

THE IMPACT OF TRANSITION FROM GLOBAL FUND SUPPORT TO GOVERNMENTAL FUNDING ON THE SUSTAINABILITY OF HARM REDUCTION PROGRAMS

A CASE STUDY FROM MONTENEGRO
EURASIAN HARM REDUCTION NETWORK



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Acronyms

BBS	Bio-Behavioural Survey
CCM	Country Coordinating Mechanism
CSO	Civil Society Organization
DfID	Department for International Development (of the UK)
EC	European Commission
EECA	Eastern Europe and Central Asia
EHRN	Eurasian Harm Reduction Network
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EU	European Union
GFATM	The Global Fund to fight HIV/AIDS, Tuberculosis and Malaria
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH (German Society for International Cooperation)
HCV	Hepatitis C Virus
HPVPI	HIV Prevention among Vulnerable Populations Initiative
HR	Harm Reduction
ICASO	International Council of AIDS Service Organizations
IPH	Institute of Public Health
KAP	Key Affected Population
MDR	Multi-Drug Resistant
MMT	Methadone Maintenance Therapy
MSM	Men who have Sex with Men
NAC	National AIDS Commission
NASA	National AIDS Spending Assessment
NATO	North Atlantic Treaty Organization
NGO	Non-Governmental Organisation
NHIF	National Health Insurance Fund
NSP	Needle/Syringe Programme
OST	Opioid Substitution Treatment
PHCC	Primary Health Care Centre
PR	Principal Recipient
PWID	People Who Inject Drugs
PWUD	People Who Use Drugs
SW	Sex Worker
TB	Tuberculosis
TRAT	Transition Readiness Assessment Tool
UNDP	United Nations Development Programme
VCT	Voluntary Counselling and Testing
XDR	Extensively Drug-Resistant



Executive Summary

Montenegro is one of the countries of the South Eastern Europe region that has significantly benefited from support of the Global Fund from 2006 to 2015. Together with UNDP as the principal recipient (PR), Global Fund provided direct support for the implementation of two national strategies on HIV/AIDS (2005-2009 and 2010-2014) and a national Tuberculosis (TB) strategy (2007-2011). This support resulted in maintaining the low prevalence of HIV in the country and the remarkably low prevalence of HIV among people who inject drugs (PWID). Nevertheless, the country reports a high proportion of patients diagnosed at a late stage of infection, potentially indicating a relatively large number of people - including PWID - unaware of their HIV infection as well as high prevalence of viral hepatitis C (HCV) among PWID.

25%
Montenegro
readiness to sustain
harm reduction
interventions

Through providing its support over the years, the Global Fund has helped Montenegro in all key strategic areas, as per its set strategic principles and goals. The Government has already completely financed all treatment related components, while it has fully taken over financing of procurement of rapid tests and urine tests, voluntary counselling and testing (VCT) services, procurement of methadone and methadone maintenance therapy (MMT) services in public institutions, routine HIV surveillance (with the exception of surveys whose future financing is not yet secured), TB/HIV activities, as well as health education modules. In terms of TB/HIV activities, for HIV/AIDS patients, TB diagnosis and treatment is provided through the National Health Insurance Fund (NHIF), while VCT is provided for TB patients also through the NHIF.

Finally, the Global Fund helped Montenegro to establish a network of harm reduction (HR) programmes, including opioid substitution treatment (OST) and needle and syringe exchange programmes (NSP). The Government, i.e. the National Health Insurance Fund, has taken over the financing of the OST and harm reduction programmes in the public health institutions as of 2013. However, it has not yet taken over the financing of HR programmes and services, including NSPs, inside the civil sector, although it is evidenced that these programmes are highly efficient and effective for maintaining the low level of HIV prevalence inside the most at-risk populations, including PWID.

The Round 9 Global Fund financed grant integrated measures for developing national capacity for implementation of the programme after the phasing out of Global Fund support and it was planned that UNDP would step down as the PR in year 3 of the grant in order to allow the Institute of Public Health and the NGO, CAZAS, to take over implementation. Although the transfer of implementation did not materialize in Phase 2 of the Round 9 Grant, a plan was put in place to develop the capacities of CAZAS and to prepare it for transition of SR management¹. These efforts were also supported within the CAZAS project “Strengthening management capacities of CCM and CSOs that implement HIV programmes funded by GFATM Round 9 grant”, supported by German GIZ, whose main purpose was to support transition and strengthen capacity of the NGO, CAZAS. In parallel with the above, UNDP and the Global Fund Country Team have advocated for government and donor funds to be allocated to the programme².

Although having clearly articulated support for HR programmes, the government has had no financing plan for using domestic money to fill the gaps left by the Global Fund’s withdrawal. This has resulted in a significant reduction in



scale of services and interventions on-the-ground by civil society and even interruptions, leaving the beneficiaries without services that they were used to receiving for many years. It remains unclear as to which sources of funding, and what financing mechanisms, can be used to fund NGOs and community groups for HR related work. In spite of this, significant efforts both by the Global Fund and UNDP, neither of them have found it necessary to recommend to the Government the development of a transition plan - or a similar document - which could be a roadmap for relevant state authorities on how to deal with the situation. The same applies to the CCM which should have been more proactive in terms of transition and sustainability efforts³.

Since the support from the Global Fund ended in June 2015 through the completion of the Round 9 HIV grant, and by not being eligible to benefit from further support, Montenegro started the transition process to domestic funding primarily for its HIV key affected populations. The Eurasian Harm Reduction Network (EHRN) and APMGlobal Health have developed a Transition Readiness Assessment Tool covering policy, governance, finance and programme. By using this tool, this case study analyzes the readiness and risks in the transition from donor funding to sustainable domestic financing, identifying key barriers and formulating recommendations to all stakeholders involved. Montenegro scores 25%, meaning that Montenegro shows a low level of readiness to sustain harm reduction interventions in the upcoming period.

Nevertheless, Montenegro might improve its overall score during 2016 and 2017 if it starts delivering results based on the current National AIDS Strategy, 2015-2020, and the Strategy for Prevention of Drug Abuse, 2013-2020; all stakeholders could contribute to this. The Global Fund should continue providing political, technical and financial support to the process while ensuring that key affected populations are central to the process. This could include supporting civil society advocacy and further capacity building efforts, and to closely monitor and analyse the process. The Government should translate its commitments into well defined and coordinated delivery of a set of actions and interventions to support the implementation of harm reduction programmes in the country as one of the pillars of these strategic documents. It should also make decisions about the level of funding to be committed, including the new financing mechanism for CSOs through the National Health Insurance Fund which could be the main source of funding for HR related services in the future. Civil society should continue to play an important role in the transition processes and continue its advocacy on behalf of the key affected populations.

Introduction

Rapid economic growth over the last decade in large parts of Eastern Europe and Central Asia, including the Balkan area, has coincided with important economic and public health shifts that have rendered countries of the region ineligible for development assistance, in particular support from the Global Fund concerning HIV/AIDS. The exponential growth in international aid for health that was previously seen followed by the economic crisis has resulted in a decrease in donor funding available, including for HIV and tuberculosis programs.

In 2014, the Global Fund introduced the New Funding Model (NFM), a new approach to resource allocation that has transformed financing for the three diseases. In upper middle income countries (UMICs), Global Fund invests 100% of its financing to support key and vulnerable populations. According to World Bank classification, there are no longer low income countries in Eastern Europe and Central Asia (EECA), including the countries of the Balkans in Southeast Europe. Although pledges by donors to the Global Fund increased from \$10.08bn. for the period 2011-2013 to \$12.23bn. for 2014-2016⁴, the EECA region saw an overall reduction of 15.1% as a result of the NFM allocation methodology⁵. Furthermore, the recent UN Secretary-General's report includes a table that calls for a significant pullout of international funding from Upper-Middle Income Countries (UMICs) by 2020 that could lead to dramatic consequences in terms of the spread of the HIV epidemic among Key Affected Populations (KAPs) in these countries⁶.



Consequently, there is widespread concern as to how to ensure the successful transition from Global Fund supported HIV and TB programs to national funding and the sustainability of such programs, especially those programs targeted at KAPs. As a result, EHRN decided to conduct a number of case studies in 2016 to evaluate the processes and the consequences of the transition from the Global Fund financing of the HIV response among KAP with the sustainability of harm reduction services used as an example in five Balkan countries: Albania, Bosnia, Macedonia, Montenegro and Romania.

Methodology

A **desk review** of relevant documents (both available in English and in the Montenegrin language) was undertaken to analyse the availability of internal and external funding for harm reduction projects in the country, as well as the processes around transitioning from Global Fund to national or other donor funding, together with sustainability planning for harm reduction and related services. This has included, for example, an analysis of Global Fund Round 9 implementation and close-out plan; the National HIV/AIDS Strategy, 2015-2020; the National Strategy for Prevention of Drug Abuse, 2013-2020; the EMCDDA national report on Montenegro 2014; the EC Report on Montenegro 2015, as well as several civil society analyses and policy documents.

A case study interview guide was developed by EHRN and adapted to the Montenegrin context, and key informants were identified and then **interviewed using one-on-one conversation, skype and email**. A total of six key informant interviews were conducted with individuals from the Institute of Public Health, the CCM Secretariat, the National AIDS Commission, the Global Fund Secretariat, and two CSOs implementing harm reduction services in Montenegro. **Feedback on the draft case study (with the exception of Attachment 2) was provided by the Global Fund Secretariat, colleagues from local UNDP office and the representative of the local NGO, Juventas.**

Information and data obtained through this process was then entered into a **'Transition Readiness Assessment Tool'** developed by EHRN and APMGlobal Health to analyse the readiness and risks of transition from donor funding to sustainable domestic financing, identifying key barriers that must be addressed before sustainable transition is possible with a particular emphasis on assessing the sustainability of harm reduction services through and beyond the transition period.

Background

Country context

Montenegro is an upper-middle-income country (as classified by the World Bank) with a population of roughly 630,000, a GNI per capita of \$7,320⁷, and significant growth potential. While Montenegro's economy has huge potential, it is hindered by significant structural, economic, and fiscal risks. The global economic crisis exposed some pre-existing fissures in the foundation of Montenegro's economy and the combination of a series of economic developments has caused a deeper recession in the country than previously anticipated⁸.

The percentage of government expenditure on health is 6.5% of GDP (2013) while total expenditure on health per capita is \$926 (2013)⁹. Montenegro's Human Development Indicator (HDI) for 2013 is 0.789, positioning the country 51st out of 187 countries and territories and is above the average of 0.735 for countries in the high human development group and above the average of 0.738 for countries in Europe and Central Asia¹⁰.



