and other infectious diseases is regulated by law and on the other hand the law forbids importation of blood and other blood products. So according to the legislation, each blood unit in Albania is screened for the presence of antibodies anti-HIV.

Albania shares a history of paid blood donors but their number is decreasing from 18,000 in 1991 to 4,000 in 2002. The culture of voluntary blood donations started in the middle of 90s and their number even increasing every year (1,900 in 1999) is still insufficient to outweigh the fall of paid blood donations. . But there is an overall attitude against voluntarism in Albania following years of forced "voluntary" acts during the pre '90-ies period and the level of awareness about voluntary donation among general population is still low. Donations from family are in continuous increase reaching the number of 2,000 in 2002.

The policy of minimizing blood transfusions is in place but even so there is a shortage in blood supply. A significant number of paid donors come from vulnerable or even especially vulnerable population groups (Roma population, drug users, rural-urban migrants, etc) so the awareness for self-exclusion is low.

The process for ensuring blood safety in respect to HIV infection in Albania passes through the following stages: Self exclusion of the donor, exclusion during the interview with the Blood Bank staff, exclusion in case of positive or undetermined test result.

In total since 1993, 16 persons were detected as HIV positive following the routine screening before blood donation. Epidemiological investigation has shown that only in three cases the transmission of infection was via infected blood (3% of total number of PLWHA). Further investigation of these three cases proved that the transmission occurred during the sero-conversion period. This is an evidence for the success of the screening program in Albania, but it also stresses the need for continuous improvement in the testing techniques. A manual of blood safety is in place since 2000 and a national policy has been adopted since 1993.

### ***3.1.5. Legal acts ensuring health and human rights***

The improvement of legal framework has been gradually carried out, according to the development of epidemiological situation, political and socio-economic changes and the level of awareness among policy-making and decision-making government structures. These efforts were finalized with approval of the law "For prevention and control of HIV/AIDS in the Republic of Albania", in 2000. The law ensures the informed consent and confidentiality as well as the right to treatment, care and social support. There have also been critics for different aspects of it and certain amendments might be needed to bring about improvements and to make it more similar with legislation of the other countries. Aspects like confidentiality are not properly dealt with and the law is not yet completed with the required legislative framework. The rights of PLWHA are protected by law. The reproductive health law had already passed the parliament and ensures the rights of women. Training for advocacy and awareness raising purposes are often organized.

### ***3.1.6. Activities in the area of prevention and care and support for PLWHA***

#### ***3.1.6.1. Information, education, communication and training***

First preventive efforts, through information leaflets and small round tables have started in the beginning of 90s. With the establishment of national program, these efforts became more organized, including national campaigns, compilation and distribution of information, education and communication materials, and an active participation in international campaigns. The Department of Health Education and Promotion at the

Institute of Public Health serves as a reference center on IEC problems related to prevention of HIV/AIDS under the technical guidance of NAP.

Health education in schools for HIV/AIDS problems is part of primary school curricula and sex education has been addressed through preparation of very few manuals. Although, teachers have been trained in these topics, there are considerable gaps in the implementation of education programs especially sex education.

National AIDS Program has been involved in regional initiatives aiming at offering support to drug users, MSMs and FSWs. University Toxicological Center is the center where methadone detoxification therapy with is provided for injecting drug users.

Peer education programs for youngsters, women, victims of trafficking, prisoners, MSM etc have been designed by NAP and IPH staff in collaboration with different NGOs.

Training programs for nurses, doctors, social workers, behavioral surveillance, sex education etc are developed through collaboration of NAP,IPH and Faculty of Medicine, Faculty of Social Sciences and UN agencies.

Vaccination programs are offered free of charge for all groups at risk.

NAP offers a strong political and technical support to representatives of communities especially at-risk or vulnerable groups.

### ***3.1.6.2. Condom use and condom promotion***

The contraceptive use, including condom, was introduced in Albania for the first time in 1992 when Albanian Government approved the Family Planning activities with the "Decision No.226-date 27.05.92. No political or legal barriers to sell or promote condom use exist in the country. Since 1993 contraceptives are distributed in all the public health services for family planning free of charge provided by UNFPA. In 1996 in Albania had started also the programs for social marketing of contraceptives with two big national programs NESMAR and ASMA PSI. According to the source of distribution of condoms, is estimated as 96 % from social marketing and 4% from the public sector in the second half of the year 2002. From the supervision done from the MOH in the public family planning clinics results that the preferences for condom use are increasing. Every health care facility offers contraceptives within family planning programmes. Receptiveness to condom use is plagued by barriers, including embarrassment or timidity

to obtain condoms from sources that require person-to-person contact. For this reason Health Centers – particularly family planning clinics may be seen as inappropriate. Training programmes with health service providers towards changing of attitudes and condom use are ongoing. Many providers view condoms only for their role as contraceptives, downplaying or ignoring their infection prevention properties. Often, when faced with recommending contraceptive choices, providers choose methods that are less user-dependent at the time of sexual relations, such as injectables or oral contraceptive pills. Some providers are openly uncomfortable discussing condoms, will not discuss condoms, or are biased against unmarried youth obtaining condoms.

Even 82 % of men knew what a condom is, only 9% had used it the last time they had sex according to a KAB study. Also according to RHS (unpublished data) the condom use is still very low.

### ***3.1.6.3. Confidential and voluntary counseling and testing***

The first capacities to offer HIV related CVCT were created in the first years following the changes in the socio-economic situation of Albania (post '90-ies) where emigration favored the penetration of HIV in the country (1992). Since the beginning CVCT was offered for free (no price) to volunteers, persons referred from clinics and blood donors. Pretest and post test counseling is offered at IPH (NAP) .Most of the lab professionals in the other districts admit that they feel unprepared to provide pre and post-test counseling to their clients. Since now over 1,500 pre and post counseling sessions related to voluntary HIV testing are performed at the Counseling Room of the NAP. Several attempts have been made to train medical and other staff to perform CVCT related to HIV/AIDS and these attempts still continue. Infectious Diseases Department at TUHC offers voluntary counseling but a proper facility is still missing. Albania lacks a network of CVC.

