ASOCIATIA ROMANA ANTI-SIDA

romanian harm reduction network

UN Administered Province of KOSOVO

Most-at-risk adolescents and young people, HIV and substance use

COUNTRY MISSION REPORT

2006

UN ADMINISTERED PROVINCE OF KOSOVO

Most-at-risk adolescents and young people, HIV and substance use

Country Mission Report

2006

produced within the
"Support Network for HIV Prevention among Injecting Drug Users in South Eastern Europe"

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This report would not have been possible without support and valuable contribution of our colleagues from ***South-Eastern European Human Rights and Treatment Collaborative Networking on HIV/AIDS and Drug Use*** *(SEE Collaborative Networking) and* ***all the institutions and organizations met during the country mission****:*
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We would like to express our special gratitude to Tania Goldner (UNICEF Romania), Paula Bulancea (UNICEF Romania), Maria Georgescu (ARAS), Nora Stojanovik (Macedonian Harm Reduction Network and SEE Collaborative Networking), Edoardo Spacca (SOFRCO SAP and European Network on Drugs and Infections Prevention in Prison), ARAS and Labyrinth teams.

The aim of the mission to Kosovo is to assess vulnerabilities and risks related to HIV and problem drug use, to map national and local response and capacities, as well as identify potential ways to strengthen national policies and strategies in the field of HIV/AIDS and drug use. Two international experts together with representatives from the local partner carried out a number of interviews and site visits in January 2006. This report is based on gathered information and views, as well as on previous research and analysis, available statistics and legal documents. It was officially launched at the regional Inter-country Consultation "Counting Lives!" in Bucharest, on February 15- 17, 2006.

The Kosovo mission is part of the project "Supporting Network for HIV Prevention among Injecting Drug Users in South-Eastern Europe", which is implemented under coordination of Romanian Harm Reduction Network, with financial and technical support from UNICEF.

The opinions expressed in this report do not necessarily reflect policies or views of the Romanian Harm Reduction Network and UNICEF. The designations employed and the presentation of the material (including maps) do not imply on the part of UNICEF the expression of any opinion whatsoever concerning the legal status of any country or territory, or its authorities or the delimitations of its frontiers.

Descrierea CIP a Bibliotecii Naţionale a României
UNICEF. Reprezentanţa în România
Albania: Most-at-risk adolescents and young people, HIV and substance use; country mission report/ UNICEF – Reprezentanţa în România
ARAS – Asociaţia Română Anti-SIDA/Reţeaua Naţională de Reducere a Riscurilor Asociate Consumului de Droguri (RHRN) – Bucureşti: MarLink, 2006
Bibliogr.
ISBN : (10) 973-8411-54-8; ISBN (13) 978-973-8411-54-8

I. Asociaţia Română Anti-SIDA (Bucureşti)
II. Reţeaua Naţională de Reducere a Riscurilor Asociate Consumului de Droguri - RHRN – (Bucureşti)

314.4:616-008.6-SIDA(497.115)(063)

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ARAS	Romanian Association against AIDS
ART	Antiretroviral therapy (for HIV treatment)
BCC	Behavioural change communication
CCM	Country Coordinating Mechanism
CEEHRN	Central and Eastern European Harm Reduction Network
CIDA	Canadian International Development Agency
DU	Drug user
EAR	European Agency for Reconstruction
ELISA	Enzyme-Linked Immuno-Sorbent Assay
EU	European Union
EUR	Euro (currency in part of the EU territory, also in Kosovo)
FYR	Former Yugoslav Republic
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
IDU	injecting drug user
IOM	International Organization for Migration
KAC	Kosovo AIDS Committee
KAP	Knowledge, Attitude and Practice
MARA	Most at risk adolescents
MSM	Men who have sex with men
NGO	Non governmental organization
PISG	Provisional Institutions of Self-Government (of Kosovo)
PLHIV	Person/people living with HIV
PSI	Population Service International
RAR	Rapid Assessment and Response
RAR SUYP	RAR on substance use and young people
SEE	South-East Europe or South-Eastern European
STI	Sexually transmitted infection
SW	Sex worker
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
UNMIK	United Nations Mission in Kosovo
UNTG	United Nations Theme Group on HIV/AIDS
USAID	United States Agency for International Development
VCT	Voluntary counselling and testing
WHO	World Health Organization

Foreword

Every year the number of the HIV-positive young people increases dramatically. The most common ways of HIV spreading are the drug use and the heterosexual intercourse. The data reveals that the region of Eastern Europe and Central Asia is experiencing the fastest-growing HIV/AIDS epidemic in the world.

Although the regional initiative **The Human Rights and Treatment Collaborative Networking on Drug Use and HIV/AIDS in South-Eastern Europe** (SEE Collaborative Network) is less than 1 year old, it has already had a great impact in the region. It was established to develop and implement a regional strategy to improve the health and rights of at risk and vulnerable populations in relation to drug use and HIV/AIDS in this region.

UNICEF Romania had the privilege to collaborate with Romanian Harm Reduction, member of the SEE Collaborative Network, in implementing the **"Support Network for HIV Prevention among Injecting Drug Users in SEE"** Project, aimed to strengthen the regional response for maintaining long-term, viable HIV/AIDS prevention, treatment and care services. Through this project, teams of international and national experts collected data about most at-risk adolescents (MARA), mapped the existent services for MARA, assessed the availability of international and national funds for HIV/AIDS services, and elaborated a general overview of the situation and the needs of at risk and vulnerable populations from Albania, FYR of Macedonia, Kosovo and Romania. Four country mission reports reflect all this information, creating the baseline for the development of the national evidence-based interventions, including advocacy.

Sharing experience and good practices among the SEE-CN members and improving their competence to plan advocacy activities and their skills to advocate for sustainable HIV services at the national and regional level represented two major objectives for this project. The inter-country consultation held in Bucharest, February 15-17, 2006, provided the opportunity to share lessons learned, to discuss common issues, and to establish contacts for further networking. The report of the meeting includes the main issues discussed during the consultations, conclusions and recommendations.

All the reports developed within the project represent useful advocacy tools for governments as well as for the local, national and international organizations that are involved in advocacy networking in the SEE region.

UNICEF Romania appreciates all the efforts that countries from the region have already started in this area and is willing to offer its support for the continuation of their endeavours in preventing the AIDS epidemic among young injecting drug users, with a focus on most at-risk adolescents, and in advocating for quality harm reduction services.

Pierre Poupard,
Representative, UNICEF Romania

Executive Summary

"The current low levels of HIV in SEE [South-Eastern Europe] countries represent a challenge in gaining recognition of the potential impact of HIV/AIDS on health systems, social structures, and individuals. Moreover, the approach to HIV/AIDS in SEE is complicated by the relatively high levels of stigma against persons most likely to be exposed to HIV (injecting drug users [IDUs], commercial sex workers [CSWs], ethnic minorities such as the Roma, mobile population, and men who have sex with men [MSM])." (Novotny et al., 2003)

Kosovo[1] is highly affected by growing mobility, drug and human trafficking, increasing drug use and sex industry, as well as serious gaps in healthcare and social protection. Half of the population (around 1 million) is under 25 years old. Though anecdotal reports and a few studies show the increasing number of young people[2] who are involved in behaviours which put them at-risk of HIV infection and growing number of injecting drug users (IDUs), female sex workers (SWs) and men who have sex with men (MSM), yet specific data remain unavailable.

Like the rest of the Balkans, Kosovo is considered to be a territory of low HIV prevalence. Out of 65 HIV cases only about one infection case was reported by a result of injecting drugs and none among MSM or SWs. One quarter of the people living with HIV (PLHIV) were under 25 years old when identified to be HIV-positive or with AIDS.

The Kosovar authorities are grappling with post-conflict economic, social and political transitions, leaving few resources and little attention to issues that affect the lives of persons most likely to be exposed to HIV.

Kosovo declares high commitment to the prevention of HIV. International and national documents, notably the Kosovar Strategy for HIV Prevention (2004-2007), reinforce support for targeted HIV interventions among persons most at-risk of HIV. No drug strategy exists. Available studies conclude with calls for specific and sustainable services for IDUs, SWs and MSM, as well as other key populations at risk of HIV.

Existing HIV services include voluntary counselling and testing (VCT), condom distribution as well as general youth anti-AIDS campaigns, and rather expensive, but quality HIV treatment. However, at the beginning of 2006, almost no HIV preventive services addressed the needs of most at-risk adolescent boys and girls[3] (MARA). The few programmes for those most at-risk of HIV are part of the HIV strategy and include a VCT site integrated in a non-governmental drug treatment clinic in the capital city of Pristina, and awareness raising and promotion of VCT among MSM. There were no services for sex workers, mobile populations or for those in prison neither in 2005 nor at the beginning of 2006. in addition, there are poor drug dependencies treatments, no vaccination and treatment for hepatitis B and C.

Anecdotal stories and key interviewed stakeholders report about challenges related to stigma and discrimination of IDUs, MSM, SWs and PLHIV, as well as criminalization of sex work and ambiguity related to drug possession punishment.