A Stabilisation and Association Agreement between Montenegro and the EU entered into force in May 2010 and the European Council granted the status of EU candidate country to Montenegro in December 2010 and accession negotiations were opened in June 2012. . In addition to EU accession, Montenegro's key foreign policy priority during the reporting period was securing an invitation to join the North Atlantic Treaty Organization (NATO). Both priorities are linked by the focus on the rule of law: progress in this area is a key condition for both processes¹¹.

The Government of Montenegro adopted the new National AIDS Strategy, 2015-2020, in June 2015. The strategy leans on the strategic goals, principles and areas defined in the previous strategy (2010-2014) whose implementation was generously supported by the Global Fund focusing on service delivery among most at-risk populations (people who inject drugs (PWID), men who have sex with men (MSM), sex workers (SW), Roma, and prisoners). The development of the strategy was coordinated by the NGO, CAZAS, through financial support provided by GIZ, within the CAZAS project, 'Strengthening management capacities of CCM and CSOs that implement HIV programmes funded by GFATM Round 9 grant'¹².

Montenegro has prepared its second annual report on the implementation of the 2013-2020 national action plan on drugs. The capacity of the Montenegrin authorities to identify new psychoactive substances is limited and needs to be strengthened. Destruction of seized drugs is not yet systematic. An appropriate process for the destruction of precursors has yet to be set up. In October 2014, Montenegro submitted to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) its first report on the use of drugs in the general population as well as information on new psychoactive substances¹³.

The last European Commission (EC) Report on Montenegro emphasises that Montenegro needs to provide sustainable financing for services dealing with HIV/AIDS and to improve its capacity for, and provision of, psychosocial support and help to patients with chronic diseases. Additionally, Montenegro needs to do more to implement its national drug abuse prevention strategy, especially among young people, and civil society needs to be actively involved in the National Council for the prevention of drug abuse¹⁴.

Epidemiological situation with HIV/TB and current trends

Montenegro remains a low HIV prevalence rate country (0.02%) but faces challenges with possible growth in concentrated epidemics, especially among populations of MSM which could spread to the general population¹⁵. According to the HIV registry in Montenegro, in the period from the beginning of the epidemic in 1989 until the end of 2015, there have been 194 persons registered with HIV in total, while in the same period 41 people died from AIDS. The prevailing mode of transmission of HIV in Montenegro is unprotected sex (85%), and retains this increasing trend since the beginning of the epidemic. Blood borne infections, whether among PWID or persons who have received infected blood via a transfusion in health facilities, still remains very rare. Only 4% of registered HIV cases were through infected blood, out of which 1% were infected inside medical institutions outside of Montenegro, and 3% due to the sharing of contaminated injecting equipment¹⁶.

In 2014, TB prevalence was 18 per 100,000 people and in 2015 it was less than 20 per 100,000, which is significantly lower when compared to 2005 (27 per 100,000). Since 2010, Montenegro has been categorized from a 'high' to a 'low' risk TB disease country¹⁷. In 2015 there were only 4 TB/HIV co-infected patients registered¹⁸. In the period 2004 - 2015, there were 14 multidrug resistant (MDR) TB patients, of which one patient is alive and is extensively drug-resistant but currently on treatment in Romania, one patient dropped out of treatment, four were cured completely, and eight passed away. Each patient who underwent treatment at the Special Hospital for Lung Diseases in Brezovik was tested for HIV¹⁹. During the period 2005-2015, there were 13 cases of laboratory-confirmed MDR-TB cases. The percentage of survivors in this group of patients is extremely low, about 30%, although the goal is 70%.



In 2015, 1,031 persons at-risk of being infected with HIV were tested within the Voluntary Counselling and Testing (VCT) Centres, which is a 22% decrease compared to the 1,321 persons the previous year²⁰ which, in turn, is a 29% increase as compared with 2013. Out of the total number in 2015, 18% were MSM, PWID and SWs. During 2014, according to the data that health institutions submitted to the Institute of Public Health (IPH), the total number of people tested for HIV was 22,141 (this number does not include 470 PWID and 120 MSM tested through surveys conducted among these populations).

Bio-behavioural surveys (BBS) among PWID (implemented in 2008 – sample size 265 respondents, 2011 – sample size 331 respondents and 2013 – sample size 387 respondents) provided the opportunity to determine the behaviour of adult PWID in Montenegro and to follow the changes in risk behaviour and the prevalence of HIV, hepatitis B and C in this population. HIV prevalence among PWID has increased in each survey conducted, with 1.1% in 2013, while in 2011 it was 0.3%, and in 2008 it was 0.4%. Prevalence of hepatitis B, i.e. HBsAg, in 2013 was very low (1.4%), similar to the previous surveys, while the prevalence of hepatitis C was very high (53%) in 2013, and slightly changed compared to 2011 and 2008 (53.6% and 55%, respectively). High prevalence of HCV indicates that, at least in the past, there was a significant degree of risky behaviours among the PWID population²¹. This study confirmed the importance of harm reduction services that are functioning within the NGO sector²². According to the research conducted among the MSM population in 2014 - sample size between 100-150 respondents, HIV infection was detected in 12.5% of the respondents (the study conducted in 2011 showed HIV infection detected in 4.5% of respondents)²³, which, combined with the trend of most newly detected HIV cases coming from this population, clearly shows the tendency of concentrated epidemics. Nevertheless, this study is based on the 'snowball' sampling method and must be treated with caution. Finally, low HIV prevalence was detected among registered SWs (0.8% in a survey conducted in 2008 – sample size 134 sex workers, 1.1% in a 2010 survey – sample size between 100-180 respondents and 0% in a study from 2012 – sample size between 150-200), with HIV among SW in Montenegro appearing to correspond to a low intensity type of epidemic²⁴.

Available data on the number and characteristics of persons who use drugs that seek treatment in health institutions are not yet complete nor reliable, although the registry of demand for treatment was established in 2013 by the Institute of Public Health. Although the reporting is obligated by law, there is a significant underreporting in practice²⁵. IPH took up intensive work on educating health workers on the need and purpose of reporting the data to the registry, aiming at improving the dynamics and quality of reporting. However, it should be clarified that this registry contains "only" the data on people who use drugs (PWUD) that appear for assistance in the health system institutions, with the exception of private institutions and institutions of social protection. It is, therefore, necessary to conduct further research and methodologically demanding analysis to arrive at a valid and scientifically based estimate of the total number of PWUD in the country²⁶. Until then, the available data comes from the health care information system, according to which in 2014 Montenegrin health facilities treated 675 PWUD (not taking into account the so-called 'legal drugs', such as tobacco and alcohol). About 86% of such people turned to the institutions due to being in need of treatment for opiate dependence, while other drugs are significantly less represented in demand for treatment in medical institutions. This data cannot provide the percentage of users who take drugs by injecting²⁷.

As for the estimates of the size of the population of drug users, the only available information came from a study conducted by the IPH in collaboration with the School of Public Health 'Andrija Štampar' in Croatia. The study was conducted in 2011 and resulted in an estimated 1,282 PWID in Podgorica, the capital of Montenegro (0.7% of the total population)²⁸. This is, unfortunately, the only available official PWID population size estimation while, at the same time, CSOs believe that the true number is higher²⁹. There are still no evidence-based estimations of population size for SWs, nor for MSM, respectively.



Global Fund eligibility

A five year work plan (2005 to 2009) was developed in 2005 to accompany the National AIDS Strategy with a total budget of Euro 4,258,895. In the same year, Montenegro was granted Euro 2,424,124 by the Global Fund for the period August 2006 to August 2010 (Round 5 HIV Grant which was based on this Strategy)³⁰. The Global Fund support formed over half (57%) of the identified national resource requirements with 37.3% of the budget allocated to groups most at-risk of HIV through supporting NGOs within the Global Fund financed grant.

A comprehensively revised National AIDS Strategy for Montenegro, 2010 to 2014, was developed in 2009 and was ratified by the government on 2nd December 2010 with a total budget requirement of Euro 15,014,747 over the five year period. This strategy was used as the basis for the development of the successful proposal to the Global Fund for the Round 9 HIV Grant and Euro 3,970,130³¹ was granted with effect from 1 July 2010 to 30 June 2015 when it ended.

Finally, a Round 6 TB Grant, 'Establishing and Pursuing a High Quality Programme of Tuberculosis Control in Montenegro', has been implemented from 2007-2012, totalling 1.3 million euro and financed by the Global Fund³². The primary recipient for all three grants was UNDP Montenegro.

In 2011, the Global Fund introduced new eligibility criteria for its support. According to this policy, high income countries (HICs) and upper middle-income countries (UMICs) with a moderate or low disease burden were deemed ineligible for further Global Fund support³³; Montenegro – classified as a UMIC with a low disease burden - is one of these countries.

According to the Global Fund Eligibility Lists, HIV/AIDS and TB components in Montenegro were not eligible for a funding allocation in 2014 and 2015. However in 2016, Montenegro's HIV disease burden categorization changed from 'Moderate' to 'High' according to the Global Fund 2016 Eligibility List³⁴. Components that become eligible during an allocation period may receive an allocation, subject to availability of funding, only after being newly eligible for 2 consecutive years³⁵. This could mean that Montenegro might receive a new allocation if its disease burden remains high for 2 consecutive years in accordance with UNAIDS evaluation³⁶.

Overview of HR status in the country

In 2004, the first NSP programme in Montenegro was introduced in the Primary Health Care Centre (PHCC) of Podgorica with 13 injection sites, through the HIV Prevention among Vulnerable Populations Initiative (HPVPI) funded by DfID, Imperial College London and UNDP. The programme implied the exchange of needles and syringes by encouraging users to return the used needles and syringes in exchange for sterile ones and was implemented in 2004 - 2006.³⁷

Later, these programmes were expanded to the NGO sector as of September 2006, since the coverage was initially quite modest and limited only to the capital, Podgorica. The programmes were implemented through outreach work in 8 out of 21 municipalities and drop-in centres led by the NGO, CAZAS (in Podgorica and Bar), and the NGO, Juventas (in Podgorica), at the local level. In addition to the provision of sterile injecting equipment, these centers offered other services including preventive education and counselling on different topics (STIs, HIV/AIDS, hepatitis B and C, the use of condoms, drug use, substance abuse treatment, safe injecting, methadone maintenance, overdose, stigma, social assistance), basic medical care, distribution of condoms, psychosocial assistance and referral to relevant institutions, with a focus on institutions for treatment and rehabilitation. Annual coverage in



2015 was around 1,500 individuals³⁸. It is expected that the coverage will be significantly reduced in 2016 due to the lack of financial support³⁹ which, together with a lack of an adequate estimation of population size, considerably decreases the manoeuvring space for proper strategic planning and response of relevant institutions and NGOs, i.e. 'the system'. An unofficial estimated number of drug users in Montenegro including PWID is between 10-15,000, based on information from NGOs in the field⁴⁰.