### ***3.1.6.4. Care and support for people living with HIV/AIDS***

The first response towards HIV/AIDS in Albania remained in the framework of a medical response. It included training medical professionals in specialized clinics in European countries in the following disciplines: clinical care, testing and epidemiology. The Infectious Diseases Department in TUHC "Mother Therese" has a fully trained team of medical doctors able to provide the whole range of medical care to PLWHA. IDD was thought to become the Clinical Reference Center at national level for medical care towards

PLWHA. It remains till now the only center in Albania where PLWHA can get specialized medical care. Due to lack of CD<sub>4</sub> count and viral load tests, the diagnosis of AIDS and symptomatic HIV infection is only based on clinical signs and symptoms, as well as on simple leucocytes' count. Although the AIDS Law in force (On the Prevention and Control of HIV/AIDS in the Republic of Albania) grants the PLWHA the right to free treatment (including the antiretroviral therapy), no ART was ever provided by the public sector. 6 patients were treated with ART (combination of two drugs) and 2 with a regular drug cocktail (combination of three drugs). The patients were purchasing themselves the medicines in other countries and due to the high price of drugs, they could continue with the medication only for short periods of time. This conditioned the effectiveness of the medication. Actually 2 patients are in regular tri-therapy and they are surviving at AIDS stage since respectively 3 and 5 years. The remaining of the AIDS patients were receiving only non specific medical care (in other words medication directed towards opportunistic infections and other diseases related to AIDS) and palliative care. Even the non specific medical care was sometimes influenced by shortage in drugs and there have been frequent cases in which the patients have provided themselves for purchasing the needed drugs. Due to the lack of ART the surviving period for an AIDS patients has been lower than 2 years and determined the actual case fatality rate (31 out of 36 AIDS cases or CFR = 86%). Recently MoH has allocated fund to purchase ART and through an agreement with UNICEF and with the help of WHO the procedures have already started.

**Stigma and discrimination in relation to HIV/AIDS are still present in the Albanian society.** The counseling cabinet at the Institute of Public Health reports cases of severe discrimination of PLWHA by family and community members when they revealed their HIV status to them. There are also cases of PLWHA who have not yet revealed their HIV status even to their sexual partners. High figures of stigma and discrimination are also suggested by the surveys. So, 22% of the women interviewed in the context of a Multiple Indicator Cluster Survey said that a teacher with HIV/AIDS should not teach and another 10% that they would refuse to buy food from a PLWHA. The fact that more punitive attitudes were found among higher educated women and urban vs. rural dwellers is astonishing and suggests an apparent underreporting. There is no association of PLWHA or any other form of self help group.

PLWHA can benefit from the social assistance once they receive the status of the chronically sick person from a Specialized Medical Body. The amount that is benefited

(~US\$35) and the fear from stigma and discrimination brings to a situation where none of the PLWHA has received that status.

Although the staff dealing with PLWHA (medical staff of IPH and IDH, lab personnel, councilors, etc.) has always tried to comply with confidentiality in respect to HIV status of patients/clients, there have been a few cases of legal and human rights violation of PLWHA in Albania (sometimes with the involvement of written and electronic media).

### **3.1.2. Other government structures and country coordinating mechanism**

Ministry of Health is responsible and monitor and evaluates the work of NAP and within the Directory of Primary Health Care there is the RPH program. Also a data base of condom distribution has been established. MoH funds the NAP and almost all HIV/AIDS related activities in the country.

Other government institutions such Ministry of Education, Ministry of Justice, Ministry of Social Affairs have designed programs related to HIV/AIDS but their contribution is still low and they do not have independent initiatives but always relying on MoH or other health actors initiatives.

HIV/AIDS inter-ministerial committee is the highest body for adopting policies and regulations related to HIV/AIDS. A country coordinating mechanism has been established near MoH where NAP and IPH staff are the secretary and involves all strategic partners identified from NAP in the fight against HIV/AIDS (see implementation structures).

### **3.2. NGOs**

There are only a few NGOs (e.g. Aksion Plus, Stop AIDS) which focus strictly on HIV/AIDS, but many more are including HIV/AIDS/STDs and drug harm reduction related activities in their programmes. It is clear that the evolving NGO scene will provide future opportunities for HIV/AIDS prevention programmes. Aksion Plus and APRAD are applying harm reduction programs for drug users in Tirana. ASMA-PSI is involved in condom distribution and life skills education projects in the main cities of Albania. The Albanian Red Cross is organising life skills education via peer to peer activities in four remote areas, and the Albanian Youth Council, including OSPES (Albanian Association for Sexual Education), has been involved in an awareness campaign centred around the December 1<sup>st</sup> World AIDS Day celebration. ISOP has been involved in KAB survey and the survey of know ledges, attitudes and believes among specially vulnerable groups.

Representatives of NGOs have organized IEC activities directed especially toward young people using a variety of methods as the TV and radio programs, publication of posters, booklets and leaflets, seminars, conferences, competitions etc. Training of peer educators is a method commonly used in schools, army, prisons etc. Involvement of NGOs in activities organized in the framework of International Campaigns against AIDS (finalized with World AIDS Day) has been highly effective.

NESMARK and ASMA/PSI are the major sources for condoms providing both an estimated amount of 96% of condoms actually used in Albania. (MOH/SEATS USAID, report on safety for contraceptives, March 2002). Part of their activities was the social marketing for condoms. Condoms (For YOU) and FOUR YOU more (Nesmark); Love + (PSI/ASMA) were distributed at all the pharmacies of the country with low affordable prices. Both the programs also have included a big part of their activities on IEC promotion for condom use. There are examples of solidarity, care and support for members of gay community infected with HIV/AIDS, but they are still sporadic and not organized.