The findings of this report, based on results of the mission to Kosovo in January 2006, support the need for effective policy responses. These responses require a multidisciplinary approach and

[1] [1] Currently under United Nations Administration (United Nations Interim Mission in Kosovo)

[2] The UN definition of young people is referring to those between the ages of 10 and 24. However, the national statistics, strategies or other documents use other definitions for young people. In this report, we used the UN definition, except the situation where official data is reported (in this last situation, the ages are indicated in brackets).

[3] The UN definition of adolescent is referring to those between the ages of 10 and 19. However, the national statistics, strategies or other documents use other definitions for adolescent. In this report, we used the UN definition, except the situation where official data is reported (in this last situation, the ages are indicated in brackets).

partnerships of national and local authorities, NGOs and affected communities, international and bilateral agencies and other donors, as well as international organizations and researchers.

Recommendations for:

Policy makers

- Initiate and accelerate penal and judicial reform to address factors increasing HIV risk behaviour in marginalized populations, as well as introducing and sustaining efficient and cost-effective programs
- Together with different stakeholders in the field, develop and implement a multi-sectoral and comprehensive drug strategy and action plan with funding
- Keep HIV/AIDS high in the health and social agenda, including other infections and drug dependency in order to minimize the social and economic costs

Governmental institutions and healthcare system decision makers

- Develop drug treatment system, which could be supported by training potential drug treatment teams and building connections with reliable treatment providers in other countries (especially in case of services which are not available in Kosovo)
- Broadly introducing and funding sustainable harm reduction approaches (including in prisons)
- Improve data collection and surveillance and disaggregate data by age, sex, diversity and risk behaviour
- Develop and sustain other services for at risk populations (including but not limited to outreach, STI treatment and peer education for SWs and MSM)

NGOs and services providers

- Developing Advocacy strategies aimed at development of drug treatment system, harm reduction services and other HIV prevention services among marginalized groups
- Actively participating in design, implementation and evaluation process of the HIV prevention and treatment services
- Develop pilot service programs among marginalized groups with effective and meaningful involvement of persons most likely to be exposed to HIV.

Donors, bilateral and multilateral agencies and international organizations

- Help to advocate for the need of national drug strategy and drug services, including harm reduction
- Build local capacities to introduce effective policies and strategies (including policy-makers, governmental institutions, NGOs and service providers)
- Assist in addressing gaps in targeted preventive strategies among most at risk groups that are not addressed by the state

Researchers

- Research links between policies and practices related to persons most at risk of HIV
- Assist NGOs and other service providers to build accurate and inexpensive monitoring and evaluation of programmes (effectiveness, economic benefits)
- Develop a comprehensive epidemiological system
- Closely work with NGOs and community based services, in order to obtain accurate information related to HIV risk behaviours and practices

I. Introduction

Injecting drug use is a major factor driving new HIV infections in Eastern Europe and Central Asia. It primarily affects young people *(UNAIDS/WHO, 2005)*. While HIV is low throughout the Balkans, the region reports all risk factors that are present and associated with HIV in higher prevalence countries such as Estonia, Ukraine and Russia.

In June 2005, a new regional initiative ***South-Eastern European Human Rights and Treatment Collaborative Networking on HIV/AIDS and Drug Use*** (SEE Collaborative Networking) was launched in order to develop and implement a regional strategy to improve the health and rights of persons most likely to be exposed to HIV in relation to drug use and HIV in this region. The SEE Collaborative Networking is built on important work initiated by various networks and key players in the region, linking together related programmes and projects. It focuses on filling the existing gaps, building synergies and maximizing organizational strengths. The network includes organizations, national networks, and individuals from 9 countries and territories (Albania, Bosnia and Herzegovina, Bulgaria, Croatia, The Former Yugoslav Republic of Macedonia, Kosovo[4], Romania, Serbia and Montenegro, Slovenia) who share common values and interests in building relationships, exchanging knowledge and learning.

The goal of the project **"Support Network for HIV Prevention among Injecting Drug Users in SEE"** developed with financial and technical support from UNICEF Regional Office in Geneva and UNICEF Country Office in Romania is to increase the capacity building of Romanian Harm Reduction Network to offer support for other national harm reduction coalitions in order to strengthen the regional response for maintaining a long term, viable HIV prevention, treatment and care services.

As part of this project, in **January 9-15, 2006**, a mission was conducted in Kosovo. The main objectives of the mission were to collect data about most at risk adolescent (MARA) boys and girls, to map the existing services for MARA boys and girls, to assess the availability of international and national funds for HIV services, and to elaborate a general overview of the situation and recommendations for policies and strategies in Kosovo. All information and conclusions will create the base for the development of the national evidence-based interventions and advocacy. The mission organization was done by the in-country partner non-governmental organisation (NGO) Labyrinth and the UNICEF Office in Kosovo.

The Kosovo mission included four-day meetings with representatives of governmental and healthcare institutions, NGOs and international agencies from Kosovo that are actively involved in response to HIV and drug use. The mission started with a meeting where major stakeholders from HIV and drug use fields participated and during which the project objectives and the initiative of SEE Collaborative Networking were presented. Individual interviews focused on different themes, collection of information and opinions. The terms of reference of the mission, as well as agenda and list of contacted and interviewed people are available in annexes of this report.

The international team involved in the country mission was **Catalina Iliuta**, project coordinator at Romanian Harm Reduction Network, and **Raminta Stuikyte**, Executive Director at Central and Eastern European Harm Reduction Network. The in-country partner for the Kosovo mission was NGO Labyrinth, represented by **Safet Blakaj**.

[4] [4] Currently under United Nations Administration (United Nations Interim Mission in Kosovo)

II. Background

2.1. General information

Population	**Approximately 1.9 million (1.8-2.0 m)** **(capital city Pristina; population 0.5 m)**
Political status	**Since June 1999, interim international governance under direct administration of the United Nations, according to UN Security Council's Resolution 1244; Kosovo does not have country status and formally is part of Serbia and Montenegro**
Languages	**Albanian, English and Serbian**
Ethnic composition	**Albanians (around 90%); Serbs (around 7%), Turkish, Bosnians, Roma, Ashkali and Egyptians**
Neighbouring countries	**Albania, TFYR of Macedonia**
Children and young people	**Half of population is under 25 years old; around 30% is under 18 years old**
Gross Domestic Product (GDP)	**1.78 billion EUR, or 930 EUR per capita (2003)**
Unemployment	**50-60%, without taking into account seasonal variations and the grey economy.** **23-33% (World Bank estimate adjusting for seasonality and informal employment)**

Source: UN Interim Administration in Kosovo. Fact Sheet: Kosovo in April 2005.

Kosovo is one of the poorest territories in Europe. The UN Interim Administrative Mission in Kosovo (UNMIK) pursuant to UN Security Council (UNSC) Resolution 1244 administers Kosovo since June 1999. After the first assembly elections in late 2001, the Provisional Institutions of Self-Government of Kosovo (PISG) were established. Transfer of authorities from UNMIK to PISG is increasing each day, with more power, responsibility and competence for governance.

A number of vulnerability factors for potential HIV spread are present in the territory, including: young age of population, high unemployment rate, increased drug use (including injecting drug use), flourishing sex industry, tensions between different nationalities and high presence of international staff. Another important factor is the high mobility of population. More than 200,000 Kosovars were living outside the territory in 2003, as compared to the period before 1999 when this number was 400,000. The economic, social, education and health infrastructure is being rebuilt after years of conflict.

According to UNMIK statistics, young people[5] represent 20% of the population in Kosovo. Most of them have been affected by the years of conflict. Young people now face a world of rapid change.

Facing rapid social and economic changes, boys and girls are a key population group most likely to be engaging in HIV risk behaviour. The age of sexual debut is declining rapidly. The situation of high unemployment, especially among young people, has resulted in migration towards West European countries.

Epidemiological data, as all statistics related to Kosovo, are limited and/or lack accuracy. This is related to the absence of general population registration: last census was conducted in 1980.

[5] The UN definition of young people is referring to those between the ages of 15 and 24. However, the national statistics, strategies or other documents use other definitions for youth. In this report, we used the UN definition, except the situation where official data is reported (in this last situation, the ages are indicated in brackets).

2.2. Epidemiology and persons most likely to be exposed to HIV

2.2.a. National statistics on HIV and AIDS

In Kosovo the first confirmed AIDS case was registered in 1986. A cumulative total of 65 AIDS cases had been registered by the end of 2005. Until 2002, only AIDS and not HIV cases were reported. 7 PLHIV are being monitored in the Infectious Disease Clinic at University Clinical Centre of Kosovo.[6] The interviewed people support the idea that due to lack of HIV tests promotion for general public HIV/AIDS cases are not appropriate even though a national HIV surveillance system was set up in late 2002 when the Unit for HIV/AIDS Surveillance was established. The second generation surveillance system for HIV needs to be strengthened.