In 2014, needle and syringe exchange programmes were functioning in all major municipalities of Montenegro (3 Drop-in centres and an outreach programme) with 92,683 syringes and 91,954 needles distributed during that year. Condoms have been distributed to PWID, SWs and MSM as well as amongst sailors, workers in the tourism industry, Roma and Egyptian youth and youth in schools.

Today, almost a year after the end of the Global Fund HIV grant on June 30th 2015, harm reduction programmes within two NGOs - CAZAS and Juventas - have been significantly reduced to a minimum due to the lack of funds – from three NSPs to only one (led by Juventas) operating in Podgorica. The other two NSPs - in Podgorica and Bar (led by CAZAS) - were forcedly closed until the first available funding opportunity. However, CAZAS is still conducting outreach work and is closely cooperating with Juventas who still run their drop-in services, both in Podgorica, but their services are poorly funded through the "Commission for allocating funds from games of chance" and with a highly reduced number of outreach workers and drop-in centres compared with the Global Fund era⁴¹. For example, it was estimated that for the successful continuation of drop-in centre and outreach operations it would be necessary to provide between €130,000-€150,000 per year, but these two NGOs together (for the operation of a drop-in centre by Juventas and outreach work by CAZAS) received only around €22,000 in 2015⁴². The calculation was made according to the figures provided by UNDP as the principal recipient during the implementation of the Global Fund financed HIV grant for the purpose of conducting harm reduction related activities among PWID (approximately €110,000 per year), with an additional €20,000-€40,000 estimated to be needed for procurement of needles and syringes, as well as other necessary supplies (condoms, lubricants, leaflets, cookers, etc.) which were at that time directly procured and distributed to NGOs by UNDP⁴³. Nowadays, there are not enough NSPs to reach all PWID in need. Similar to the situation with drop-in centres, outreach work at the national level has significantly reduced and it is questionable as to how is it going to be implemented with so little resources allocated. After the completion of the Global Fund financed grant, the Government has not stepped in to fully take over funding of all services provided by civil society, including NSP.⁴⁴ But it must be acknowledged that there are some positive developments in terms of allocation of certain funds to support services for most at-risk populations at the governmental level. Namely, at the end of 2015, the Parliament of Montenegro adopted the Law on the Budget of Montenegro for 2016, accepting the amendment of one opposition party submitted in close cooperation with civil society, i.e. the NGO, Juventas. This amendment allowed for the first time the allocation of funds (€100,000) specifically for, 'non-governmental organisations who provide services for support to people living with HIV/AIDS and affected populations'. However, these funds are not allocated just for HR services and have still not been operationalized and it is unclear as to whether or not such funding is going to be committed for each year on an ongoing basis⁴⁵.

The programme of methadone detoxification, substitution and maintenance was introduced in 2005 in Montenegro when the first methadone maintenance therapy (MMT) centre was opened in the PHCC in Podgorica through HIV Prevention among Vulnerable Populations Initiative (HPVPI) funded by the DfID, the Imperial College London and UNDP. This was followed by the opening of other MMT centres in the PHCCs of Kotor, Berane, Bar, Niksic and Pljevlja (which is not yet operational) supported by the Global Fund and UNDP. By the end of 2014, a total of 548 clients were part of the methadone programme⁴⁶. The procurement of methadone is secured through the National Health Insurance Fund as of April 2013. In order to promote and achieve a unified working practice of MMT centres in



Montenegro, PHCC Podgorica produced a Guide for the application of methadone for opiate addicts. Work of MMT Centres have not been discontinued after the termination of the Global Fund support thanks to support by the Government and their integration into the public health system. However, the resources allocated do not provide an opportunity to increase MMT coverage, especially in the capital, Podgorica⁴⁷.

In late 2014 and several times in 2015, some MMT centres (e.g. in Kotor and Bar) experienced a shortage of methadone. This impacted upon clients in prisons as well as methadone is transported from the local MMT centres to the national prison. MMT clients that were sent to prison have the possibility to continue on MMT while serving a prison sentence in the Institute for the Execution of Criminal Sanctions in Podgorica and Bijelo Polje (17 users of the end of 2014 in Bijelo Polje and 12 users in Podgorica). Also, as approximately 1/3rd of the total Montenegrin population live in Podgorica, there are waiting lists for initiation into MMT. There are approximately 200,000 inhabitants in Podgorica with an estimated 1,292 PWID but current MMT capacity in Podgorica is a maximum of 50 clients (approximately 3.9%) which is not enough and requires further enhancing, as per the relevant international guidelines and recommendations⁴⁸.

Buprenorphine substitution has not yet been introduced into regular practice at all MMT centres. Having in mind the necessity and importance of the introduction of this type of substitution, as well as the fact that it is supported by the relevant strategic documents, it is of utmost significance to develop and adopt a protocol for buprenorphine substitution therapy, to include penal institutions⁴⁹. It is already certain that the introduction of buprenorphine will definitely represent a new challenge for the health care institutions and the health system as a whole. Similarly, responding to the prevention of risk and harms caused by the use of other drugs, especially synthetic stimulants, is a further challenge.

There is no adequate data on mortality due to overdose because, in most of these cases, the reported cause of death is the condition, or the cause, associated with overdose, but not the overdose itself. Overdose, as such, can be classified only after its identification through an autopsy. As a result, this significantly underestimates the problem of overdose in the PWID population and, therefore, its importance remains neglected for future policy and public-health interventions in the area of reduction of the harmful consequences of drug use⁵⁰.

Regarding the availability of naloxone and overdose prevention programmes in Montenegro, there is a lack of specific national or local overdose prevention programmes. Existing methadone maintenance programmes are an exception and can be viewed in this context as the risk of mortality due to opiate overdose is significantly reduced among users of these programmes⁵¹. Naloxone is available as a medicament on the Main List of Medicaments adopted by the Government's resolution of November 2014⁵² which was confirmed by adoption of the relevant legislation in January 2015⁵³.

Transition processes analysis

Policy

In 2015, the year in which the Global Fund HIV R9 Grant closed in June, civil society continued with public advocacy targeting decision makers for the sustainability of HIV/AIDS services for most at-risk/key affected populations. Namely, it was obvious that the government had still not taken any concrete actions to enable the sustainability of the services of CSOs. Although verbally they supported NGOs and were very keen to provide support, the situation on-the-ground was different. Their efforts were additionally reinforced with actions by the CCM Secretariat which,



together with CCM members, drafted and sent letters to all key ministries and institutions demanding meetings with key responsible persons in these institutions, as well as by the remarks and recommendations in the EC report on Montenegro on the necessity of providing sustainability of HIV/AIDS related services. Advocacy efforts paid off, and in late 2015 one opposition party submitted an amendment to the Law on State Budget for 2016 in close cooperation with civil society, i.e. the NGO, Juventas, demanding an allocation in the state budget for the purpose of providing a sustainable and durable solution for securing the financing of HIV/AIDS services for key affected populations. This Law, and the related amendment, passed the Parliament and was adopted in late 2015. Nevertheless, to date, this endeavour has not resulted in any concrete mechanism(s) of support to NGOs due to political issues and turbulence over the position of the newly appointed Director of the National Health Insurance Fund (NHIF). Additionally, as per the above mentioned Law, once the NHIF has received these funds, it needs to transfer them to NGOs selected via a transparent and open process of application to an Open Call for Proposals of the NHIF that should happen during 2016. Hence, this should soon result in a clear and transparent procedure on the criteria, requirements and responsibilities of NGOs that would implement their activities through this fund and to enable sustainability of the services that will be nominated by the most prominent NGOs to be supported.

There are no transition and/or sustainability plan(s) for transition from the Global Fund support to domestic funding for harm reduction and other HIV related services. Neither the Government (Ministry of Health/CCM) predicted or planned for the development of any kind of transition plan, nor did the Global Fund Secretariat and UNDP as the Principal Recipient of the Global Fund financed grant. Transition is on its way due to efforts made by the civil society sector and the CCM Secretariat, but there is no official transition plan on paper. It is rather a compilation of needs assessed by all relevant stakeholders according to the developed Action Plans for the implementation of relevant strategies. This remains an issue in the period to come⁵⁴. As a result, **Indicator 1** ("A fully-resourced Transition Plan including harm reduction is proactively guiding transition") of the transition readiness assessment tool **is ranked at 0**, as indicated in the tool.

The Government of Montenegro adopted two key strategic documents that covers this area: the National AIDS Strategy, 2015-2020, and the Strategy of Montenegro for the Prevention of Drug Abuse, 2013-2020. Both of these strategies are accompanied with relevant costed action plans.

In 2011, drug usage became only an administrative offence (a major step towards decriminalization of drug use), as well as the possession of small amounts of drugs for personal use⁵⁵. But the country still doesn't have a normative basis to regulate HR services and to protect HR service providers from criminalization and pressure from law-enforcement agencies.

It is forbidden by law to provide HR services to minors. NGO reports show that there is an evident growing need for increasing the availability of appropriate HR services to this population and thus suggest preparing the legal and technical framework for the implementation of OST programmes with regard to the current legal age⁵⁶.

In addition, gaps in the normative basis of HR still expose service providers to a high level of threat and risk when conducting their duties. Although the national strategy for the prevention of drug abuse recognizes HR services provided by NGOs, they are still not legal due to the absence of relevant by-laws regulating this issue. Therefore, NGOs are required to possess a special permit from the police and the state prosecutor's office. This causes a highly difficult and awkward circumstance for the service providers given that all activities must be announced to the police and the state prosecutor some time in advance. Although it was planned to develop the missing by-laws 5 years ago, they are still not in place.



Despite the fact that HR programmes are one of the key pillars of both strategies in terms of coverage of actions and interventions among PWID, the distribution of sterile needles/syringes remains illegal. As a result, **Indicator 2** (“There are no legal or policy barriers to the implementation of harm reduction programs”) of the transition readiness assessment tool **is ranked at Stage 2** (“Actions have been taken to amend problematic legislation and policies, but some barriers still exist”).

Finally, there is in place a mechanism for state and/or municipal government to fund NGOs (in any area) but not specifically for HR. Nevertheless, if the above mentioned arrangement with the National Health Insurance Fund is successful, there might be some allocation in the state budget specifically for HR but it is not clear yet when and how much. Regardless, there is still not in place a systematic and durable mechanism that will ensure the sustainable domestic financing of HR services⁵⁷. As a result, **Indicator 3** (“Policy or legislation is in place to state and/or municipal governments to contract or grant NGOs for the delivery of harm reduction and other HIV prevention services.”) of the transition readiness assessment tool **is ranked at Stage 1** (“There is policy or legislation that supports a mechanism for the government to fund NGOs (grant or contract) for some activities, but it does not currently include provision of harm reduction services”), since neither the national HIV strategy nor the strategy to prevent drug abuse specify the role of NGOs as government-funded (through grant or contract) service providers of HR and other HIV prevention services.