Monthly meeting on HIV/AIDS of NGOs under UNICEF and IPH initiatives started since end of 2002.

### ***3.3. International organizations***

Many of the United Nations agencies present in Albania have been actively involved in the area of prevention and control of HIV/AIDS. The first contribution in the efforts for the prevention and control of HIV/AIDS in Albania has been given by WHO through the Global Program against AIDS (GPA). Collaboration with WHO/GPA has consisted on the following direction:

- Establishment and qualification of a core group of Albanian specialists
- Provision of necessary equipments for diagnostic labs and screening of donated blood
- Technical assistance for the problems of prevention and control of HIV/AIDS and health promotion.
- Short-term trainings of National Aids program

- Financial support for the participation of Albanian specialists in international activities.
- Technical assistance for introduction of sex education in school curricula.

The UN Theme Group on HIV/AIDS in Albania was established in 1997. It consists of five agencies: UNFPA, UNDP, UNICEF, WHO, and the World Bank. The UNICEF Representative chaired the group from July 1998 to April 2001, and was succeeded by the WHO Representative. In November 1997, the post of a National Programme Adviser was established, cost-shared by the UNAIDS and the co-sponsors at country level. The assets of the UN Theme Group in Albania are shared responsibility, advocacy, and a consensus policy. The main achievements of the UN assisted responses to date are:

- the establishment of the above mentioned post; and
- the organisation of a second National Conference on "Policies of Prevention and Control of HIV/AIDS/STD Epidemic in Albania", which was held in Tirana in July 1998. The Conference strategy paper defined the following main priorities:
  1. Political commitment
  2. Prevention
  3. Supervision, monitoring, research
  4. Treatment, care, support.
  5. Social legal and ethical issues.
  6. Inter-sectorial and multi-disciplinary cooperation.

UNICEF has supported research programs (Rapid Assessment and Response HIV/AIDS among especially vulnerable young people in Albania, conducted in collaboration with Institute of Public Health in 2001-2002, KAB study, RHS etc. ), IEC programs, preparation of life skills manual, health education in schools, pilot project on youth friendly services, trainings of health personnel, representatives of NGOs, vulnerable groups etc. and training on VCT. UNICEF has contributed to the establishment of a network of NGOs with activities in the area of prevention and control of HIV/AIDS in Albania.

UNFPA has supported programs of reproductive health and facilitated the implementation of social marketing of condoms. UNFPA plays the role of the Center for logistic management distribution system of contraceptives (including condoms). Since 2003, UNFPA is involved in youth friendly services programs. UNFPA has offered financial

support for international campaigns against AIDS and research programs and participated in both KAB and RHS

UNDCP has played an important role in drug demand reduction programs, and has financially supported various IEC intervention programs implemented by NGOs.

IOM has been involved in programs of medical care for victims of trafficking, and in collaboration with Institute of Public Health and Albanian Community Health Organizations (ACHO) offers HIV testing and counseling medical care for STI, trainings of rehabilitation centers personnel for and has been involved in regional studies on HIV/AIDS.

UNDP has been the technical and financial support of the project for the development of this strategy. Also participated in the study of knowledge and attitudes among specially vulnerable groups.

USAID has been very active in the programs related to reproductive health including condom promotion as well as strengthening the role of primary care in HIV/AIDS/STI prevention and treatment, training activities, gender related issues, trafficking and health, surveillance and supported technically and financially RHS.

#### **4. Strategy goal, strategic components and objectives**

**Strategy Goal: BY 2010, ALBANIA WILL CONTINUE TO REMAIN A LOW HIV PREVALENCE COUNTRY**

##### **4.1. Strategic Component No. 1:**

##### **GENERAL POPULATION AND VULNERABLE POPULATION GROUPS**

**Objective: To keep the prevalence of HIV among the general population less than 0,1% by 2010**

##### **4.1.1. General population**

**Increase the level of knowledge and promote safe sexual behaviors among the sexually active adult population**

Strategy:

- Increase the level of awareness and involvement of the general population towards creating a supporting environment and eliminate the barriers that hinder the programs of prevention, intervention and care
- Strengthen the National Center of Reference (DHE,NAP at IPH) that would ensure standard setting and excellence in relation to IEC activity
- Compile, implement and evaluate evidence based and theory driven programs for increasing the degree of information and communication of the population and promoting safer sexual behaviors.
- Strengthen the capacity within partner organizations to develop and implement culturally appropriate interventions for characterized audiences
- Ensure the continuity of current social marketing condom programs and support the establishment of a monitoring framework

#### **4.1.2. Youth**

The objectives and activities for prevention and control of HIV/AIDS among youth will be coordinated and adapted to the objectives and activities included in the National Strategy of Youth that has been drafted under the auspices of the Ministry of Culture, Youth and Sports.

#### **Increase the level of safer behaviors and, therefore, decrease the level of risk among adolescents (13-18 years old) and young adults (19-24 years old)**

##### Strategy:

- To increase the level of safer behaviors and, therefore, decrease the level of risk among adolescents (13-18 years old) and young adults (19-24 years old)
- Develop low risk and establish risk prevention skills among adolescents and young adults that are culturally appropriate
- Compile, implement and evaluate evidence based and theory driven school based IEC and BCC programs
- Design and implement through out reach risk prevention programs for adolescents and young adults out of the schools
- Compile, implement and evaluate evidence based and theory driven IEC and BCC programs for young people serving in the army
- Expand the concept of youth friendly health services and establish youth friendly environments in the places where such services are offered

#### **4.1.3. Women**

#### **Increase the percentage of women at sexually active age that are engaged in behaviors that reduce the risk of HIV transmission**

##### Strategy:

- Create a supportive environment and eliminating the barriers that prevent the programs of prevention and support among women at a sexually active age
- Compile, implement and evaluate evidence based and culturally appropriate programs that increase the women's level of knowledge and skills thus enabling them to take decisions that reduce the risky behaviors and increase the behaviors that protect against exposure towards HIV (these programs will put particular focus on the wives of the emigrants)
- Compile, implement and evaluate evidence based and culturally appropriate IEC and BCC programs targeted towards young women living in the rural and peri-urban areas as well as programs that aim to prevent trafficking and involvement in sex work
- Establish culturally appropriate HIV risk reduction programs through community training and planning activities
- Implement HIV/AIDS prevention programs through reproductive health ones and use mother and child clinic to promote HIV prevention activities
- Increase women empowerment and their negotiating skills through culturally appropriate training and intervention programs in urban and rural areas.
- Establish alliances of women associations on HIV prevention activities
- Establish women friendly services all over the country.