Experts report that Kosovars living abroad and working as migrant workers represent a substantial proportion of the HIV and AIDS cases known outside Kosovo. The majority of known AIDS cases were acquired through sexual intercourse (mainly heterosexual). At least one known case is related to injecting drugs (however this person is not in contact with an infectious diseases doctor for monitoring and there is no data whether they are alive and/or still in the country). There was one case of mother-to-child transmission. No cases of HIV infection through blood donations have been reported.

Table 1: Registered HIV/AIDS cases according to transmission route

Mode of transmission	Cumulative AIDS cases		In 2005	
	Cases	Percentage	Cases	Percentage
Heterosexual	63	97%	4	100%
Men who have sex with men (MSM)				
Injecting drug use	1	1.5%		
Blood transfusion				
Mother to child transmission (MTCT)	1	1.5%		
TOTAL	65	100%	4	100%

Source of this and other figures in this section is the National Institute of Public Health, Department of Epidemiology, HIV/AIDS/STI Surveillance Unit

Table 2: HIV/AIDS cases and deaths 1986-2005

Year	HIV cases	AIDS cases	Number of deaths
Cumulative before 2001	n/a	30	22
2001	n/a	12	0
2002		5	0
2003		7	1
2004		7	2
2005		4	0
TOTAL		65	25

[6] However, in officially received data, there are no separate data for HIV and AIDS cases, even those after 2002. In general, most cases are reported in quite late stages.

Table 3: Registered AIDS cases by age

Age group	Cumulative cases	Cases registered in 2005
0-15 years	2	0
16-25 years	15	0
25-35 years	21	0
35-60 years	12	2
>60 years	4	2

Table 4: Testing for HIV at sites of voluntary testing and counselling (VCT), April 2003-end of 2005

	Tested	HIV +	Female	Age (12-26 years*)	IDUs	FSWs (female)	Clients of SWs	MSM (including bisexual)	Prisoners
Number	1323	4	315	593	156	18	24	18	0**
Percentage of all tested (%)	100%	0.3%	23.8%	44.8%	11.8%	1.4% (or 5.7 of all females)	1.8%	1.4%	0.0%

* Only the age group of 12-26 years old is reported; disaggregated information about more specific age groups is not available

** Prison authorities report about 1 prisoner who was referred to VCT centre for testing.

From April 2003 to end of 2005, a total of 1,407 "new client" visits to VCTs was recorded. 94% of clients were tested and 100% went through pre (and post-test where relevant) counselling procedures. 4 people were identified as HIV-positive. None of them were young people, who made up almost half of people who were tested.

No information about testing and HIV cases according to nationality is available. After 2000, all HIV/AIDS cases were identified among Kosovo Albanians with exception of 9 cases among internationals. According to Kosovar authorities, "Serbian minority living in Kosovo does not report about HIV cases to Kosovo authorities in any manner;" HIV cases among Kosovo Serbians, if any, may be incorporated in Serbian reports.

Screening blood donations suggest low prevalence for syphilis (<0.1%; although no syphilis cases have been reported since 1996), Hepatitis C (HCV) (0.2%), HIV (0.0%), and Hepatitis B (HBV) (3%). The National Centre of Blood Transfusion identified 7 people with HIV during 2002 and the first trimester of 2003 (n=2,600) through ambulatory tests.

USAID currently funds research on biological and behaviour indicators among injecting drug users (IDUs), sex workers and men who have sex with men (MSM) in Kosovo towns. Results of this research will be used for planning the next steps together with other stakeholders and further advocacy. USAID previously supported a condom marketing campaign and a survey of knowledge, attitude and practice (KAP).

All experts approached were cautious about officially registered data and their representativeness, as numbers of people tested for HIV are low. On the other hand, low HIV numbers among potentially the most at-risk populations are confirmed by testing results among IDUs, sex workers, inmates, and MSM who were tested through VCT.

2.2.b. Drugs, drug use and problem drug use

Interviewed NGOs, experts and a previous WHO study in 2001 show dramatic increase of drug use in Kosovo. It might be related to increased drug supply, increased travel, migration and cross-border trade, post-trauma after conflicts, socio-economic instability and vulnerability of young people (people under 25 years comprise around half of overall population). In addition, Kosovo is located on the major drug route, which crosses the Balkans.

There is no monitoring of substance use in the territory. Existing data on drugs and substance use are limited to Rapid Assessment and Response on Substance Use and the Young People of Kosovo in 2001 (RAR-SUYP 2001), two studies on knowledge, attitude, practice and behaviour among youth, as well as from services providers and NGOs interviewed directly in 2006 or—if not available—through the summary report on substance abuse produced by Brisson and colleagues in 2004.

The number of drug users is not known in the territory. An official register of drug users, which was in place before the conflict period in mid-1990s, is not maintained and thus no official numbers of drug users is available. Interviewed experts estimated that there were up to 1.500 injecting drug users (0.3% of population[7]) in Pristina. Earlier reports were estimating the number of heroin users in overall Kosovo between 3,000 and 5,000 (0.17-0.28% of Kosovo population). No national-wide estimates of IDUs (of heroin or other drugs) are available. Subsequently, age distribution and estimates of male and female adolescents and young people among IDUs and among drug dependants are not available; however according to service providers, the average age is decreasing and was below 20 in the first half of 2005.[8]

A number of general tendencies were repeatedly indicated in different surveys:

- decreasing age of drug users
- increasing injecting drug use
- increasing number of drug users not only in towns but also in rural areas
- decrease in the price of "hard" drug (heroin, cocaine)

There were no representative studies on behaviours, and STI, HIV, Hepatitis B and C virus (HBV and HCV) incidence among IDUs. However, some data are available through VCT service at NGO Labyrinth (n=208; data for March-December 2005). Among IDUs (91,7%; n=191), no HIV cases were identified; 23% (n=44) were positive for HBV and 29% (n=55) were positive for HCV. All the IDU clients who were tested reported that they shared injecting equipment at least once in last 12 weeks before testing.

RAR SUYP 2001 also reports on risk behaviours among IDUs. Among 20 surveyed IDUs, 13 of them (65%) had used someone-else's syringe; 11 IDUs (55%) gave their used syringe to someone-else. High rates of sharing injection equipment were also confirmed during focus group discussions.

According to RAR SUYP 2001, among school youth 0.4% reported lifetime heroin use and 0.3% used heroin in the past 30-days (the report does not provide data disaggregated by gender). In café and bars, 6.4% of adolescents (age 14-17 years) reported heroin use at least once in their life. In Gjilan and Pristina, past 30-day use was reported by 6.6% of young respondents in café and bars.

RAR SUYP 2001 did not include Serbs in the survey and mainly focused on Albanians. A survey among Serbs regarding problem drug use has not been conducted. Local NGO JAZAS working in northern Mitrovica (where most Serbs live in Kosovo) reports drug use problems among Serbian youth.

This is relatively small number in comparison with capital cities in neighboring countries – Albania (0.40%), Macedonia (0.37%), Serbia and Montenegro (0.25%) and Romania (0.66%) (EMCDDA, 2004).

[8] According to NGO Labyrinth, average age of drug users in their service decreased (from 24,4 years in 2003 to 19,8 years in the first half of 2005).

Prices for drugs are relatively low and accessible, at least in Kosovo, Gjilan, Prizren and other (border) towns. According to NGO Labyrinth, in early 2006, street prices in Kosovo are:

- cannabis: 1 gram = 2-3 EUR
- heroin: 1 gram = 8-12 EUR
- ecstasy: 1 pill = 6-10 EUR
- cocaine: 1 gram = 60-80 EUR

Low heroin price raises a major concern (before the conflict estimated price was 50 EUR, in 2004 it was 10-30 EUR per gram and dropped even lower in 2005). Cannabis use is high. Ecstasy use is on rise. In 2001, RAR SUYP showed use of other substances, including non-prescribed trodon/tramadol, and some other pharmaceutical drugs.

According to Labyrinth, the main injecting drug is heroin (and some cocaine). Use of amphetamines is low and they are not injected.

Information on condom use and sexual behaviour among drug users are not known. More information about behaviours that increase risk of infections and other negative health consequences, as well as the prevalence of HIV, Hepatitis C and STIs will be researched by mid 2006 in two towns (Pristina and Prizren).

Experts confirmed a number of fatal drug overdose cases in Kosovo (at least 5), however statistics are not available on this and overdose cases are often not properly documented according to interviewees.

2.2.c. HIV and drug use in prisons

Official data from the Kosovo Correctional Service show that 1,320 people were incarcerated at the end of 2005. The penal system includes 8 prisons and detention centres located around Kosovo. One of the detention centres, Lipjan, houses small numbers of juveniles and women. The largest male facility is Dubrava Prison and often has more then 500 male inmates of whom a small number are detainees[9] and about 20 juveniles. According to correctional administration representatives, the main reasons for conviction are theft, murder, sexual or physical violence; an increased number of people convicted for illegal drug possession have also been seen.

No HIV cases have been registered in prisons. Information on hepatitis C is not known. According to official data at the end of 2005, 164 inmates (12.4%) are known to have history of drug use; out of them 25.6% (42 inmates) were less than 24 years old.