Governance

A multi-stakeholder body called the National AIDS Commission (NAC) was established in 2002 as the advisory body of the Ministry of Health in the area of HIV/AIDS policy and practice. Tasks of the Commission include: consideration of technical issues in the field of protection of the population of Montenegro from AIDS and the promotion of such protection; providing opinions in the process of changes and amendments to the law relating to AIDS; preparing draft programmes and measures for the prevention of, and fight against, AIDS; and developing a strategy for AIDS. Honorary Chairman of the Commission is the President of Montenegro, whilst the Chairman of the Commission is the Minister of Health. Re-election of new members is conducted every second year. Members of the Commission include representatives of NGOs, government institutions and representatives of associations of people living with HIV.

The Country Coordinating Mechanism (CCM) is a multi-sector, multidisciplinary body of the Ministry of Health established in 2004 whose primary purpose is to evaluate and monitor projects in the area of HIV/AIDS financed by the Global Fund. There are 21 members of this body including representatives of the various ministries and institutions, media, people living with HIV, NGOs, NHIF and representatives of UN organizations gathered around the UN Theme Group on AIDS. The CCM is the coordinating body that reports to the NAC. The mandate of the members of the CCM, as well as the Chair and Vice-Chair, is for four years. During the Global Fund financed grants, this body has governing and oversight functions over the Grants. The unofficial plan for the future is for the NAC to take over the responsibilities and functions of the CCM, as was the case before establishing the CCM.

Although not always in its full composition, the CCM has fulfilled its role during the implementation of the Global Fund financed grants and has continued to be operational even after the closure of the Global Fund financed Round 9 grant⁵⁸. The CCM Secretariat in Montenegro continued to function under the auspices of the Institute of Public Health (IPH) thanks to a CCM grant received in August 2015 that became operational as of September 2015. This was the first time that Montenegro had received such assistance from the Global Fund, mostly thanks to civil society that was initially seen as the recipient of the funds. In close communication with the Global Fund Secretariat,



the initial decision of the CCM was changed and the recipient became the IPH mostly because the Global Fund Secretariat expressed concern over the sustainability of the CCM Secretariat inside the civil sector and its ability to better influence the transition processes, policy and systemic gaps if the Secretariat was integrated within a public institution⁵⁹. This grant is operational until August 2016 and, according to the information received both from the Global Fund and CCM Secretariat, will most probably be continued for at least one more year. This grant is mostly used as yet another effort to encourage the country to develop and implement transition-related activities and to fill gaps at the national level in terms of advocacy, coordination and monitoring with regards to the national strategic response to HIV, as well as the capacity building of key stakeholders, especially civil society.

There are no official government-endorsed plans on taking over the programmatic monitoring and oversight functions of the CCM by the NAC, while, at the same time, in practice the CCM has continued its oversight function of the transition and national strategy. Although there is an operational and still well-functioning CCM and Secretariat, there are no official government-endorsed plans to monitor the implementation of the National AIDS Strategy and harm reduction programme as one of the areas, which should be one of the tasks of the NAC in the future. As a result, **Indicator 4** (“A multi-stakeholder national governance body, including at least government, civil society, and technical partners, is institutionalized to steer the transition process, and to continue program planning and oversight after the end of donor funding”) of the transition readiness assessment tool **is ranked as 0**. Consequently, both remaining **Indicators 5 and 6** have been **ranked as 0**, as the CCM functioning in the system is no longer that important due to the completion of the Global Fund financed grants and due to the fact that the NAC is a more advisory, rather than decision-making, body of the Ministry of Health.

Although the establishment of the National AIDS Office/Department that would have been under the auspices of the Ministry of Health was planned for in the previous and current AIDS strategies, no action has occurred. Similarly, the National Commission on Drugs was predicted to be established according to the Law on Drugs adopted in 2011 and the Strategy for the Prevention of Drug Abuse but has never been formed. Four major NGOs in the area of drug abuse prevention (Juventas, CAZAS, 4Life and Preporod) have requested the relevant state authorities - including the National Council on Drug Abuse Prevention and the Ministry of Health, i.e. the Department on Drugs functioning under the auspices of this Ministry - to finally establish the National AIDS Office/Department and to ensure proper representation of key civil society actors in the body. At the time of writing, the procedure for the constitution of this body had been initiated and a public call for NGOs to nominate just one representative on behalf of the whole sector has been announced. The non-formal coalition of NGOs has nominated one representative who will, in the upcoming period, advocate for expanding the number of CSOs present on the Commission, including one representative of the affected population, similar to the NAC. This Commission has been officially established after persistent pressure on institutions initiated and conducted by the aforementioned NGOs by the decision of the Ministry of Health of 11 May 2016, No. 011-57/2016-1, and has held only one constitutional meeting at the time of writing.

Finance

A two-year action plan (2015-2016) was developed to accompany the National HIV/AIDS Strategy, 2015-2020. The dedicated action plan and resources necessary to successfully implement it are far less than what was allocated during the era of Global Fund financed grants in Montenegro. For example, it is already now recognized that it is a significant challenge to secure the resources for continued functioning of the HR services which have been significantly reduced (from an estimated €130,000-150,000 to approximately €22,000), causing the immediate decrease in the number of services provided to PWID, as well as to continue with regular BBS among most at-risk



populations, as well as among the general population, youth and health professionals. The stated need, as shown by the costed projection undertaken by UNDP and CSOs, are not official estimations, thus causing the sense that appropriate budget planning and optimization of those funds will be undertaken in an ad hoc manner without conducting strategic budget optimization exercises. As a result, **Indicator 7** ("Funds for harm reduction are allocated according to an optimized budget scenario") of the transition readiness assessment tool **is ranked at Stage 1** ("There has been a need projection and costing process to develop a budget for the transition period and/or beyond").

Currently, the National Health Insurance Fund (NHIF) does not provide support to NGOs implementing HR services and programmes. According to the law, NHIF is in charge of planning for, and procuring, the necessary medical equipment for the efficient and effective functioning of the health system. An allocation of €100,000 in the state budget for the purpose of providing sustainable and durable solutions by the NHIF for securing the financing of HIV/AIDS services to key affected populations might revolutionize the existing mechanisms of support to NGOs who are service providers.

Partial funding for NSP is provided through the National Lottery/Games of Chance Fund. Namely, in 2011 the Government of Montenegro established a *Commission for the Allocation of Funds from Games of Chance with NGOs and public institutions as potential beneficiaries, including those who are fully or partially funded by the state budget. There are, in total, six priority areas, with one of them being for "Contributing to combatting drugs and other forms of addiction"*. This funding mechanism works in a way in which all potential beneficiaries are submitting their project proposals on the basis of an open call by the Commission, i.e. the Ministry of Finance under whose auspices it functions. It functions on the basic principle that everyone who fulfils the criteria of the call gets a small piece of the funding available. From the experiences of the key informant NGOs, fully requested amounts have never been received by NGOs, since their financial requests usually amount at somewhat between 20-30% of required funds. In 2015, approximately 25% of the total planned budget for the NSP was covered by this fund (only fees for outreach workers and other staff, as well as their additional training) which is not enough and requires further actions by the relevant decision makers, especially the Ministry of Health⁶⁰. On the other hand, OST medications, staff and other needs are fully covered by the national funding, thus providing full sustainability. As a result, **Indicator 8** ("Core harm reduction services are funded by the government and delivered by NGOs via grants or contracting mechanisms") is ranked at Stage 1 ("Either needles and syringes for harm reduction OR opioid substitution therapy medications (not both) are included in the domestic budget") and Stage 3 ("Specific funds are allocated for services to be provided by NGOs, through contracts or grants") with 1, while at Stage 2 ("Both needles and syringes for harm reduction AND opioid substitution therapy medications are included in the domestic budget") with 0.

Despite the effort made by the United Nations to support capacity building of national experts in the area of the national AIDS spending assessment (NASA), and which could then easily be used for other areas as well, the country does not have both properly developed and organized National Health Accounts for this area, nor are there adequate human resources allocated to properly plan, monitor and evaluate budget planning for HIV/AIDS and/or drug abuse prevention purposes, including harm reduction.

There are no official plans to integrate donor procurement systems into national systems, thus assuring reasonable price controls, since there is in place relevant legislation for public procurement, including medical equipment and commodities, which is aligned with relevant EU and international standards. Since the government is not yet procuring all core harm reduction commodities, as a result, **Indicator 9** ("Donor procurement systems are integrated into national systems and assuring reasonable price controls") **is ranked at Stage 2**.



Program

During the past ten years, government and NGOs, together with the Global Fund, the UN and bilateral donor support, have intensified efforts to provide HIV interventions and the delivery of services to most at-risk populations⁶¹. Involvement of members of the target population (or ex-members) has facilitated access to most at-risk populations, especially amongst PWID.

Although there are centers for opiate substitution therapy (OST) in Montenegro, there is still no official legal framework for the implementation of this type of intervention. Therefore, developing and adopting by-laws regulating HR programmes and activities is necessary, especially having in mind that this area is not clearly regulated by the existing legislation. Also, defining a unique position on the use and mode of implementation of substitution therapy with buprenorphine through adopting relevant national guidelines and by-laws might be a key step forward to ensure the creation of necessary preconditions for the initiation of this type of substitution in accordance with the national strategic documents. There is in place only a Guide for MMT among opioid dependent people developed by the Primary Health Care Centre, Podgorica. There are no official harm reduction guidelines, protocols or similar by-laws that regulate this area. There is neither an official stance of relevant authorities on buprenorphine substitution therapy nor any kind of unique guidelines for its application. All these, together with establishing the National Commission on Drugs, were supposed to put in place as of 2011 when the Law on Drugs was adopted, and the Department on Drugs of Ministry of Health was tasked to do this, in accordance with both the Law and the national strategy.

Regarding the monitoring of HR services, there is a mechanism of internal monitoring of HR services in place but not external monitoring since the end of the Global Fund financed HIV grant. Internal monitoring is conducted by the service providers themselves through standardized reporting forms, rules and procedures adopted during implementation of the Global Fund HIV grant. When this grant was closed, the Ministry of Health did not develop any standards, guidelines or by-laws on HR service provision despite the foundations already being in place in terms of the above mentioned reporting forms, rules and procedures. As a result, **Indicator 10** (“Defined service provision standards exist for at least needle/syringe programs and opioid substitution therapy”) of the transition readiness assessment tool is ranked at 0.