#### **4.1.4. Mobile population**

The activities for the prevention and control of HIV/AIDS among the mobile population will be coordinated and adapted with the activities that are included in the National Strategy for migration and host countries

#### **Reduce the risky behaviors that expose the mobile populations towards HIV/AIDS and improve their health seeking behavior**

Strategy:

- Create an enabling and culturally appropriate environment and eliminate the barriers that obstacle the programs of prevention and interventions among migrants and their families
- Compile, implement and evaluate IEC and BCC as well as programs of care and support targeted to the mobile populations, including information and counseling programs during pre-departure and after the arrival
- Advocate for migrants rights, compile, implement and evaluate programs for improving the health seeking behavior of the mobile populations while they are in the country of emigration and on return
- Compile, implement and evaluate bilateral and regional programs with the participation of governmental and nongovernmental partners in the field of IEC, BCC and provision of care and support

#### **4.1.5. Blood safety**

#### **Continue to monitor and support the programs that ensure the safety of blood, blood products, tissues and organs**

##### Strategy:

- Compile, implement and evaluate evidence based and culturally appropriate programs for promoting the voluntary (non designated) blood donation and the self-exclusion of donors (both paid and voluntary) that manifest risky behaviors
- Promote public private partnerships for promoting voluntary blood donation
- Implementation of strict scientific criteria for eligibility of patients for transfusion of blood and/or blood byproducts and promotion of use of blood substitutes
- Improve/strengthen the technical and human capacities for increasing the accuracy of screening methods for blood, tissues and organ donors
- Strengthen the epidemiological follow up of persons that might have been exposed to HIV during blood transfusion or tissue and organ transplant

- Ensure gradual regionalization of the blood transfusion service
- Review the legal framework in respect to importation of blood and blood products

#### **4.2. Strategic Component No. 2:**

##### **ESPECIALLY AT-RISK AND VULNERABLE POPULATION GROUPS**

**Objective: To keep the prevalence of HIV infection among the especially vulnerable groups less than 1% by 2010**

##### ***4.2.1. Injecting Drug Users (IDU):***

The activities for prevention and control of HIV/AIDS among the injecting drug users will be coordinated and adapted to the activities included in the National Strategy for Drug Demand Reduction which has been drafted under the auspices of the Ministry of Health

**Reduce number of injecting drug users who abstain for drug use and for those who do not abstain, and increase the percentage of users who attend the harm reduction programs**

Strategy:

- Create a supportive environment and eliminating the barriers that prevent the programs of prevention and interventions among the injecting drug users such as: peer education programs, community oriented programs etc.
- Compile, implement and evaluate culturally appropriate and theory driven IEC and BCC programs for preventing the spread of HIV among the IDU
- Compile, implement and evaluate evidence based and theory driven programs for reducing the demand for drug, stressing primary prevention programs among young people
- Strengthen and expand the capacities for offering services to the IDU, including confidential and voluntary counseling and testing (CVCT), referral to mental health programs, methadone maintenance and detoxification programs, as well as needles and syringes exchange programs

- Compile, implement and evaluate evidence based and culturally appropriate programs for IDU belonging to the Roma community
- Review the legal framework in respect to facilitating the implementation of harm reduction programs

#### **4.2.2. Men who have Sex with Men (MSM):**

**Decrease the percentage of MSM who manifest risky behaviors for the transmission of HIV and improve the behaviors that reduce the risk of transmission**

Strategy:

- Create a supportive environment reducing stigma and eliminating the barriers that prevent the programs of prevention and interventions among the men who have sex with men
- Strengthen the organizations that assemble the communities of lesbians and gays and establish partnerships among these organizations, governmental, nongovernmental and civil society organizations in order to promote prevention and care programs
- Compile, implement and evaluate evidence based IEC and BCC programs, especially targeted to young MSM and MSM who practice sex work
- Increase the availability and acceptability of the bio-medical prevention methods among the MSM community (special condoms, lubricants, etc.)
- Strengthen and expand the capacities for offering services to the MSM, including confidential and voluntary counseling and testing (CVCT), care for patients with STI from the MSM community and establishment and referral to gay friendly services

#### **4.2.3. Commercial Sex Workers (CSW):**

**Reduce the percentage of commercial sex workers that have risky behaviors for transmitting HIV and promote safer sexual behaviors in this population group**

Strategy:

- Create a supportive environment and eliminating the barriers that prevent the programs of prevention and interventions among the commercial sex workers
- Compile, implement and evaluate evidence based and culturally appropriate IEC and BCC programs for the CSW and protectors
- Increase availability and acceptability of HIV/AIDS bio-medical preventive methods (male and female condoms, lubricants etc) for the CSW as well as for the clients
- Initiate and strengthen the concept of CSW friendly services and establishment of environment where such services are offered. (These services should include medical care and psychosocial support, referral to appropriate CVCT services and existing shelters and/or reintegration programs)
- Compile, implement and evaluate evidence based and culturally appropriate programs for the commercial sex workers belonging to the Roma community
- Foster HIV/AIDS partnerships among NGOs dealing with victims of trafficking, women shelters and NAP
- Review the legal framework in respect to decriminalization and regulating the commercial sex work and the provision of care and support for this population group