Females comprise 3.5% of prison population (n=46) at the end of 2005. Six (13%) have a history of drug use. Among female IDUs, 2 were underage and 3 used to work as sex workers.

RAR SUYP 2001 shows that lifetime prevalence of heroin use among inmates is 8.8% (for comparison, 6.4% in other young people). Lifetime prevalence of cocaine use among prisoners in Gjilan was 40% and in Lipjan 20% and is notably high, compared to other prisoners and other groups of young people in Kosovo.

According to prison authorities, there is no injecting drug use in prisons and in general drug dependent people do not use drugs in prisons. RAR SUYP 2001 experts did not assess drug use while in prison[10] and say that from key informants they "did not get an indication that illicit substance use takes place on a large scale in the prison population." During the mission in 2006, only prison administration provided information on this matter. While this is a valuable source,

[9] Detainee is a person who is arrested by police.
[10] Recent drug use in prisons was not assessed in RAR 2001 due to considerations about the confidentiality of the questionnaire outcomes and rigorous implications it may have for individual prisoners when they report recent substance use.

similarly as in other countries additional interviews with stakeholders (especially those who have confidence among released prisoners and former prisoners themselves) are needed.[11]

According to Kosovo Correctional Service, there are no data which would indicate MSM in the prison.

2.2.d. Sex workers and clients

National estimations of the female sex worker population vary from 1,500 to 3,000. No reports of male sex workers (heterosexual and MSM) were received.[12] Females involved in sex work are between 14-35 years old. There is no more specific and accurate demographical data. The main proportion of sex workers are thought to be women from other countries (Moldavians made above 50%; Romanians 22%; Ukrainians 13%; Kosovars up to 5% and the rest from other Eastern and South-eastern European countries, according to one survey *(source: US Department of State, 2005)*. Anecdotal data link increased sex work with the presence of UN staff and troops in the area.

Trafficking women for the purpose of sexual exploitation is an important issue. In the Balkans, Kosovo is a territory known for such trafficking. Internal trafficking of females for sexual exploitation is also increasing, according to experts.

The number of clients of female sex workers (SWs) is not known. However, a Population Services International (PSI) survey showed that in 2003 4% of sexually active men had relations with a SW within the last year (of those men 33% were married; 73% of them used condom during the last intercourse with SW). From the PSI KAP survey, it is seen that adolescent males are also using SW services (5.7% of surveyed 15-17 year Albanian males). According to testimonies of trafficked sex workers, 80-85% of clients are local Kosovars. No data are available on the number of male clients who are international staff.

Anecdotal stories from international SWs, who worked in Kosovo in 2003, show that the above testimonies should be viewed with some caution and that the organization of sex for internationals present in Kosovo differs considerably from overall sex work. Sex for internationals is usually sold in different bars by 'better girls' and does not involve trafficked girls (but some might be foreign girls). The women selling sex to internationals have better life conditions and charge more for sexual services.

No data are available on sex work-related behaviours, which could increase risk of HIV (e.g. sexual practices and condom use with paying and non-paying partners). However, there are a number of indirect indicators showing high risk behaviour, e.g. clients pay more for sexual intercourse without condom (additional 20 EUR fee).

2.2.e. MSM

Experts estimate around 3,000 gay and bisexual men to live in Kosovo. An interviewed service provider knows about 200-300 gay men. Their age varies between 18 and 60 years. However, young MSM of 18-24 years form the major part of the MSM population. According to anecdotal reports, at least 4-5 MSM are known to be using drugs in Kosovo. No information was received about sex work in MSM community. High-risk behaviours are present in the gay community in spite of relatively good awareness about HIV.

No HIV cases were reported among men who have sex with men.

[11] Importantly, one interviewee confirmed to know at least two cases of former inmates who are injecting drugs, which indicates that even if drugs are not used in prisons, they do not "cure" drug dependent people.

[12] However, male prostitution is possible. This is indirectly shown by PSI 2003 KAP survey: at least three non-Albanian and three Albanian young (18-25 years) women (4,7% in each ethnic group) indicated buying sex work services at least once in their lives and one in each group bought services within last year. Sex of sex workers involved and/or sexual preferences were not surveyed, however.

2.3. National Legal and Policy Framework on HIV, Drug Use and Harm Reduction

In terms of HIV and AIDS, the key specific document is the Kosovar Strategy on HIV/AIDS 2004-2008, which does not have the status of law but is adopted by three ministries. On December 1, 2003, three ministers signed a Declaration of Commitment on HIV/AIDS, a key document of political commitment and a tool for maintaining this commitment. Legislation on HIV prevention, treatment and care and human rights related issues was suggested in 2005, and specific actions are underway.

There is no specific document of strategy on drugs in Kosovo at any level.

2.3.a. Legal framework

The following laws are of high relevance:

- Kosovo Health Law,
- Provisional Criminal Code,
- UNMIK Regulation No. 2000/52 (on pharmaceutical products, including narcotic drugs),
- Law No.2003/26 on Medical Products and Medical Devices,
- Law No.02/L-17 on Social and Family Services.

In 2006 a number of other highly important documents are planned to be adopted: Strategy on Youth, Reproductive Health Plan and Law on Reproductive Health.

Kosovo Health Law (Law No.2004/ 4) outlines the healthcare system. Communicable diseases and reproductive health are high on the agenda of the Law's provisions. Article 22 indicates that early detection of communicable diseases and compulsory immunization should be provided and done free of charge. Health care and treatment should be provided through prevention and treatment of drug dependency and HIV infection among other means (Article 23). Children (up to 15 years of age), school and university students, as well as specified persons should be provided treatment at no cost.

According to the Law on Social and Family Services, people who have addiction to alcohol and/or drugs are defined as people in need, and who, regardless of their status and place of origin, should receive adequate social services (counselling by specialist at the Centres for Social Work).

2.3.b. Strategy on HIV/AIDS

The Kosovar Strategy on HIV/AIDS 2004-2008 is a programmatic document which outlines key priorities and guiding principles for this low HIV prevalence country. Among them:

- priority is prevention, especially among those most at-risk of HIV (and with their participation)
- provision of care, support and treatment, as well as combating stigma and respect of rights of people living with HIV are essential
- high leadership and active participation of NGOs and private sector in AIDS needed

Persons most at-risk of HIV are MSM, female sex workers and their clients, IDUs. Groups considered by vulnerable to HIV risk behaviour include male and female youth**, migrants and prisoners**. For each group a separate action plan is defined building on existing services and available information on needs and possibilities. Most of the strategies are aimed at improving understanding of population needs, increasing awareness on HIV, outreaching hard-to-reach populations, improving access to healthcare and reducing stigma.

For drug users and IDUs, three strategies are foreseen: (a) harm reduction; (b) access to services; (c) awareness and behaviour changing campaigns (BCC). Harm reduction strategies include promotion and development of harm reduction interventions: advocacy and preparations for such interventions as needle exchange (review of legal position of the needle exchange programme and best international practices), support for drop-in centres; promotion of condom use among drug users; developing substitution therapy (advocacy for political support, piloting substitution therapy in

Pristina and including family counselling). It does not indicate which medication(s) should be used for substitution treatment and leaves this issue to be decided professionals. It is important to note that substitution treatment is in line with the UN Drugs Conventions' framework, which is directly applied in Kosovo.[13]

Key coordinating bodies are:

- Kosovo AIDS Committee (KAC) - local multi-sectoral technical council on AIDS, which includes officials of Ministries, relevant governmental and NGOs[14]; it is coordinated by the Office for HIV/AIDS within the Ministry of Health
- United Nations Theme Group on HIV/AIDS in Kosovo, as coordination body of the UNAIDS cosponsors in Kosovo, since December 2000 (initiated by the WHO and strongly supported by the UNICEF and UNFPA offices in Kosovo)

A Country Coordinating Mechanism (CCM) has been formed. Kosovo has not been granted funding for HIV project from the Global Fund to fight AIDS, TB, and Malaria (GFATM) neither in round 4, nor in round 5. However, its project on TB to GFATM was successful in round 4. Information about the CCM activities is limited.

The GFATM project on TB has been frozen. According to interviewees, funds for project implementation could not be used due to failure of UNMIK offices to timely and effectively review the proposal before its submission; within the last half a year UNMIK, GFATM, Ministry of Finance and Ministry of Health have tried to resolve barriers related to UNMIK legal procedures. The process might influence Kosovo chances to raise support from GFATM for HIV issues.

KAC does not include high political officials and this was raised in one interview as an unused opportunity to build better knowledge and political commitment among high officials, especially in the Assembly (parliament), where 10% of parliamentarians have a medical background.

The development of the Kosovar Strategy on HIV/AIDS 2004-2008 was coordinated by the HIV office of the Ministry of Health and was co-financed by the United States Agency for International Development (USAID), the European Agency for Reconstruction (EAR), World Health Organization (WHO) and the Canadian International Development Agency (CIDA) through UNICEF. Key stakeholders participated in the inclusive process.