Regarding the availability of the priority harm reduction services, as already described in the previous section of this study, the main obstacles for reaching the set targets are the lack of financial support to NSP and the limited capacity of MMT centres to receive and treat clients. Also, the lack of a scientifically and methodologically accepted, evidence-based, population size estimation remains one of the key barriers for future planning and implementation of the national HR programme. Additionally, the lack of a secure, sustainable and durable systematic mechanism for programmatic support to NGOs providing HR services and implementing HR programmes proves to be the biggest obstacle of all. As a result, **Indicator 11** (“Core harm reduction services are available at levels of coverage recommended by the World Health Organization”) of the transition readiness assessment tool is ranked at 0.

The dedicated and hardworking NGOs supporting key affected populations represent one of the essential strengths of the national response to both HIV/AIDS and problematic drug use. This is also recognised by the relevant authorities. However, this has still not translated into practice by providing a sustainable mechanism to support the proven efficiency and effectiveness of HR programme implementation in Montenegro, with the exception of the OST programme that is implemented within the network of primary health care centres and is fully funded by the state (although the coverage is extremely low). A further major barrier is the fact that there are no funding mechanisms



in place yet that are available to civil society, including drop-in centres, outreach work and NSP that will permanently secure the functioning and sustainability of all such HR services in the country. As a result, **Indicator 12** (“NGOs are critical partners in delivery of harm reduction and other HIV prevention services financed by domestic resources”) of the transition readiness assessment tool **is ranked at Stage 1**

Identified challenges and barriers

There are no transition and/or sustainability plan(s) from Global Fund support to domestic funding. Transition is on its way due to the efforts made by the civil society sector and the CCM Secretariat, but there is no official transition plan on paper. During the implementation of the Global Fund financed HIV grant, neither the Government (Ministry of Health/CCM) nor the Global Fund as financier and the UNDP as the principal recipient predicted or planned the development of any kind of transition plan.

However, the Global Fund financed Round 9 HIV grant integrated measures for developing national capacity for implementation of the programme after the phasing out of Global Fund support. Thus, it was planned that the role of principal recipient in Year 3 of the grant was to be taken over by the Institute of Public Health and for the NGO, CAZAS, to continue with implementation. In recognition of the above, the special condition was reflected in the Phase 1 Grant Agreement consistent with the principle of supporting the long-term sustainability of the Programme and the Principal Recipient’s mandate to develop national capacity to enable local partners to implement the Programme and any future grants. Thus, this special condition implied that the Principal Recipient undertakes and agrees to, among other things, develop the national capacity of both Government and non-Governmental partners as referred to in the Programme proposal and in the detailed budget and work plan for Phase 1 to ensure the prompt transfer of expertise, knowledge, information, documents, processes, procedures, personnel and responsibilities of the Principal Recipient to identified national entities to enable them to become the principal recipient for Phase 2 of the Programme.

Although the transfer of implementation did not materialize at Phase 2, a plan was put in place to develop the capacity of the NGO, CAZAS, and to prepare it for transition to sub-recipient management. A relevant special condition was integrated into the grant agreement requiring the Principal Recipient to conduct an assessment of the performance and capacity of CAZAS during the first 10 months of Year 3 of the Programme, by 1 July 2013, with the aim of evaluating whether CAZAS had the capacity to undertake activities related to the NGO segment of the programme from Year 4 of the Programme onwards. The Principal Recipient provided to the Global Fund the findings and recommendations of the assessment which afterwards resulted in putting in place the mentioned arrangement taking effect as of July 2014. The whole arrangement was initiated with the twofold aim: to further improve the preventive-educational programmes of the main sub-recipient (CAZAS) and thus improve its organisational capacities; and, to further improve the preventive-educational programmes of the sub-sub recipients and their organisational capacities as well. However, this arrangement did not produce the wanted effect as CAZAS was the main sub-recipient for only one year instead of for three years as initially planned and foreseen.

In general, the main obstacles for the successful and effective implementation of HR programmes are the lack of financial support to the NSP and limited capacity of MMT centres for receiving and treating clients. This hinders the efforts on expanding the coverage and reaching the set targets. Due to this, the barriers in accessing the services have increased. First of all, after the end of Global Fund support there were fewer HR services for PWID to access, especially informative leaflets on safe injecting, condoms and lube. The one remaining drop-in centre is not capable of covering all PWID who are in need of HIV prevention services and with the existing funding this work cannot be expanded⁶². As an illustration, the current level of funding of one drop-in centre and outreach work led by two of



the above mentioned NGOs are supported with roughly €20,000 in total from the available domestic funds, which is approximately 8-10 times less as compared to the Global Fund support.

The existing harm reduction interventions in Montenegro include programmes of opioid substitution with methadone and buprenorphine. From mid-2015, substitution therapy was available within secondary and tertiary health care institutions, sterile injection equipment exchange programmes within drop-in centers, and other risk prevention programmes that include the distribution of condoms and lubricants. Although there are centers for OST in Montenegro, there is still no official legal framework for the implementation of this type of support. There are no official harm reduction guidelines, protocols or similar by-laws that regulate this area. There is neither an official stance of relevant authorities on buprenorphine substitution therapy nor any kind of guidelines for its application. There is in place only a Guide for MMT among opioid dependent people developed by the PHCC, Podgorica, which is not an official toolkit adopted by the Ministry of Health and standardized. Although the HR programme is officially recognized by relevant institutions and is in place in both the public and civil society sector, the Government lacks the willingness to remove the existing barriers in the relevant legislation and policies, mainly in the criminal law but also at the level of by-laws. There is, in general, a significant resistance to removing the barriers, especially amongst health and psychiatric professionals. Another barrier is that the status of civil society outreach workers is somewhere between legal and illegal, sometimes resulting in them having trouble with law enforcement officers.

During the past years, notable efforts have been intensified to provide HIV interventions to most at-risk populations. Involvement of members of the target population (or ex-members) has facilitated access to most at-risk populations, especially amongst PWID. However, all of these successes were achieved during the period of Global Fund support that ended in June 2015 and have subsequently been endangered by the passivity and lack of understanding of the HR programme by relevant authorities, as well as by the absence of a proper funding mechanism that would permanently secure the functioning and sustainability of drop-in centres, outreach work and NSP implementation⁶³. Currently, the National Health Insurance Fund (NHIF) does not provide support specifically to NGO service providers implementing HR services and programmes. Also, the lack of a scientifically and methodologically accepted, evidence-based population size estimation, as well as poor counselling services for sex workers who also inject drugs, and the absence of Drop-in Centres for people engaging in HIV risk behaviours in other towns of Montenegro outside of the capital, Podgorica, remain key barriers for future planning and implementation of a national HR programme⁶⁴.

The HR approach has been identified in, and supported by, the 'Strategy of Montenegro for the Prevention of Drug Abuse, 2013-2020', but there is no unique national doctrine, no protocol that regulates this area. Although the most significant harm reduction services are in place, and have been justified multiple times, the sustainability of these services, especially those run by civil society, is very much questionable following the completion of the Global Fund financed HIV grant.

Lessons learnt

Although the Global Fund and UNDP have made certain efforts in terms of supporting the transition activities, one of the key lessons learnt from the case of Montenegro is that the Global Fund, UNDP and the Montenegrin government, including the Ministry of Health and the CCM, needed to engage much earlier in a more consistent and strategic manner to plan for the transition from Global Fund to national funding for HR services and in ensuring their sustainability at a time when Global Fund resources were still available and it was viewed as a key partner. This is particularly important when having in mind that these services were funded primarily through the Global Fund support and a very limited amount through domestic channels of funding, primarily the Fund from Games of Chance.



Instead, when the Global Fund left the country, although aware that resources will not be available anymore, the Government of Montenegro did not have a viable plan and sufficient resources in place to maintain its HIV and AIDS programming. When Global Fund support ended in 2015, the government was not ready to lead and coordinate Montenegro's HIV response – especially among key populations⁶⁵. Once again, it has been shown that a country's wealth has little to do with its readiness, willingness, or ability to respond to HIV⁶⁶ - especially when it comes to funding programmes for people who use drugs and other 'politically unpopular' groups⁶⁷. Therefore, one of the urgent priorities that emerges is to secure sustainable and durable systematic mechanisms for financing programmatic support to NGOs providing HR services and implementing HR programmes. This is especially important keeping in mind the significant level of coverage of PWID with HR related services while the Global Fund support was available and the reduction of available funds on an annual basis from an estimated €130-150,000 to around €20,000 for this purpose after the completion of Global Fund financed grant, inevitably causing the significant decrease of available HR services in the field.

It is necessary here to emphasize that access to harm reduction in the state cannot be full, efficient and effective without services provided in the civil sector. As an additional argument, the current estimation is that the cost of preventive services is between 6 and 8 Euros per person, per month, while the cost of HIV treatment is between €1,200 and €1,500, and the treatment of Hepatitis C between €1,500 and €2,000 per person, per month⁶⁸. Also, the author of this study strongly believes that an annual investment of approximately €150,000 estimated by civil society is optimal and necessary for the successful and efficient implementation of the HR programme in Montenegro, an amount that is neither large nor unrealistic in comparison with the benefits gained and increased safety for the health of PWID as well as for the health and safety of the general population as a whole.

Another lesson learnt is from the 2015 showcase, the year of closure of the Global Fund financed HIV Round 9 Grant, when civil society was united in advocating for the sustainability of HIV/AIDS services aimed at key affected populations (KAPs) and especially HR related services among PWID. This advocacy campaign primarily targeted decision makers but also the wider public through constant reports in the media about the advantages and achievements of the HR programme in Montenegro. Advocacy efforts paid off, and an amendment to the Law on State Budget for 2016 demanding an allocation in the state budget for the purpose of providing a sustainable and durable solution for securing the financing of HIV/AIDS services to key affected populations was adopted by the Montenegrin Parliament in late 2015. However, this has still not resulted in any concrete mechanism(s) of support to NGOs due to political issues and turbulence, but the hopes of civil society are growing and this pathway seems to have a brighter future than that of the past. It should soon result in clear and transparent procedures on the criteria, requirements and responsibilities of NGOs that would implement their activities through this fund and enable sustainability of the services that will be nominated by the most prominent NGOs to be supported, including those implementing HR programmes.