**4.2.4. Victims of trafficking (VoT)**

The activities for the prevention and control of HIV/AIDS among the victims of traffic will be coordinated and adapted to the activities that are included in the National Strategy against the Traffic of Human Beings, which was drafted in 2001 under the auspices of the Council of Ministers

**Reduce the risk behaviors of the VoT exposed to HIV/AIDS and to promote the adoption of safer behaviors**

Strategy:

- Create an enabling environment and eliminate the barriers that obstacle the prevention programs and interventions among victims of trafficking
- Compile, implement and evaluate IEC, BCC and early intervention programs aiming to promote the adoption of safer behaviors
- Compile, implement and evaluate programs for the provision of treatment and support to the VoT, including shelter, protection, psychosocial counseling, medical care and reintegration opportunities
- Compile, implement and evaluate programs to build capacity on prevention efforts and trafficking issues
- Compile, implement and evaluate bilateral and regional programs with the participation of governmental and nongovernmental partners in the field of IEC, BCC and provision of care and support
- Design regional programs East-West to develop culturally appropriate and evidence based interventions of reducing risky behavior

#### **4.2.5. Persons with Sexually Transmitted Infections**

As STIs are a strong biological co-factor in the sexual transmission of HIV their prevention, although a strategy in itself, must be included in the strategy of HIV prevention.

#### **Decrease the number of persons infected with a STI and reduce the possibility for HIV transmission among these persons**

##### Strategy:

- Establish and strengthen the Center of Reference (IPH) that will ensure expertise, training and set standards for the prevention, control and management of the persons with STI
- Establish and implement policies for the management of the persons with STIs through combining the syndromic and laboratory approach and adapt them to the existing conditions, as well as to the epidemiological situation
- Compile, implement and evaluate culturally appropriate programs for increasing the awareness, level of knowledge, adoption of safer sexual

behaviors and improvement of the STIs health seeking behavior of the general public, women, young people and especially vulnerable population groups

- Establish, strengthen and expand capacities for offering services of prevention, control and management of STIs at the central, regional and local level
- Strengthen systems for reporting and surveillance of STIs as part of the second generation surveillance
- Review the legal and institutional framework for increasing the level of response of the existing capacities and epidemiological situation

#### **4.2.6. Prisoners**

##### **Prevent the spread of HIV among the persons who suffer detention**

###### Strategy:

- Increase awareness of the senior staff of the prisons' administration in relation to HIV prevention activities in the prisons' structures
- Increase the level of knowledge of the medical and other prisons' staff in relation to HIV/AIDS prevention and control
- Enable the prisoners to benefit from awareness raising, IEC and BCC programs, treatment as well as mental health care
- Compile, implement and evaluate harm reduction programs in the prisons' system for both sexual and IDU at risk
- Review the legal framework in respect to facilitating the implementation of HIV/AIDS prevention and control programs in the prisons' setting

#### **4.2.7. Roma community**

##### **Prevent the spread of HIV among Roma community by reducing and preventing risky behaviors and promote healthy ones**

###### Strategy:

- Increase the awareness among Roma community about risky behaviors related to HIV
- Eliminate barriers that impede prevention programs and interventions by empowering Roma community
- Establish culturally appropriate IEC programs and BCC for safe behaviors
- Establish a network of peer Roma health promoters and educators
- Establish a network of HIV prevention among Roma community all over the Balkans and promote prevention activities related to Roma community among all NGO operating within the country

### **4.3. Strategic Component No. 3:**

#### **IMPROVE CARE AND SUPPORT FOR THE PERSONS LIVING WITH HIV/AIDS**

**Objective: Ensure access to quality services for care and support for all persons living with HIV/AIDS and those affected by the epidemic**

##### **4.3.1. Medical care**

#### **Ensure full medical care and treatment for all the persons living with HIV/AIDS**

##### Strategy:

- Strengthen the capacities at the Center of Clinical Reference (IDD)
- Ensure inpatient and outpatient hospital care for all persons living with HIV/AIDS based on standard protocols for treatment
- Ensure access to treatment for all PLWHA in need for it
- Establish the policies and create/strengthen the capacities for ensuring home care and primary health care to PLWHA
- Gradual establishment of regional specialized centers that ensure suitable medical care (including diagnosis, treatment and follow up) for the PLWHA

- Coordinate and support the nongovernmental organizations that provide care and support to the PLWHA
- Review and adapt the HIV/AIDS related legislation, compile the regulatory framework and ensure implementation in relation to care and support for the PLWHA
- Establish community oriented intervention efforts that reduce stigma and discrimination

#### **4.3.2. Confidential and Voluntary Counseling and Testing (CVCT):**

##### **Ensure and expand adequate counseling and testing services for all persons who seek these services and for the PLWHA**

###### Strategy:

- Establish and strengthen the Center of Reference for CVCT (IPH) that will provide experience and training and will set standards in delivering confidential and voluntary counseling and testing in relation to HIV/AIDS
- Compile, implement and evaluate programs for strengthening the capacities for delivering CVCT in relation to HIV/AIDS especially pre- and post-counseling, including counseling to people who are found negative but who are at risk because of their behavior or environment.
- Compile, implement and evaluate evidence based and culturally appropriate programs designed for the large public and, in particular, for the especially vulnerable groups in order to increase awareness and motivation for performing HIV testing
- Create a supporting environment and eliminating the barriers that obstacle from seeking CVCT services
- Establish new VCT centers near IDD,BB, and other testing services
- Review the legal framework with respect to anonymous testing and (eventually) establish a network where such service will be offered

#### **4.3.3. Mother To Child Transmission (MTCT):**

**Reduce the mother to child transmission of HIV through preventive efforts and ensure appropriate care for the children living with HIV/AIDS**

Strategy:

- Strengthen the capacities for the prevention of MTCT and care for children living with HIV/AIDS
- Promote the opt out approach of HIV testing offering it for every pregnant women among other tests
- Compile, implement and evaluate culturally appropriate programs for integrating IEC components in relation to MTCT of HIV in the antenatal care services (mother and child centers, family planning clinics, gynecologic-obstetric hospitals, etc.)
- Compile, implement and evaluate standard protocols for counseling, risk assessment, referral, diagnosis and treatment for the pregnant women that attend the antenatal care services
- Compile, implement and evaluate standard protocols for risk assessment, diagnose, referral and suitable treatment for pregnant women and children living with HIV/AIDS
- Establish the treatment for all pregnant women reducing the risk of MTCT

#### **4.3.4. Prevention of nosocomial infection of HIV infection**

**Reduce the possibility of nosocomial transmission of HIV infection through increasing awareness of health care workers on universal precaution measures and ensuring the proper means and equipments for protection**

Strategy:

- Compile and distribute guidelines on universal precaution measures, including recommendations, protocol on post exposure prophylaxis (PEP) and reviewing of related legal framework
- Compile, implement and evaluate the training programs for health care workers (HCW) on universal precaution measures and further steps followed in case of HIV exposure of medical personnel and patients.
- Ensure the antiretroviral therapy for post exposure prophylaxis among health care workers as well as proper means and equipments for protection

#### ***4.5.1. Social care and support***

#### **Ensure full social support for all the persons living with HIV/AIDS**

##### Strategy:

- Increase awareness among social workers about HIV/AIDS
- Ensure social support for PLWHA and their families
- Revise and improve legislation acts related to social support of PLWHA and their families
- Establish friendly environments in all social services for PLWHA and their families
- Establish training programs for all social workers, psychologists etc on HIV/AIDS and health and human rights
- Establish the policies and create/strengthen the capacities for ensuring social care, support and protection of human rights of PLWHA and their families
- Reduce stigma and discrimination towards PLWHA by fostering links of social services and communities

#### **4.4. Strategic Component No. 4:**

## **MONITORING, IMPACT ASSESSMENT AND SCIENTIFIC RESEARCH**

**Objective: Establish effective systems of monitoring and evaluation based on epidemiological, behavioral and environmental indicators**

### ***4.4.1. Second Generation Surveillance***

**Establish an effective system of the second generation surveillance in order to monitor the prevalence of HIV infection and the prevalence of the risky behaviors that facilitate the transmission of HIV**

Strategy:

- Create/strengthen the required capacities for establishing, implementing and evaluating a national system of the second generation surveillance and for analyzing the data generated by it.
- Establish systems for monitoring, ensuring quality control and unified standard in relation to the second generation surveillance
- Compile, implement and analyze the data generated by different surveys to complete the biological surveillance of HIV/AIDS
- Strengthen the sentinel surveillance of HIV/AIDS among especially vulnerable groups
- Develop a system of behavioral assessment and continuously identify opportunities, barriers, and appropriate approaches to promoting behavior change.
- Compile, implement and analyze the data generated by behavioral surveillance among the general population, at risk and vulnerable groups and especially marginalized groups whose rights must be preserved through proper attention.
- Institute an efficient system for reporting and collecting routine data from the passive surveillance in relation to HIV/AIDS

- Develop the capacity in Albania to train for second generation surveillance according to international standards
- Establish an applied epidemiology training program for HIV/AIDS/STI according to international standards for all health and social workers
- Create/strengthen within the surveillance system of an analytical framework that will allow the identification and characterization of populations and sub-populations at increased epidemiological, behavioral or social risk

#### **4.4.2. Impact assessment and service delivery**

##### **Establish a system to guaranty the assessment of the impact of activities and service deliveries in the framework of this strategy**

###### Strategy:

- Create/strengthen capacities to ensure the monitoring and evaluation of the interventions and periodical review of the strategy
- Establish clear scientifically based indicators, collect reliable data of the baseline level and in ongoing basis, in order to ensure that service delivery organizations have the capability to build effective interventions, target the interventions to where they are most needed and assess the impact of the strategy
- Initiate and/or strengthen the development of all forms of evaluation research throughout the HIV/AIDS field of interventions by creating model of success to keep a low prevalence country
- Establish a system rational system of prioritizing in area of interventions of HIV/AIDS in order to ensure the effective and cost-effective investment of human effort and funding

#### **4.4.3. Scientific research**

##### **Expand, strengthen and increase the quality of the scientific research for assessing the behavioral risk, vulnerability and the environmental factors**

**on one hand and the proper development of appropriate interventions on the other.**

Strategy:

- Establish/strengthen capacities for ensuring the implementation of qualitative and quantitative studies in relation to HIV/AIDS at the level of the general population, vulnerable groups and especially vulnerable groups
- Establish a system of mapping of at risk populations
- Establish a system of behavioral monitoring through repeated surveys in populations with the highest-risk behaviors
- Establish/strengthen capacities for ensuring the review and assessment of the scientific research in respect to the importance, priorities and methodology
- Compile, implement and evaluate descriptive/analytical research programs that are essential to the development of interventions
- Compile, implement and evaluate developmental research programs that are essential to the development of capacities and interventions
- Ensure adherence to ethical principles in HIV/AIDS related research and provide for adequate funding for research programs in respect to different aspects of the preventive work and care for the PLWHA (this will include research programs for estimating the situation, assessing the vulnerability determinants, determining the needs and compiling interventions programs designed for especially vulnerable population groups)

## **5. Strategy implementation structures**

### **5.1. The policy-making bodies**

The National Committee of HIV/AIDS Prevention and Control operates according to the Law Nr 8698, Article 4 and to the other legal framework that derives from this law. The deputy prime minister is the chair of the National Committee and the committee is composed of the vice Minister of the Ministry of Health, the vice Minister of the Ministry of Science and Education, the vice Minister of the Ministry of Public Affairs, the vice

Minister of the Ministry of Defense, the vice Minister of the Ministry of Public Order, the vice Minister of the Ministry of Culture and Sport, the vice Minister of the Ministry of Finance and the vice Director Public Radio Television that presenting different ministries.