Funds for the Kosovar Strategy on HIV/AIDS 2004-2008 implementation were not fully allocated. The AIDS Programme does not have a separate budget line for implementation of the Kosovar Strategy on HIV/AIDS 2004-2008 National funds are covering antiretroviral (ARV) treatment and diagnostics, testing, awareness campaigns and HIV office.

International donors collaborate closely with the National AIDS Committee and provide support in line with the Kosovar Strategy on HIV/AIDS 2004-2008. External funding does not correspond to needs identified and actually is decreasing. Recent donors are UNICEF, USAID, partly UNFPA, and Partnerships in Health who implement a regional Balkan initiative with SIDA support.

In late January 2006, stakeholders started development of an Action Plan on AIDS and budget estimations.

[13] For more information on this issue, please see EMCDDA (2000). Reviewing legal aspects of substitution treatment at international level. Prepared by the EMCDDA at the request of the Pompidou Group Secretariat. European Legal Database on Drugs, available at http://eldd.emcdda.eu.int/index.cfm?fuseaction=public.AttachmentDownload&nNodeID=5743&slanguageISO=EN. Also UN International Narcotic Control Board (2005). Annual Report 2004. ISBN 92-1-148198-8. March 2005. Available http://www.incb.org/incb/en/annual_report_2004.html

[14] List of the body members was not received and membership information is provided based on information from the National HIV/AIDS Coordinator and UNAIDS focal point. NGO representatives confirmed participation in (at least some) meetings of the body, however did not provide clear information about their membership status.

2.3.c. National strategy on substance use

There is no national strategy document on substance use. An Inter-Ministerial Task Force on Substance Use was set up in 2001-2003, however it has not been functional for the last two years.

Many of the interviewed stakeholders emphasized the need for commitment and action to respond to increasing drug use and growing need for substance use services. A high political commitment of government is needed to respond to problem drug use.

At the same time, there are some developments. The HIV and AIDS strategy includes development of some specific services for IDUs, namely needle exchange and substitution treatment. However, no substitution treatment guidelines have been developed. Absence of substitution treatment regulations reflects overall absence of adopted guidelines on drug treatment (including for detoxification or abstinence treatment, rehabilitation or drug free treatment, medically assisted opioid antagonist treatment) in the territory.

Drug control is being strengthened. A special narcotics investigation section in the directorate for organized crime, which is situated within the Kosovo Police Service structure, deals with drug-related investigations *(European Commission, 2005)*.

2.4. Social Perceptions of HIV epidemic

Kosovars (the general public, youth and high school adolescents) do not think that they are risk of HIV. Different surveys conclude that young males and females in Kosovo have more knowledge about HIV transmission, but less information on prevention. Studies in 2001 and 2003 found that HIV positive persons are stigmatized.

According to the PSI survey on youth knowledge, attitude and practice (KAP) related to HIV/AIDS in 2003 (n=1.005), Kosovo has a high overall awareness of HIV (95% had heard of the disease compared with to 85% in 2001). However, their attitudes are stigmatizing and they are more likely to engage in HIV risk behaviour than the general population.

The main sources of information about HIV mentioned were TV (86%) radio (35%), friends/relatives (21%), schools (20%) and newspaper (19%). Few young people had heard about HIV from a health care provider (5%) or at work (6%) *(PSI, 2001)*. When youth were asked if they discussed HIV with anyone in the past six months, 56% said yes. Out of those that responded positively, friends were the most commonly reported person with whom they talked (80%), followed by their partner (31%) and family (28%).

Overall, the age of first sexual intercourse did not vary much between young men and women. Over 60% of the sexually active men and women had their first experience before the age of 19. The most common age for first sexual experience of both women and men was between 16 and 18 years of age (40%); while 12% of the youth surveyed had sexual relations by the age of 16. Preventing pregnancy was the most common reason for using condoms (83%); however, for those youth who had casual sex, condoms were more often used to reduce the risk of contracting HIV (90%) or STI (50%). USAID produced a high-profile media BCC and VCT campaign on HIV prevention that has reached over 100,000 young people and a considerable segment of the general population.

KAP study was also carried out among Kosovars living abroad, who, according to HIV statistics, are at high risk. For comparison, a control group of Kosovars in Kosovo was surveyed using the same methodology. All respondents (n=684, including 584 abroad and 100 living in Kosovo) were above 18 years old. The level of information on HIV and AIDS was quite low among respondents. 56% did not know what AIDS means, only 48% knew the correct way of transmission and 46% thought that a person with HIV looks different and only 32% were aware of anti-retroviral therapy. Thirty percent of Kosovars living abroad and in the territory reported a negative attitude toward PLHIV and the majority would not use the same toilet, food, and clothes; 68% thought that having sex with SWs, MSM and IDUs, even if using condoms, were at risk; 34% judged a person with HIV as "immoral", only half of the study population perceived themselves to be at risk of HIV.

III. National Responses to HIV and Injecting Drug Use

3.1. Targeted HIV Prevention Services

One of the greatest challenges is to advocate for a multidisciplinary approach to the epidemic, because HIV does not respect political or legal boundaries set up by governments to address public policy. More challenging is to advocate for HIV prevention in a low prevalence country, with poor financially and technical resources.

In a country with low HIV prevalence, but with populations engaging in HIV risk behaviours, the development and implementation of targeted HIV prevention services is the most cost effective response.

Research and international practices proved in time that the HIV prevention works.

In this report, we consider HIV prevention services to be the following:

- **BCC campaigns**
- **Condom distribution**
- **VCT**
- **STIs diagnosis and treatment, and other services for reproductive health**
- **Peer education and peer counselling**
- **Risk reduction counselling**
- **Needle/syringe exchange**
- **Overdose prevention**
- **Vaccination for hepatitis A and B**
- **Opioid substitution therapy and other drug dependence treatments.**

These services can be provided by outreach, or in drop-in centres, and they should target populations engaging in HIV risk behaviours, such as SW and their clients, IDUs and MSM.

HIV prevention services are successful if they adapt to characteristics and needs of the groups they target. Even if preventive messages are similar, and focus on reducing risks associated with unprotected sex and/or injecting drug use, the specific behaviours of the groups need to be understood in designing and implementing the interventions. That is why most of the good practices and experiences from different countries support the idea of direct involvement of affected people.

3.1.a. Young males and females

It is necessary to develop and implement different HIV prevention services, taking immediate actions to reduce harm from injecting drug use using non-sterile injecting equipment and unprotected sex. It also requires taking longer-term steps to educate young males and females about sexual risk, and improving access to the commodities needed to reduce risks. Disseminating information about how to avoid HIV and distributing condoms are essential components of HIV prevention. By themselves, such activities do not produce the kind of behavioural changes needed to stay uninfected. International experience indicates that young people need places to go where they can feel safe in discussing sexuality, peer pressure, and problems in negotiating safer sexual practices. Issues of poverty, violence, substance dependency, and sexual abuse must also be addressed to reduce young people's vulnerability to HIV.

In Kosovo, HIV prevention among young males and females has been mainly done through general awareness campaigns and peer education.

Several NGOs for youth established a coalition "Make Love, Not AIDS!" The activities are performed mainly during summer time and for December 1, the World AIDS Day. Other active youth NGOs in HIV prevention are Jazas (NGO working with Serbs) and Kosma (like Integra works with Albanians; PSI successor).

As a result of the various campaigns in 2002 and 2003, some knowledge among young people has increased considerably: as mentioned above, PSI survey mentions an increased number of young people who have heard of HIV from 86% in 2001 to 96% in 2003.

Currently, either information on HIV and AIDS, nor health education is part of school curricula. The Ministry of Culture, Youth and Sports and UNICEF are in the process of developing integrated modules on healthier life styles including education on HIV, STIs, healthy nutrition and drug use. After the module is ready, it is anticipated that these will be into the school curricular.

Notably, there are no specific interventions targeting most at-risk young people (such as, young IDUs, young MSM, young sex workers and their young clients) and reaching these groups remains a challenge in Kosovo. Also, little is known about whether some groups of young males and females, (such as those living in rural areas, or who are out-of-school, illiterate, using or experimenting with non-injecting drugs or alcohol, students, unemployed, and those working or studying away from home, especially abroad).

3.1.b. Drug users and injecting drug users

No specific HIV prevention programme targets drug users and/or IDUs has been developed and implemented in Kosovo, even if it is foreseen in the National HIV/AIDS Strategy.

The first attempt to target IDUs with specific HIV prevention information is through the VCT service in Pristina. Anonymous, free-of-charge pre- and post- HIV counselling and testing operates from March 2005 in NGO Labyrinth. VCT staff works under the supervision of HIV/AIDS Office in Pristina and according to VCT National Protocol. Within 10 months of operation, 208 people have used counselling and testing services (91% were identified as IDUs, other groups counselled and tested were MSM, SWs or trafficked women). Of the total number, 86.3% were males, 13.6% were females; 65.9% were from Pristina, and 34.1% come from other places of Kosovo. 64.25% of VCT clients were between 14 and 26 years old. The youngest client was 14 years old. For the clients that are under 18 years old, the parents need to sign a written formal consent. No HIV cases have been found by the end of December 2005.