Another lesson learnt is that all health commodities, including needles, syringes and condoms, need to be continuously available for both the PWID population and also for other KAPs, especially given the nature of their risky behaviour and their high sensitivity and vulnerability to the spread of HIV and HCV, respectively. The key informants for this study agree that the current low HIV prevalence, especially amongst PWID, is encouraging but also represents a significant challenge and obligation for maintaining such a situation in Montenegro in the future. Although not showing an increasing trend, high HCV prevalence points out that at least in the past there was a significant level of risky behaviour in the PWID population, as well as the potential for the spread of HIV among them. Results show that targeted preventive programmes have positively impacted the prevention of the spread of blood-borne infections but for further progress it is necessary to invest more⁶⁹. Therefore, the Ministry of Health



and the National Health Insurance Fund need to do more on enabling the necessary health commodities to NGOs providing HR-related services in the field directly to members of KAPs.

Montenegro's experience also shows that the policy commitments set by the government are insufficient if there is no financial support behind them. Despite its clearly articulated support for HIV and AIDS programming and the above described positive developments, the government has had no financing plan for using domestic funds to fill the gaps left by the Global Fund's withdrawal. It still remains undefined as to which sources of funding, and what financing mechanisms, it can use to fund NGOs for HIV and, more specifically, to HR-related work. Civil society has successfully advocated for the provision of sustainable HIV/AIDS related services in the EC report on Montenegro and on securing the financial support from the state budget for NGOs working with key populations. In addition, civil society seems unable to identify and use other possible sources of international financing, although their capacity has been significantly raised over the years, due to donor withdrawal from the country as it progresses towards EU accession. At the same time, the government has failed to appeal for EU funding for these services and has not proactively sought other international donor support. In addition, there has been no coordination from other donors to help Montenegro fill these gaps.

Finally, if the Montenegrin government does not prioritize HIV and AIDS programming, the work will not be maintained. Though the government has allocated resources to continue some activities like antiretroviral therapy (ART), OST and VCT, HIV prevention and HR-related programmes remain largely unfunded. As a result, programmes that deliver services for KAPs have no financial resources to continue their work. The Global Fund's withdrawal has also weakened community systems in Montenegro since, without funding, grassroots groups led by those most affected by HIV cannot sustain themselves⁷⁰.

By applying the Transition Readiness Assessment Tool (TRAT), Montenegro has a readiness score of 25%. Out of 12 indicators defined in the Tool, Montenegro fulfilled the first out of three stages in 6 transition readiness indicators, achieved the second stage in 2 of them, and the third stage in only 1 of them, according to specific benchmarks predefined in the Tool. Montenegro scores a bit better in the areas of policy and finance although there is still some room for improvement, while it still needs to make significant progress in indicators related to governance and programming.

Montenegro shows modest positive developments in terms of planning of allocations of national resources to support and sustain the gained successes in implementation of the HR programme, but concrete progress is still far away. Its readiness percentage might level up in the coming years, especially keeping in mind the ongoing process of transition. Although it is not yet completely clear as to what modus operandi Montenegro will use in allocating these resources, it should be noted that 2016 is the year when it is expected to have a new action plan for its AIDS strategy (2017-2018) as well as the action plan for the drug abuse prevention strategy (2017-2020). These processes should be led primarily by the Ministry of Health but with strong support both by the CCM, i.e. the National AIDS Commission (NAC), and the National Commission on Drugs that is to be established soon. Based on these, there is significant room for improvement in all four key identified areas in the future. Additional efforts will be needed beyond 2016 to achieve a strong governance model with CCM functions fully adopted by the NAC. Nevertheless, additional time and support will be needed to fully establish a durable, sustainable and functional system based on domestic financing.



Recommendations for key stakeholders

The successful transition in Montenegro will depend on the efforts invested by all key stakeholders. This study finds the following recommendations necessary for it to happen, including the recommendations that are part of the situational analysis in 'The Public Perception of the Degree of Distribution of Drugs in Montenegro'⁷¹ published by the NGO, 4Life, and the joint Initiative of four NGOs (Juventas, CAZAS, 4Life and Preporod) on improving conditions in the area of drug abuse prevention in Montenegro⁷², and the Policy Paper on the Reduction of Drug Related harm in Montenegro, published by the Montenegrin Harm Reduction Network, including the NGOs Link and Juventas.

Government

1. Government should plan for, and approve, a significantly increased allocation of funds for the purpose of implementation of the National AIDS Strategy and the National Drugs Strategy to cover the funding gaps as a result of the phasing out from the country of the Global Fund and other donor support. This could be done through both the existing mechanism of funds from games of chance and the National Health Insurance Fund by increasing the available finances and setting a clear and transparent process for its allocation and disbursement. It should urgently consider, and find an appropriate solution for, providing service provider NGOs with free-of-charge premises for the successful and long-term operation of drop-in centres. Finally, it should urgently enable NGOs with free needles and syringes and other health commodities that are currently not legal, to be procured by NGOs themselves (e.g. as a donation by health institutions);
2. Policies to combat drug abuse in Montenegro need to integrate a variety of approaches in the field of drug use prevention and harm reduction related to drug use in order to create a unique national system for combating drug abuse. This principle includes measures of prevention, reduction of harm to health and society as a whole in relation to drug abuse, psycho-social treatment and cure, rehabilitation and social reintegration of drug dependent people, as well as enhanced control of drug supply to reduce the availability of drugs. To achieve this principle, the state has to support a balanced development of all professional and scientifically-based approaches and programs, as well as to search for new solutions and models that can be used to control drug abuse. Generally, priority should not be given to any one approach in the prevention of drug abuse over any other and need to be connected and balanced through integrated activities at different levels;
3. Ensure that remaining legal barriers for civil society organizations to conduct harm reduction and HIV testing services, as well as most basic medical interventions and sexual and reproductive health services for key populations, are entirely removed from legislative sanctions by amending relevant laws, including the Criminal Law, as well as by developing the missing by-laws, especially those affecting HR service delivery. Due attention should be given to considering the possibility of licensing services in the context of the social protection system after the adoption of secondary legislation regulating the field of non-institutional provision of social services, as well as considering the introduction of the occupation 'outreach worker in harm reduction programs' into the system of social and/or health care;
4. Consider endorsing the financing mechanism for civil society organizations providing harm reduction related services within the Ministry of Health. There are some examples from the practice that some ministries have at their disposal for an annual budget allocation to CSOs to support activities and interventions that are aligned with relevant national strategies and thus contribute to their better and more effective implementation;



5. The Ministry of Health should intensify the process of setting new targets for preventive and HR-related programmes and services in order to cover gaps and meet WHO recommendations of availability of core HR services at all levels of coverage. The strategic planning should also include the appropriate costing of strategic interventions and activities and the possible optimization of expenditures;
6. On the basis of this study's findings, the Government, i.e. the Ministry of Health, should work on improving the functions of the National AIDS Commission and extend its mandate to performing structured monitoring and oversight of programme implementation and related expenditures. The capacities built within the CCM, including those for oversight of programme implementation, should be transferred to the NAC which can adapt some of the procedures of the CCM as a good practice for implementation. It should also create a plan for how the CCM will evolve and be institutionalized as a national governance body with decision-making powers for HIV programming. This should be done in close coordination and collaboration with relevant counterparts (the Global Fund Secretariat, the UN, civil society, and other donors), with the active participation of representatives of key affected populations, including PWID. The basis for developing this plan could also be the existing strategic documents and their respective action plans. Priority should be given to the interventions among KAPs, as well as to strengthening the coordination, monitoring and evaluation of service delivery;
7. Ensure that there is an adequate and formal participatory process with the inclusion of civil society in developing relevant strategic documents. Consequently, representation of CSOs both in the National Commission on Drugs (NCD) and the National Council on the Prevention of Drug Abuse should be ensured, similar to the experiences with the CCM, i.e. NAC;
8. Continue the well-established communication and cooperation with civil society in the context of HIV programmes, and build further upon it in the context of HR-related programming and planning, especially in terms of multi-disciplinary and multi-sector approaches between the Government/public sector and civil society. Therefore, building upon these successes is strongly recommended;
9. Provide regular bio-behavioural surveys (at least one survey every five years among each of the KAPs), including PWID, in order to identify trends in the spread of HIV and other sexually transmitted and blood borne infections, as well as the frequency of risky behaviours, the monitoring of new drugs and trends in drug consumption. The Government should also ensure support for regular research on drug use in the general population and among youth including the specific situation of female drug users as well as children and young people who use drugs;
10. The Ministry of Health should prioritize and intensify the efforts on conducting scientifically and methodologically accepted, evidence-based population size estimations for KAPs, especially PWID;
11. Using regional and international good practices and WHO guidelines, define a unique doctrine at the national level on the use and mode of implementation of substitution therapy with buprenorphine (the Ministry of Health, the Mental Health Commission, the NCD once established, the Section of psychiatrists of Montenegro, etc.), and develop a protocol and application guide in order to create conditions for the initiation of this type of substitution in accordance with the relevant national strategic documents;
12. Urgently expand the existing capacities for opioid substitution treatment in Podgorica in accordance with the number, and needs, of PWUD, and consider enhancing the scale of provision of HR services in other cities outside of the capital, especially in Pljevlja which is still not fully operational. Podgorica is the largest city with the largest number of PWID and, thus, there is an increasing number of people on the waiting list.



However, the situation does not differ much in the other 5 cities where MMT centres have been established a decade after the one in the capital. Most of these centers have long waiting lists for admission of new clients, indicating the need for the expansion of the HR programme;

13. Improve the functioning of the registry of people using drugs who seek treatment in medical institutions by enhancing the capacity of people working on the registry, introducing better surveillance and reporting by public health care institutions; and,
14. Improve the availability of the counselling and testing of HIV and other sexually transmitted and blood borne infections for persons using drugs and sex workers, especially by considering the introduction of these services into the drop-in centers and in the field through mobile teams.

Global Fund

1. Provide an on-going, backstopping technical support for an effective transition process for the period between 3-5 years at the end of a grant. This is particularly important having in mind the necessity of ensuring sustainable, national financing of the HR-related services that cannot be funded anymore through foreign donations or grants;
2. Make additional efforts in terms of advocacy and lobbying to mobilize more political support at the highest level with emphasis on diplomatic representatives of donor countries in Montenegro, the UN and other bilateral donors present in and out of the country;
3. Provide further support to the CCM Secretariat and especially consider supporting civil sector in advocacy, capacity building and monitoring. This is particularly important regarding taking over the functions of the CCM by the NAC during 2016 and especially during 2017 and beyond as these are years when new action plans for strategies on both HIV/AIDS and drugs should be developed and when the CCM Secretariat supported by the Global Fund can still play an important role in this sense; and,
4. Remain involved until programmes become sustainable without Global Fund support, either through support to the CCM Secretariat or through direct technical, backstopping support to the Ministry of Health and CSOs, i.e. CCM/NAC. This is particularly important as Montenegro's HIV disease burden categorization changed from 'Moderate' to 'High' according to the Global Fund 2016 Eligibility List, which could enable Montenegro to receive a new allocation if its disease burden remains high for 2 consecutive years in accordance with UNAIDS evaluation.