In accordance with the epidemiological situations and the needs that might arise, each Ministry can organize National Conferences, Symposiums and consultation processes, roundtables, etc. Only through in-depth situation and response analysis this forums can assess the effectiveness of the response, determine policies and propose interventions at various levels.

## **5.2. Implementation structures**

### **5.2.1. The National Program of HIV/AIDS/STI near IPH**

The strategy is conceived like a reference document that will be implemented through the joint activity of organizations that are responsible for different aspect of prevention, control and care.

The National Program of HIV/AIDS is responsible for the coordination of the activity between the governmental structures, NGOs and international organization as well as for ensuring the adherence to national policies. NAP is part of Institute of Public health as the Unit of HIV/AIDS/STI Prevention and Control. It collaborates closely with the National Reference Laboratory for the examination of HIV/AIDS and STI in IPH, and with the respective clinics and with the other strategic partners (see below). A strategic partnership has been established that need to be strengthen to increase the efforts for effective interventions, better community planning, civil society and government partnerships as well as public private partnerships. The management quality of NAP need to be strengthened in terms to enable the program to work in new environments and better coordinate the strategy implementation process.

### **5.2.2. The Centers of Reference**

The Centers of Reference set standards and monitor accomplishments to these standards. The following Centers of Reference are/will be established besides the National Program:

- a. The Clinical Center of Reference (within the Department of Infectious Diseases in TUHC "Mother Therese")

- b. The CVCT Center of Reference (within NAP and laboratory of HIV/AIDS in IPH)
- c. The IEC and BCC Center of Reference (within NAP and the Department of Health Promotion at the IPH)
- d. The MTCT Center of Reference (as a collaboration between NAP and the Obstetric-Gynecologic University Hospital and the University Pediatric Department in TUHC "Mother Therese")

### **5.2.3. Strategic Partners**

The need for the establishment of strategic partnerships is necessary due to the fact that HIV/AIDS prevention and control is a multi-sectorial issue. The establishment of strategic partners consists on identifying partners among with governmental, nongovernmental and international agencies. Those partners are members of Country Coordinating Mechanism.

The strategic partners include:

1. The strategic partner from the policy-making structure.

- Ministry of Health
- Ministry of Work and Social Affairs
- Ministry of Education
- Ministry of Culture, Young and Sport
- Ministry of Justice
- Ministry of Defenses
- Ministry of Finance

2. The strategic partners from other state structures

- Faculty of Medicine
- Faculty of Social Science

- National Center of Blood Transfusion
  - University Hospital Center“ Mother Teresa”
  - Toxicology Center
  - The Directory of Public Health in the cities
  - The Institute of Education and Pedagogical Studies
  - The Municipality of Tirana, Vlora, Shkodra, Korca and Gjirokastra
  - The other structure of the local government
3. The strategic partners from international organization (UN Theme Group and other organizations)
- WHO (World Organization of Health)
  - World Bank
  - UNDP (United National Development Program)
  - UNICEF (United National Infant and Child Emergency Fund )
  - UNFPA (United National Population Fund)
  - UNDCP (United National Drug Control Program)
  - UNHCR (United Nation High Commission for Refuges)
  - USAID (United Stated International Development Agency)
  - IOM (International Organization of Migration)
  - SIDA (Swedish International Development Agency)
  - CIDA (Canadian International Development Agency)
  - Swiss Cooperation Fund
  - Italian Cooperation

#### 4. The Strategic Partners from non-government organization

- Action Plus
- Stop AIDS
- APRAD (Association for Prevention and Rehabilitation for Alcohol and Drugs)
- ASMA/PSI (Albanian Social Marketing Association)
- ALGA (Albanians Lesbians and Gay association)
- SGA (Shoqata Gay Albania)
- Emmanuel Center
- Institute of Public Opinion Studies.
- ACHO (Albanian Community Health Organization)
- Albanian Youth Council
- Albanian Family Planning Association
- Vatra
- Women Shelter and Women Center of Counseling
- Albanian Roma Association

#### **5.2.4. Implementation of Local Structure**

The same model applied at central structure will be applied at local structure. A team lead by Public Health Directory or any other governmental organization experienced in the field of HIV/AIDS will create strategic partnerships among the government structures at local level, civil society, community and private business according to actual strategy of health care and decentralization reform. The multisectorial plan will depend on present capacities and strengthening of new local capacities. It applies strategic objectives and is in close relationship with central structures. Local structures strengthen the links

between the community and central structures and foster the community participation and planning

#### **5.2.5. A monitoring and evaluation structure**

A monitoring and evaluation structure will be established at Department of Policy and Planning in IPH. This structure will produce reports of the impact of the activities according to established indicators of performance based on strategy goal and objectives. They can suggest review of the strategy based on performance indicators and evaluation of service delivery.

### **6. *Implementation plan***

Implementation plan is published as separate document Annex 4.