More information about services targeting drug users is provided also below in the section *3.2. Harm Reduction Interventions and Services.*

3.1.c. Sex workers

Currently there are no targeted services for female sex workers and their clients.

In 2002-2003, the NGO UMCOR, with financial support from UNFPA, developed a one year project to increase bartenders and sex workers access to quality sexual health services. As some women are afforded limited freedom of movement, it was essential to include quality care such as STI testing and treatment, counselling and health education in a secure and private setting as a priority service. Ten private gynaecologists throughout Kosovo were selected to participate in the project. To promote these services, UMCOR printed fliers, posters and brochures in different languages that contain contact information for the private clinics and basic information on STI and HIV and safer sex practices. Over 500 SWs received free services, including STI treatment and condoms within one year. This programme ended in 2003 and there were no funds available to continue.

In 2005, on a voluntary basis, one VCT centre tried to reach out to SWs and pimps in order to make their service low-threshold and more accessible. Although the intervention lasted less than 6 months, it helped to increase the number of SWs tested for HIV 6-fold (from 3 in 2004 to 18 in 2005) but

overall SWs testing remains at a low level. Service providers indicated as key barriers for outreach for sex workers the language, the illegal status of sex work, high caution of pimps, and involvement of organized crime.

3.1.d. Men who have sex with men (MSM)

Early in 2003, a local NGO for gays and lesbians in Kosovo was started. This association was registered in October 2003 as the Centre for Social Group Development – CSGD with funding from a Dutch NGO. Several projects were implemented. The NGO ex Elysium and Sappho and CSGD have a website – www.gaykosova.org – that advocates for human rights of gays, provides information on sexual orientation, same gender relations, health issues as well as other information relevant for the gay community. In addition, the local NGO is hosting HIV prevention sessions with their members and has been participating in the development of the strategic plan for the MSM community.

PSI worked with this NGO on a Peer Ethnographic Research among MSM in Kosovo. Also a 'gay-friendly' doctor training for family medicine doctors in Kosovo was done.

From June 2005 to December 2005, CSDG implemented a project funded by the Partnerships in Health, with the main objectives to assess the HIV knowledge and HIV risk-associated practices among the gay community, and to promote HIV testing and counselling. IEC materials on HIV, based on the assessment findings, were developed and disseminated. A KAP survey among MSM was completed and the report, available electronically in English ,will be available soon.

3.1.e. Prisoners

Health services within the prison system are under the competence of the Department of Justice. Health care is available for prisoners and at the time of entry to a detention centre, a medical examination is performed. No routine counselling and voluntary testing for STIs, TB, HIV, HBV and HCV is done. Few medical staff members from the prison system have completed HIV VCT certificate program. Prisoners are referred (and transported) to VCT for HIV outside prison; Correctional Service representatives reported just one case, when VCT outside prison was used by an inmate.

Condoms are not available within prison and information on sexual practices of inmates and the need for sexual health care does not exist. However, condoms are being included in the "exit" package that is given to prisoners on release.

No peer education programmes for inmates is available in prisons.

While within recent years the number of prisoners that have been punished for drug-related crimes increased, no services for drug dependence are available in prison. The main barrier is related to lack of these services in the community, outside prison.

3.2. Harm Reduction Interventions and Services

Comprehensive HIV programming should aim to provide opportunities for all IDUs to access the whole range of services. Because of the hidden and often rapidly changing nature of drug injecting, reaching as many individuals, who regularly or occasionally inject, as possible, represents a challenge to services providers and decision makers.

In Kosovo, there is no package of harm reduction services as it is recommended by WHO, the European Union (EU), United Nations Office on Drugs and Crime (UNODC) and UNAIDS. Those few services for drug users that exist are mainly accessible in the capital city only. Kosovar AIDS strategy outlines specific objectives related to some harm reduction services and other targeted interventions for IDUs; however implementation is limited. In spite of increasing drug use, still there is no harm reduction system in general (as well as strategy or coordinating body, as stated above).

The few existing services are mainly abstinence oriented, and **no specific services for different sub groups,** like minors that abuse different substances, SWs who use drugs, experimenting IDUs, occasional drug users, or women who use drugs. No specific guidelines or monitoring and evaluation system is in place for drug dependence treatment.

Since there are anecdotal stories from Eastern Europe of using methods for drug dependency "treatment" which do not comply with good clinical practice, addressing this issue and defining some good practice guidelines (e.g. using guidelines from international professional organizations) is important. It would be an important step both for services not only for the community but also for prison system: prison system applies the same treatment strategies which are applied outside the prison system; on the other hand, prison officials emphasized their readiness to implement substitution treatment as soon as there is some progress in the community.

3.2.a. Needle exchange programmes

According to WHO/UNAIDS/UNODC Policy Brief on Provision of sterile injecting equipment to reduce HIV transmission, "the provision of access to sterile injecting equipment for IDUs and the encouragement of its use are essential components of HIV prevention programs, and should be seen as a part of overall comprehensive strategies to reduce the demand for illicit drugs."

There is no needle exchange programme in Kosovo. Thus used syringes are not collected.

Some pharmacies do not sell syringes, needles and/or other components for injecting equipment to IDUs. In an unstructured interview one former pharmacist confirmed that pharmacies might reject selling injecting equipment to IDUs, mainly due to prejudice and the image of IDUs as criminals (while he could not refer to any cases of criminal offence specifically committed by IDUs in Kosovo).

As pointed above, sharing and re-using of injecting equipment is common in Kosovo.
No counselling on risk reduction is performed, related with safer drug injecting, overdose, HIV or hepatitis.

3.2.b. Overdose prevention

Drug overdose is an issue in Kosovo according to services providers, but there are no official statistics.

Emergency ambulances are expected to provide aid in case of overdose, but due to its close cooperation with police (see more in section on Human Rights of HIV-Affected Groups), IDUs avoid using this service even in life threatening cases.

Naloxone, pure opioid antagonist, which is recommended in cases of acute opioid poisoning and overdose cases, is not available in pharmacies according to interviews.

Only several leaflets are available for overdose prevention. No specific training for emergency medical staff and/or drug users has been carried out.

3.2.c. Opioid substitution therapy

Substitution or maintenance therapy is a long term approach used to reduce opiate use. Substitution seeks to reduce or eliminate opioid use by stabilizing those with dependencies for as long as is necessary to help them avoid previous patterns of drug use and associated harms, including the sharing of injecting equipment.

There is no substitution program available in Kosovo.

Conflicting information is received from reports and from interviews about the legality of methadone and of substitution treatment. In fact, methadone is available in pharmacies (three known

pharmacies in Kosovo) and could be prescribed by psychiatrists under special prescriptions. Buprenorphine seems to be unregistered and not available.

In addition, the lack of a clear Ministry of Health position on substitution treatment, needs to be addressed. The lack of knowledge related to substitution therapy, and the lack of funds remain the main barriers in developing the substitution therapy.

3.2.d. Other harm reduction services

Voluntarily counselling and testing (VCT)
4 VCT centres operate in Kosovo, and 2 of them are in Pristina. One operating from March 2005 is specifically targeting IDUs (see more at *3.1.b. Drug users and injecting drug users*).

The VCT centres were piloted with international funds (mainly from USAID and SIDA). From 2006, the tests started to be financed from the national budget (the staff working in VCT facilities is either paid from other sources or working on volunteer basis). The HIV tests are rapid tests, and are bought now from the Ministry of Health budget. The staff who work in these centres are separate from other medical services, because at this time there is no job profile for the people working in VCT centres.

Hepatitis diagnosis and vaccination for Hepatitis A, B and C
There is no available national programme that targets IDUs. Even if the data from Labyrinth and from the interviews with specialists show that Hepatitis B and C is an issue in drug using population, no treatment is available in the territory.

Harm reduction services in prisons
Evidence shows the need to address other behaviours (related with sexual activity, sexual violence, using un-sterilised injecting equipment and other sharp objects used for tattoos) in prisons.

There is no HIV prevention and drug treatment in prisons. According to reports, there is no also training on drug overdose and linkage to existing services outside prisons for released inmates.

Drug treatment services in Kosovo
Treatment services for drug dependence are very limited both in terms of coverage and quality. The services are performed through the public sector and through private and NGOs sectors.

There is only detoxification. Three types are found: acupuncture, outpatient detoxification based on infusions of neuroleptic and vitamin cocktails, and short-term outpatient methadone detoxification and opioid antagonist treatment. There is no substitution treatment and rehabilitation. According to a previous report, drug services are available in two towns only (Pristina and Gjilan) *(Brisson et al., 2004)*.

According to interviewees, some individual psychiatrists make some interventions for drug dependent people usually in their private practice. Also some drug users are going to other countries for drug treatment (e.g. Russia). Two major drug treatment providers are Psychiatric Clinic at the Institute of Public Health and NGO Labyrinth (both in Kosovo).