Civil society

1. Continue to participate in all processes aimed at ensuring governmental support of HIV services and particularly those targeted at KAPs previously supported by the Global Fund, especially in advocacy and monitoring actions;
2. Further advocate for putting in place the financing mechanism for CSOs implementing HR programmes with the National Health Insurance Fund and the Ministry of Health. Continuously work on strengthening CSO capacity, thus proving itself as a reliable and serious partner of the Government in reaching out to KAPs and providing important public health services;
3. Use good practices for further successful advocacy, especially for sustainable financing, demanding amendments to relevant laws and developing missing by-laws to complement the identified weaknesses and in contributing to the creation of an adequate legal framework for service provision, providing accountability for their delivery;



4. Continue regular communication and cooperation with Parliament, particularly the Parliamentary Committee on Health, Labour and Social Welfare, to ensure high-level oversight of the government's responsibilities in the transition process in order to sustain the ongoing transitional efforts by the CSOs and the CCM Secretariat;
5. Make additional efforts to contribute to an even greater extent to advocacy for committing support to the HR-related services and programmes by relevant authorities and in the monitoring of all ongoing processes and strategies. This should go together with an even closer partnership with the media and the communities they represent; and,
6. Contribute to an active and efficient NAC and NCD by continuously emphasising the shortcomings and weaknesses of relevant strategic responses and by providing relevant recommendations that will contribute to continued good governance and oversight of HIV programme implementation. Use the membership in both Commissions to continuously and proactively provide substantive inputs to future programming and other decision making related to the KAPs' health and rights.

Technical partners (in particular the EU and the UN)

1. Provide support to the Ministry of Health with regards to enhancing its leadership capacity in planning, implementation and monitoring of the relevant national strategic documents, its coordination and partnership capacity - particularly with NGOs - as well as providing technical/backstopping support in all four key areas (policy, governance, programme and finance), whenever possible and applicable;
2. Provide capacity building for the CCM/NAC, and the future NCD, as the relevant advisory, coordination and governing bodies of the overall national response. Proper representation of civil society and affected populations in the future NCD is necessary and should be reinforced by the technical partners, especially UNDP and the EU Delegation to Montenegro;
3. Provide necessary technical support to complement the efficiency of the ongoing processes and contribute to a greater extent to the successful implementation of both the HIV/AIDS Strategy, 2015-2020, and the Strategy of Montenegro on the Prevention of Drug Abuse, 2013-2020;
4. Provide support to the Ministry of Health and to the National Health Insurance Fund in building their capacity to undertake the strategic planning of health expenditures, the fine tuning of the financing mechanism for CSOs using good practices from the region and beyond, and in defining possible alternative sources of additional support for these services; and,
5. Ensure that civil society will continue to play a significant and reasonably participatory role in all national processes related to HIV and drug programming, as well as ensuring that the voices of KAPs are visible and heard.

Other donors

1. Having in mind the obvious needs on-the-ground and evidenced by the lack of national financing of relevant HR programmes and services, donors should consider supporting civil society and the government to establish reliable models for HIV prevention and HR related programming;
2. It is clear that necessary external financial support is not present in the country. Therefore, donors should support civil society advocacy initiatives, and especially the continued monitoring of programme implementation and related budgeting and costing;
3. The further strengthening of governing structures, such as the NAC/CCM, is needed in terms of their



mandate, transparency and good governance. Proper representation of civil society and affected populations in the future NCD is necessary through additional reinforcement by the donor community and properly communicated with the Government;

4. As an additional priority, enhance support given to initiatives that will improve HIV and HR-related programming, the scaling-up of existing service delivery and the improvement of their quality and quantity; this should also include continuous capacity building for all actors engaged in HIV and drugs/HR programming; and,
5. Donors have to reconsider their support strategies not just in Montenegro but more region-wide (the Balkans and Eastern Europe). It is crucial for them to understand that in the era of major financial cutbacks in the area of health, especially in the area of HIV and drug/harm reduction programming, their presence and continued support is an essential precondition for ensuring responsible, effective and highly successful processes of transition from international, donor oriented financing to domestic, national funding.



Attachment 1

The Transition Readiness Assessment Tool

This case study was guided by a Transition Readiness Assessment Tool (TRAT), which provides a quantitative framework for measuring a country's progress towards readiness for sustainable transition of harm reduction services from external donor funding to domestic resources.

The TRAT is based on **four thematic areas** of transition, as previously defined by the Global Fund Secretariat and the Eurasian Harm Reduction Network¹: policy, governance, finance and program. The TRAT was designed with the underlying assumption that in order for a country to be prepared for a sustainable transition, it must make progress on specific indicators in each of these thematic areas. Under each thematic area, three indicators help measure this progress.

Thematic Area	Indicators		
POLICY	Indicator 1. Transition Plan: A fully-resourced Transition Plan including harm reduction is proactively guiding transition.	Indicator 2. Legal and Policy Environment: There are no legal or policy barriers to the implementation of harm reduction programs.	Indicator 3. NGO Contracting Mechanisms: Policy or legislation is in place for state and/or municipal governments to contract or grant NGOs for the delivery of harm reduction and other HIV prevention services.
GOVERNANCE	Indicator 4. Sustainable Governance Body: A multi-stakeholder national governance body, including at least government, civil society, and technical partners, is institutionalized to steer the transition process and to continue program planning and oversight after the end of donor funding.	Indicator 5. Program Oversight: The multi-stakeholder national governance body has an oversight function to monitor implementation of the National HIV Program and harm reduction/PWID outcomes are measured as a distinct program area.	Indicator 6. Financial Oversight: The new governance body has an oversight function to monitor expenditure against the planned budget and harm reduction/PWID expenditure is measured as a distinct track of expenditure
FINANCE	Indicator 7. Optimised Budget: Funds for harm reduction are allocated according to an optimized budget scenario.	Indicator 8. Financing for NGOs: Core harm reduction services are funded by the government and delivered by NGOs via grants or contracting mechanisms.	Indicator 9. Procurement Systems: Donor procurement systems are integrated into national systems and assuring reasonable price controls.
PROGRAM	Indicator 10. Standardised Monitoring: Provision of core harm reduction services is monitored according to defined standards.	Indicator 11. Services Coverage: Core harm reduction services are available at levels of coverage recommended by the World Health Organization.	Indicator 12. Partnership with NGOs: NGOs are critical partners in the delivery of harm reduction and other HIV prevention services financed by domestic resources.

1 Eurasian Harm Reduction Network. *Transition and Sustainability of HIV and TB Responses in Eastern Europe and Central Asia: A Regional Consultation Report and Draft Transition Framework*. (2015) <http://www.harm-reduction.org/library/transition-and-sustainability-hiv-and-tb-responses-eastern-europe-and-central-asia>



For the purpose of standardizing measurement of progress against each indicator, the TRAT also assumes that there are three stages of readiness for countries actively preparing for transition:

- Stage I indicates that a country has made some progress towards preparing for a sustainable transition, but significant barriers remain.
- Stage II indicates that a country is actively in the process of making positive changes, but some time is still needed before systems will be prepared for a sustainable transition to domestic financing.
- Stage III indicates a country that is imminently ready to transition, with all core mechanism in place to sustain programming after external donor funding ceases.

Each indicator has three benchmarks corresponding to the stages to aid assessors in judging progress against the indicator. In order to quantify this progress, each benchmark achieved under each indicator is valued at one point, leading to a maximum possible score of 36 points.

$$\left[\begin{array}{c} 4 \\ \text{Thematic} \\ \text{Areas} \end{array} \right] \times \left[\begin{array}{c} 3 \\ \text{Indicators} \end{array} \right] \times \left[\begin{array}{c} 3 \\ \text{Stages of} \\ \text{Readiness} \end{array} \right] = \left[\begin{array}{c} \text{Max. 36} \\ \text{Readiness} \\ \text{Points} \end{array} \right]$$

Ultimately, the TRAT assembles a readiness profile for each country that reflects both a raw quantitative readiness score, and a visual depiction of readiness in each thematic area, by indicator. This allows the reader to visualize not only overall degree of readiness but also distribution of readiness across the thematic areas – highlighting strengths and weaknesses, and pointing to major gaps that need intensified effort in order to support a well-balanced effort towards sustainable transition to domestic financing.

Montenegro's Transition Readiness Profile

Out of the maximum possible 36 readiness points, Montenegro achieved 9, giving it a raw readiness score of 25%. This score reflects Montenegro's rather low level of preparedness in all thematic areas. Of particular concern are governance and program, with only one Stage I benchmark met and five others still unmet: no official government-endorsed plan for how the CCM will evolve and be institutionalized as a national governance body, with decision-making powers for HIV programming; a multi-stakeholder national governance body has not yet evolved from the CCM as an official governance body for the National HIV Program (the National AIDS Commission is a consultative body); there are no official government-endorsed plans on taking over the programmatic monitoring and oversight functions of the CCM by the NAC, nor is the governing body conducting oversight of the transition and national strategy. Additionally, no transition plan has been drafted, significant legislative barriers are in place (NSP is still illegal), and there is no mechanism by which NGOs providing HR services can receive government funding.