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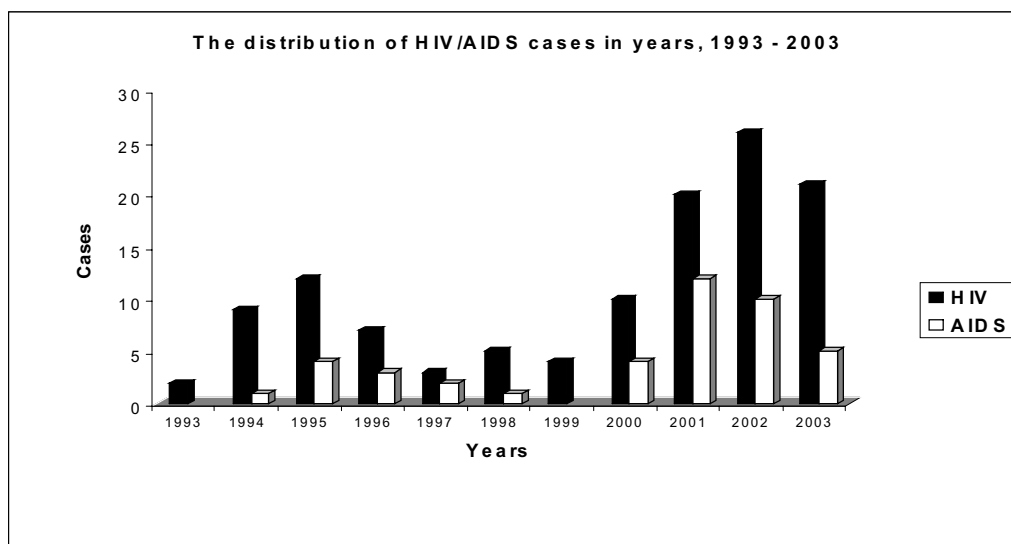
## **Annex 2. Acronyms**

<b>AD</b>	<b><i>Auto-destructive</i></b>
<b>AIDS</b>	<b><i>Acquired Immunodeficiency Syndrome</i></b>
<b>ART</b>	<b><i>Anti Retroviral Therapy</i></b>
<b>BB</b>	<b><i>Blood Bank</i></b>
<b>BCC</b>	<b><i>Behavior Change Communication</i></b>
<b>CVCT</b>	<b><i>Confidential Voluntary Counseling and Testing</i></b>
<b>CVC</b>	<b><i>Confidential Voluntary Counseling</i></b>
<b>CDC</b>	<b><i>Center of Disease Control</i></b>
<b>CSW</b>	<b><i>Commercial Sex Worker</i></b>
<b>IDD</b>	<b><i>Infectious Diseases Department</i></b>
<b>FM</b>	<b><i>Faculty of Medicine</i></b>
<b>FSW</b>	<b><i>Female Sex Worker</i></b>
<b>HIV</b>	<b><i>Human Immunodeficiency Virus</i></b>
<b>IDU</b>	<b><i>Injecting Drug User</i></b>
<b>IEC</b>	<b><i>Information Education Communication</i></b>
<b>IPH</b>	<b><i>Institute of Public Health</i></b>
<b>KABP</b>	<b><i>Knowledge, Attitudes, Beliefs and Practice</i></b>
<b>MICS</b>	<b><i>Multi Indicators Cluster Survey</i></b>
<b>MoH</b>	<b><i>Ministry of Health</i></b>
<b>MSM</b>	<b><i>Male who have Sex with Man</i></b>
<b>MTCT</b>	<b><i>Mother to Child Transmission</i></b>
<b>NAP</b>	<b><i>National HIV/AIDS Program</i></b>
<b>NGO</b>	<b><i>Non Governmental Organization</i></b>
<b>NSPCHA</b>	<b><i>National Strategy of Prevention and Control of HIV/AIDS</i></b>
<b>PLWHA</b>	<b><i>People Living With HIV/AIDS</i></b>

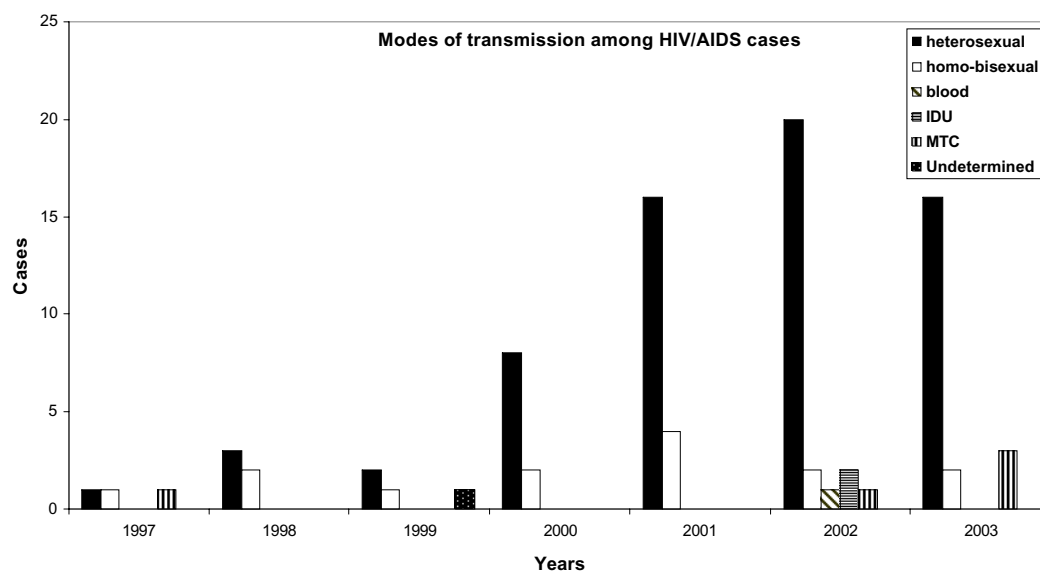
<b>RAR</b>	<b><i>Rapid Assessment and Response</i></b>
<b>RBG</b>	<b><i>Risk Behaviors Groups</i></b>
<b>RHS</b>	<b><i>Reproductive Health Survey</i></b>
<b>SEE</b>	<b><i>South East Europe</i></b>
<b>STI</b>	<b><i>Sexually Transmitted Infections</i></b>
<b>TUHC</b>	<b><i>Tirana University Hospital Center</i></b>
<b>WFP</b>	<b><i>World Food Program</i></b>

### Annex 3. HIV/AIDS Figures

**Fig.1. The distribution of HIV/AIDS cases in years**



**Fig.2. Modes of transmission among HIV/AIDS cases**



**Fig.3. Distribution of HIV/AIDS cases according to sex**