In general, in Kosovo drug treatment is part of psychiatry field and anecdotal reports show that psychiatric patients and drug dependent patients might be in the same inpatient unit.

In Pristina based on the interviews with Labyrinth staff the Psychiatric Clinic provides inpatient detoxification through acupuncture, using some technology imported from the US (however more information is not available).

NGO Labyrinth provides a 9-month treatment programme, which is initiated based on drug user motivation assessment and is implemented with high involvement of the drug user family (e.g. written consent of family member regarding treatment, family counselling, dispensing medications

through family member). If there is no family support and/or user's motivation to get treatment is low, the programme is not initiated. Also if there is evidence of drug use during treatment (through drug testing, which is part of drug treatment process), the programme is interrupted. The programme is divided into two major phases:

1. Outpatient detoxification

It lasts for 2 weeks. Two different methods of detoxification are used:

- detoxification based on infusions with different substances (vitamins, narcoleptics etc) – the users receive daily this infusion for one hour, usually in the evening when cravings and withdrawal symptoms becoming stronger .
- detoxification with methadone – short-term gradual dosage reduction within 10 days; in average 20 ml (up to 40 ml) are prescribed for the whole detoxification process (an average on 2 ml/day). Detoxification with methadone is used for patients with a long drug use history and high heroin dosage. Usually they are above 22 years old.

2. Maintenance

The main services focus on psychological counselling and therapy (individual and group). Some of the patients receive opioid antagonist naltrexone (dosage: 1 pill of 50 mg Revia per day for month 1; 0.5 pill per day for month 2-7; no medication on the month 8). During the first three months of this period the drug test is done every week and the rest of the period is done every second week). This phase lasts 8.5 months.

The same type of treatment is given to adolescents. Written consent is needed from one of the parents.

Since 2002, 537 clients have enrolled in the treatment. 123 have entered the treatment and 17 have finished successfully the nine-month treatment. No follow up services are performed. Treatment is paid by the patient (or his/her family); overall cost of treatment course is 1,000-1,200 EUR.

3.3. HIV Treatment, Care and Support Services

From 2005, antiretroviral therapy (ART) is available. At the beginning, one patient was covering therapy costs. Now the programme is fully funded from the national budget. At the beginning of 2006, 5 people were on therapy, and two other patients were monitored and will start the therapy in 2006. All the people that are diagnosed with HIV infection or AIDS and are in contact with the treatment clinic receive ARV treatment.

There are no national HIV treatment, care and support guidelines. According to one doctor, treatment guidelines by European AIDS Clinical Society (EACS) are used. Treatment is regarded as being successful and no side affects and/or non-compliance with treatment are reported.

Triple combination ART price is very high (20,000 EUR per patient per year). All interviewed individuals suggested that procurement, which is organized by the Ministry of Health, should be improved and the price should be lowered. Only brand medications are used; generic medications, even those pre-qualified by WHO, are not used due to concerns regarding their quality.

Since 1986, the clinical management of cases has been performed by the Infectious Diseases Clinic at the University Clinical Centre of Kosovo, where prophylaxis and treatment of opportunistic infections (OI) is done. Dr. Ilir Q. Tolaj (MD, PhD ID Specialist, Head of the HIV Department from the Infectious Disease Clinic) is the person in charge for the HIV ward at Infectious Disease clinic of University Clinical Centre of Kosova. There are other doctors trained for HIV treatment and care for OI at this Clinic.

All information and treatment counselling is done by Dr. Tolaj. No self help groups and/or other form of psychological support exist, mainly due to high level of stigmatization and the fact that the number of HIV positive people is very small (only 7 people alive). There is no organization of PLHIV

yet but there is preparedness from various stakeholders to support the process of development if there was initiative from the affected community.

During the mission, none of treated or monitored HIV patients was a child (under 18) and/or with drug use history. 3 of 5 people on ART are above 50 years old.

3.4. Services Provision and Coverage

Due to the lack of specific information and estimation of persons most likely to be exposed to HIV, it is difficult to assess service coverage. At the same time, most of key HIV prevention services for persons most at-risk of HIV are missing.

Most interventions that exist or/and existed in the past are characterized with discontinuing funds, which badly affect service use, access, trust of clients and coverage. Lack of sustainability badly affects the HIV prevention services for the group of most at risk adolescents (MARA), who in general don't have access to different services, are highly stigmatized in institutions and in society and do not have funds to access paid services.

Table 5: HIV services and activities – availability and funding

No	HIV Services and activities		Availability	Funds
1	**HIV Prevention services**	BCC campaigns	Partly available	International funds
		Condom distribution	Yes	UNFPA (condoms only)
		Youth friendly services		
		STIs diagnosis and treatment for persons most likely to be exposed to HIV (MSM, sex workers, others)	No specific programme	-
		Needle exchange (outreach or drop in)	No	-
		Overdose prevention services	No	-
		Services for FSWs	No	-
		Services for MSM	Partly (only educational activities) in 2005	Partnership in Health by end 2005
		HIV prevention services in prisons	No	-
		Services for other vulnerable groups (SW clients, Roma etc)	No	-
		VCT center	Yes (started in 2005)	National funds
		Hepatitis A and B vaccination	Only for general public, no targeted interventions	National funds and WHO
2	**Drug dependences treatment**	Substitution therapy - methadone - buprenorphine	No	-
		Detoxification with methadone	Yes, as part of long-term treatment program	Patients
		Detoxification centers	2 centers (1 in Psychiatric Clinic; 1 at Labyrinth)	National funds and patients
		Therapeutically communities, after care, reintegration services	No	-
		Drug dependence treatment in prisons	No	-
3	**HIV/Hepatitis B and C treatment and care**	Accessibility to Highly Active ART	Yes; started in 2005	National funds
		Accessibility to Hepatitis B and/or C treatment	No	-

IV. Human Rights, Stigma, Discrimination and Legal Status of HIV-Affected Groups

Major international conventions on human rights were promulgated and are applied in the territory. Kosovo adopted also the Convention on all forms of Discrimination Against Women (CEDAW), Anti-discrimination Law (Law No. 2004/03) and Law on Gender Equality (Law No. 2004/02). The Constitution, laws and promulgated international conventions include rights to confidentiality, quality treatment, right to privacy and body integrity, right to health among others. Some laws might lack clear provisions for implementation, however this is primary related to the slow legislation process.

Implementation of human rights norms is challenging. On one hand, there is a clear lack of funding and service development. On the other side, stigma and discrimination of particular groups is prevailing. This is also reflected in the National HIV/AIDS Strategy document.

Among experts, there was consensus of high stigma and discrimination of such groups as people living with HIV, MSM, IDUs and SWs. There are a number of generalities in this stigma, as it is very much related to status in society and family, as well as to barriers of access health care.

According to interviewed experts, no legal provisions foresee liability for HIV transmission and there are no travel restrictions for HIV-positive people (no HIV status is required for arriving to country and/or getting residence permission). Stigma and discrimination of **people living with HIV** seem to be widespread in society and among health care professionals. Infectious disease clinic reports about attempts of other medical facilities to avoid treating PLHIV. More in-depth information on this issue was not collected.

Homosexuality is not prosecuted via legal framework anymore and homosexual intercourse is not punished. **MSM** remain a closed group; at least some part of the population lives in heterosexual marriage and tries to hide their sexual preferences. Fear of violence is common as well as fear of loosing an employment when identified as gay. Use of sexual health services is limited, especially because of lack of confidentiality, MSM fear recognition by health professionals and therefore avoid visiting them. It should be noted that the society is patriarchal and Muslim, although religion is not strongly integrated into social life. According to one newspaper, in early January 2006, there was a street conflict in which some people suspected that a man might be homosexual and beat him.

Prostitution, which is defined as "offering or providing sexual services in exchange for payment, goods or services", is illegal. Punishment for facilitating prostitution starts from fines and might reach up to 13 years of imprisonment if committed against minor (under 16 years old) (Article 201). In case of forced prostitution, this is regarded as exploitation and is related to trafficking, which is harshly punished in Kosovo. **Female sex workers** avoid public institutions. Available reports of surveys among SWs indicate that their isolation is deepened by prosecution of prostitution and high accuracy of precautions of pimps. Some SWs have been trafficked, however and only 5% of surveyed SWs knew that activities that they were getting involved in would probably be prostitution.

Usually key sources of sex workers' rights violations are police, pimps, clients and media in Central and Eastern Europe and Central Asia, including neighbouring TFYR of Macedonia, Bulgaria and other countries. However, no information was collected on this issue in Kosovo.

Drug use is not a criminal offence. However, drug purchase and possession with intent to sell implies fine and imprisonment for 1-5 years. Punishment reaches up to 15 years of imprisonment in case of organized crime and other aggravating circumstances (Article 229).

Punishment for cultivation, production, procession, extracting and preparations of drugs is fine and imprisonment for 1-10 years (Article 230).