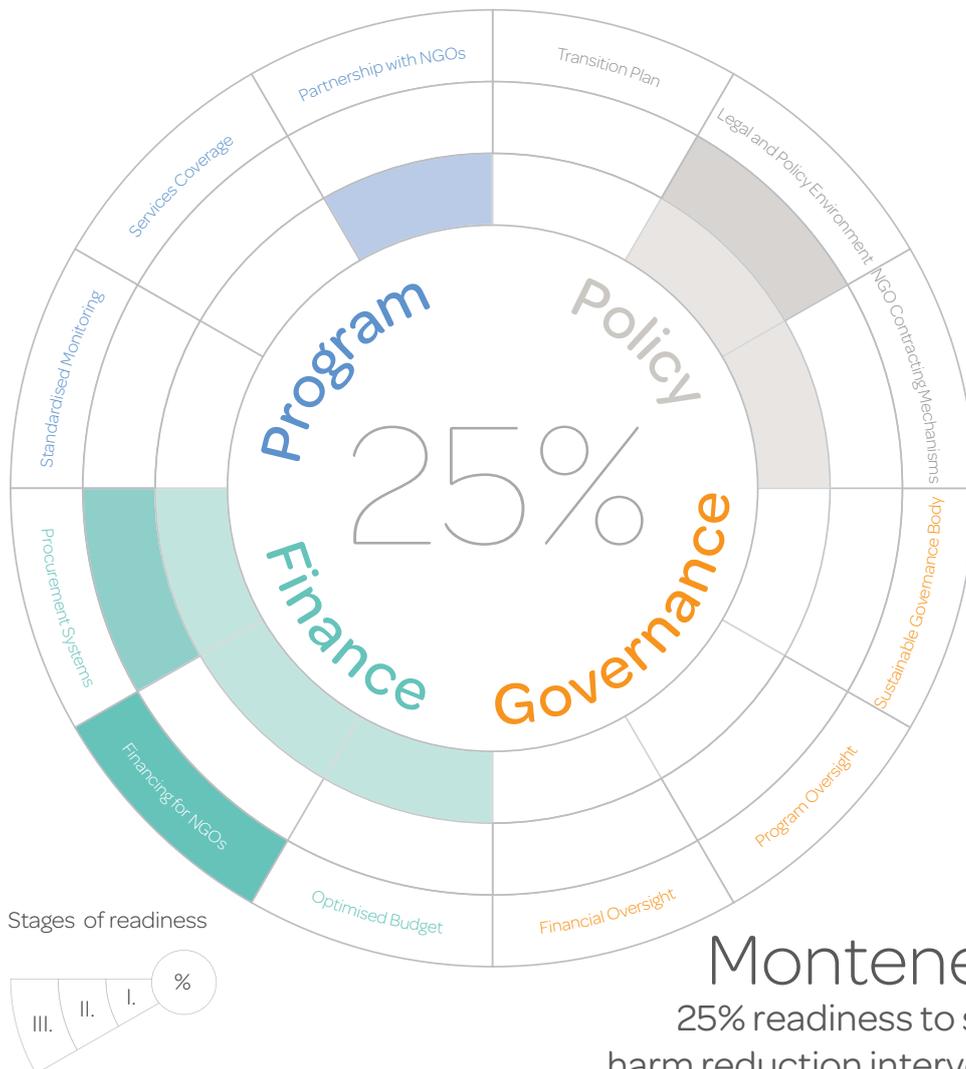
The figure below shows Montenegro's readiness by indicator in each of the four thematic areas. The lighter, innermost ring represents achievement of Stage I benchmarks for each indicator; the middle-level ring indicates achievement of Stage II benchmarks; and the darkest, outermost ring represents achievement of Stage III benchmarks. In instances where no benchmarks have been achieved, an outline serves as a placeholder to indicate that the indicator is pre-Stage I.



Transition Readiness Profile - Montenegro

Montenegro has made relatively good progress in preparing for financial and policy transitions, but the situation is still quite worrying. There are two main strategic documents in place – the National AIDS Strategy, 2015-2020, and the Strategy for the Prevention of Drug Abuse, 2013-2020. The Government is covering the cost of ART for HIV patients, methadone for MMT, staff and other needs, and VCT centers have also become fully sustainable. This means that all services available in the public sector have become sustainable, but it is not yet the case with NGO HR service providers. Although health commodities for HR service delivery are being procured for public health institutions, civil society has been left behind. Also, there are still no official harm reduction standards and guidelines, protocols or similar by-laws that regulate this area. Current coverage of PWID is significantly below the level reached during the era of Global Fund support, endangering the previously gained successes, particularly in terms of prevention of HIV and other blood borne infections.

If the situation in terms of readiness for transition is not improved immediately, Montenegro risks experiencing significant public health challenges in this area, especially given the evidenced high presence of HCV among PWID and the decrease of service coverage, limited only to the capital, Podgorica.



Montenegro
25% readiness to sustain
harm reduction interventions

Attachment 2

Budgetary and epidemiological characteristics of harm reduction programs in Montenegro

National AIDS Strategy – NAS; Strategic Area – SA; Strategic Measure – SM; National Strategy on Drugs – NSD; Drug Demand Reduction – DDR

* Figures shown here represent budget estimations according to the relevant strategic documents stated as sources.

Budget Details (in €)		2013	2014	2015	2016	2017	2018	Source(s)	Notes
Budget designated for harm reduction per national strategies, plans, etc.	NSP	150,000	150,000	150,000	150,000	N/A	N/A	NAS 2015-2020 and NSD 2013-2020	NAS, SA 2, SMs 2.1.1, 2.1.2 and 2.2.8; NSD, SA “Harm reduction of harmful effects caused by drug use”
	OST	100,000	100,000	100,000	100,000	N/A	N/A	NAS 2015-2020 and NSD 2013-2020	NAS, SA 2, SMs 2.1.3-2.1.6; NSD, SA “Harm reduction of harmful effects caused by drug use”
	Other (please specify)	0	0	0	0	N/A	N/A	NAS and NSD	/
Actual budget realized for harm reduction	NSP	150,800	120,000	110,000	22,000	N/A	N/A	Juventas and CAZAS	Estimations based on the available budgets of these two NGOs
	OST	90,000	80,000	70,000	50,000	N/A	N/A	IPH and PHCC Podgorica	Estimations based on the available information received from these two institutions
	Other (please specify)	0	0	0	0	N/A	N/A	CCM Secretariat	/



Amount from domestic funding	NSP	10,800	20,144	8,560	22,000	N/A	N/A	Juventas and CAZAS	/
	OST	50,000	50,000	50,000	50,000	N/A	N/A	MoH and CCM Secretariat	/
	Other (please specify)	0	0	0	0	N/A	N/A	CCM Secretariat	/
Amount from GF funding	NSP	140,000	99,856	101,440	0	N/A	N/A	Juventas and CAZAS	/
	OST	40,000	30,000	20,000	0	N/A	N/A	CCM Secretariat, Juventas and CAZAS	/
	Other (please specify)	0	0	0	0	N/A	N/A	CCM Secretariat	/
Amount from other external/donor funding	NSP	0	0	0	0	N/A	N/A	Juventas and CAZAS	/
	OST	0	0	0	0	N/A	N/A	CCM Secretariat	/
	Other (please specify)	0	0	0	0	N/A	N/A	CCM Secretariat	/
Calculated need for harm reduction	Please see above 'Budget designated for harm reduction' *				250,000 **	N/A	N/A	NAS and NSD	* When planning the budgets, NGOs were involved and lead the process of developing the AIDS Strategy, thus influencing the amount designated per strategy according to the needs on the ground. ** This sum is not mentioned in the strategies as such. It is just an estimated calculation based on these strategies, as per their action plans
Gap between need and funds available	All	9,200	50,000	70,000	178,000	N/A	N/A	NAS and NSD	/



PWID...	2013	2014	2015	Source	Notes
Number of government-based needle/syringe exchanges	1	1	1	CCM Secretariat, Primary Health Care Centre Podgorica and NGOs	
Number of NGO-based needle/syringe exchanges	3	3	2	Juventas and CAZAS	Two drop-in centers with NGO CAZAS in Podgorica and Bar were temporarily closed as of 1 July 2015 due to lack of finances, and there is currently only 1 drop-in running (with Juventas) and 2 outreach (CAZAS and Juventas).
Number of drug users enrolled in NSP	1250	1300	1500	Juventas and CAZAS	
Number of clients receiving minimum package of services*	1250	1300	1500	Juventas and CAZAS; GARPR Online Reporting Tool, Montenegro 2015, UNAIDS	Minimum package of services include needles and syringes equipment exchange, information and counseling on STIs, HIV/AIDS, HBV and HCV, condom use and their distribution, distribution of lubricants, as well as referral to health protection institutions.
Number of clients receiving expanded or comprehensive package of services	1250	1300	1500	GARPR Online Reporting Tool, Montenegro 2015, UNAIDS	This is the approximation according to the stated source, as there are no official available data on this. Beside sterile injection equipment exchange, clients are served with services that include preventive education (information and counseling on STIs, HIV/AIDS, HBV and HCV, condom use, drug use, safe injection, social support), basic medical care, distribution of condoms, psychosocial support, referral to health and social protection institutions with an emphasis on institutions for treatment and rehabilitation.
Coverage of NSP among drug users nationwide (Numerator: the number of drug users enrolled in NSP; Denominator: the estimated size of drug users)	N/A	N/A	N/A	GARPR Online Reporting Tool, Montenegro 2015, UNAIDS; CAZAS and Juventas	The only available population size estimation was conducted in 2011 and was 1292 only in capital of Podgorica. There is no national population size estimation available. It should be taken into consideration that the data from NGOs show that annual coverage is around 1500 PWID, and that the above estimated number of drug users in Podgorica should be multiplied several times. However, the absence of population size estimation at the national level clearly shows here that without it is impossible to state even an approximate percentage of PWID coverage in Montenegro.



For OST...	2013	2014	2015	Source	Notes
Number of OST clinics nationwide	4	4	5	Institute of Public Health	
Number of clients on methadone	N/A	548	367	Institute of Public Health	
Number of clients on other substitutions therapies	N/A	N/A	N/A		
Coverage of OST among drug users nationwide (Numerator: the number of drug users enrolled in OST; Denominator: the estimated size of drug users)	N/A	N/A	N/A		

PWID...	2013	2014	2015	Source	Notes
Newly diagnosed with HIV (by year)	0	0	0	Annual HIV/AIDS Report 2015, Institute of Public Health	
On ART (cumulative)	0	0	0	Annual HIV/AIDS Report 2015, Institute of Public Health	Out of the cumulative number of registered HIV/AIDS cases in Montenegro, there are officially only 3% of PWID, they all died and no new cases of PWID on ART since 2013

OST clients	2013	2014	2015
Diagnosed with HIV (by year)	No data available		
On ART (cumulative)			
PWID and OST clients			
Tested for HIV (by year)			
Living with HIV but not on ART (cumulative)			
Screened for TB (by year)			
Diagnosed with active TB (by year)			
Treated for TB (by year)			



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Eurasian Harm Reduction Network (EHRN) is a regional network of harm reduction programs and their allies from across 29 countries in the region of Central and Eastern Europe and Central Asia (CEECA). Together, we work to advocate for the universal human rights of people who use drugs, and to protect their lives and health.

The Network unites over 600 institutional and individual members, tapping into a wealth of regional best practices, expertise and resources in harm reduction, drug policy reform, HIV/AIDS, TB, HCV, and overdose prevention. As a regional network, EHRN plays a key role as a liaison between local, national and international organizations. EHRN ensures that regional needs receive appropriate representation in international and regional forums, and helps build capacity for service provision and advocacy at the national level. EHRN draws on international good practice models and on its knowledge about local realities to produce technical support tailored to regional experiences and needs. Finally, EHRN builds consensus among national organizations and drug user community groups, helping them to amplify their voices, exchange skills and join forces in advocacy campaigns.

BECOME AN EHRN MEMBER:

EHRN invites organizations and individuals to become part of the Network. Membership applications may be completed online at:

www.harm-reduction.org/become-a-member