The Criminal Code foresees "mandatory rehabilitation treatment of perpetrators addicted to drugs or alcohol." Such restriction of human rights could be done "to the extent that is commensurate with the nature or the content of the sanction or measure and only in a manner that provides for the respect of the human dignity of the individual, and is in compliance with international law." The court might rule mandatory rehabilitation only if crime is related to addiction. According to interviewees, however, no rehabilitation for problem drug users exists in Kosovo.

Drug users are officially not punished for dependency (considered as a chronic disease) and for possession without intent to sell, yet anecdotal reports indicate that lack of clarity in the Criminal Code might leave space for interpretation, which could be used against this chronic disease (drug addiction/dependency).

Drug users are seen as aggressive people; this perception is prevailing in media. Families feel stigma to talk openly about "family disease." On the other hand anecdotal stories confirm that family tries to take care of its family members (Diaspora).

According to service providers, a common practice of drug overdose is to inform the police. This reduces drug users' attempts to seek help in public medical system in case of overdoses and other emergencies and overall increase mistrust towards medical professionals.

An unsolved issue in terms of sustainable treatment is linkages between services in the community and in **prison** settings. For example, treatment for hepatitis C is not available in prisons; however Correctional Service would provide such treatment if there was a need but they cannot guarantee sustainability and continuation of treatment if the person should be released from prison system.

In general, some treatments and prevention means are absent (e.g. access to sterile needles, qualitative peer counselling; there is no hepatitis B and C treatment in the territory and it is not covered by the state. There is, however, a possibility to apply to the Ministry of Health for treatment abroad.

V. Conclusions and Recommendations

Kosovo is undergoing major social changes and therefore has a number of urgent priorities in improving the economy and social services and stability in the territory.

Its three national ministers announced combating HIV as a priority and adopted a strategy on HIV/AIDS. The strategy is built on aim to remain a low HIV prevalence territory and address high risks among those most likely to be exposed to HIV, including youth, sex workers and their clients, drug users and IDUs, MSM, and mobile populations. International and increasingly national funds help to set up HIV awareness campaigns and some services for those most likely to be exposed to HIV, notably to youth. Major stakeholders, including governmental officials, services providers and NGOs, are involved in planning further developments of Kosovar Strategy on HIV/AIDS 2004-2008.

There has been an inadequate government response to increasing drug use. There is no national strategy on drugs or coordinating body to ensure close collaboration of law enforcement, healthcare, social care, education, prisons, and NGOs. Even in the Ministry of Health there is no one coordinating drug dependency issues. Drug treatment is underdeveloped and is limited to two or three facilities and is mainly driven on individual initiative. Lack of leadership, advocacy, knowledge about drug treatment and international and national funds were identified as major reasons for limited response to drug use. No low cost evidence-based treatment programmes such as substitution treatment are available in Kosovo.

HIV preventive services for IDUs, SWs and their clients, MSM and prisoners are either absent or limited to four VCT centres that serve the general public and provide information materials. The level of HIV testing is low among persons most at-risk of HIV. However, HIV treatment seems to be provided to all in need and is given high priority, in spite of its high cost for state budget.

One argument that is used to explain limited services is the absence of good data on at-risk behaviours and the prevalence of infections (HIV and STIs9. For this purpose, a biological and behavioural study will be done among IDUs, SWs and MSM by June 2006.

Nevertheless, there is a clear evidence and need to further develop services for those most at risk of HIV to reduce their risk behaviour. These services should be based on cost-effectiveness, evidence and close collaboration, as funds are extremely limited.

Interviews with stakeholders did not answer the question on what possible strategies are foreseen after the biological and behavioural research is done. There is no international funding available for follow-up and development of services (with exception of possible but not confirmed funds from SIDA through Partnerships in Health; some funding for HIV testing might be available through the GFATM grant on TB); thus national funds should be secured to address the issue. Taking into account that the health care budget reduced by 20% in 2006, ensuring funding from the national budget might be challenging, especially in case of low HIV prevalence, despite evidence of HIV risk behaviours.

Another challenge to get national funding is the overall low appreciation of NGOs in Kosovo and absence of culture to buy services from NGOs.[15] At the moment, NGOs are the most important service providers for the most at-risk groups.

However, NGO activities very much depend on sustainability of funds. Previously many HIV services, which during the mission were identified as unsustainable ones, were funded through

[15] It should be noted as well, that at least some leaders of NGOs are also working in governmental institutions. Phenomenon of having two jobs is common in Kosovo due to low payments. Having two positions on one hand gives better outreach of decision makers and sustainability of income. On the other, it leads to conflict of interests and unavailability to focus on development, e.g., non-governmental organization's services.

short-term project oriented financing. Short term projects create discontinuities in services, and do not respond to the targeted population needs.

No NGOs are working based on a clear agenda and advocacy strategy, and most of them have priorities related to the donor priority.

Development of harm reduction services is limited to VCT only. Such services as outreach among IDUs, syringe provision and collection of dirty needles, substitution treatment and peer education does not exist. Harm reduction services are listed in the National HIV/AIDS Strategy. A substantial review of the need for services, their economical cost effectiveness and evidence in reducing negative health and social consequences at an individual level and in society at large has not taken place. Investment in building knowledge of good practice in healthcare, drug treatment, prison healthcare and NGO decision-makers and service providers from neighbouring countries is needed.

Other important negative factor is decreasing service availability, accessibility and coverage of at-risk groups is lack of policies, norms and regulations of specific effective prevention interventions.

Together with developing services, addressing stigma and discrimination is needed. While Kosovo society becomes more open (e.g. distribution of condoms is seen a normal practice), high stigma and discriminative views of MSM, SWs, PLHIV and IDUs prevail. For MARA boys and girls, access to services generally requires the written consent of the parents, and the characteristics related with age, and risk behaviours make MARA a hard-to-reach population. In addition, legal prosecution related to drugs, sex work, and social discrimination of these groups increase the vulnerability of young-at-risk populations.

The implementation of human rights requires rebalancing of social priorities, away from intolerance and law enforcement approaches that exclude IDUs, SWs, ethnic communities and MSM from the social mainstream. For this purpose, a specific awareness and stigma reduction campaigns and trainings (for general public, as well as for specific professions among which stigma and discrimination was reported, including health care, police, prisons, pharmacies, media), as well as empowerment of people most at risk of HIV is needed.

The vast majority of conclusions and recommendations relate to the drug field, which were written back in 2001 after RAR SUYP, remain the same *(De Jong et al., 2001)*.

Recommendations for:

Policy makers

- Initiate and accelerate penal and judicial reform to address factors increasing HIV risk behaviour in marginalized populations, as well as introducing and sustaining efficient and cost-effective programs
- Together with different stakeholders in the field, develop and implement a multi-sectoral and comprehensive drug strategy and action plan with funding
- Keep HIV/AIDS high in the health and social agenda, including other infections and drug dependency in order to minimize the social and economic costs

Governmental institutions and healthcare system decision makers

- Develop drug treatment system, which could be supported by training potential drug treatment teams and building connections with reliable treatment providers in other countries (especially in case of services which are not available in Kosovo)
- Broadly introducing and funding sustainable harm reduction approaches (including in prisons)
- Improve data collection and surveillance and disaggregate data by age, sex, diversity and risk behaviour

- Develop and sustain other services for at risk populations (including but not limited to outreach, STI treatment and peer education for SWs and MSM)

NGOs and services providers

- Developing Advocacy strategies aimed at development of drug treatment system, harm reduction services and other HIV prevention services among marginalized groups
- Actively participating in design, implementation and evaluation process of the HIV prevention and treatment services
- Develop pilot service programs among marginalized groups with effective and meaningful involvement of persons most likely to be exposed to HIV.

Donors, bilateral and multilateral agencies and international organizations

- Help to advocate for the need of national drug strategy and drug services, including harm reduction
- Build local capacities to introduce effective policies and strategies (including policy-makers, governmental institutions, NGOs and service providers)
- Assist in addressing gaps in targeted preventive strategies among most at risk groups that are not addressed by the state

Researchers

- Research links between policies and practices related to persons most at risk of HIV
- Assist NGOs and other service providers to build accurate and inexpensive monitoring and evaluation of programmes (effectiveness, economic benefits)
- Develop a comprehensive epidemiological system
- Closely work with NGOs and community based services, in order to obtain accurate information related to HIV risk behaviours and practices

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VII. Appendices

Appendix 1: Terms of Reference of the Country Mission in Kosovo

Background:

In June 2005, a new regional initiative ***The Human Rights and Treatment Collaborative Networking on Drug Use and HIV/AIDS in South-Eastern Europe*** (SEE Collaborative Network) was launched in order to develop and implement a regional strategy to improve the health and rights of at risk populations in relation to drug use and HIV/AIDS in this region. The SEE Collaborative Networking is built upon important work initiated by various networks and key players in the region, linking together related programs and projects. It focuses on filling the existing gaps and synergies and on maximizing organizational strengths. The network includes stakeholders (organizations, national networks, and individuals) from nine countries (Albania, Bosnia and Herzegovina, Bulgaria, Croatia, FRY of Macedonia, Kosovo, Romania, Serbia and Montenegro, Slovenia) who share common interests and values related to building relationships, sharing knowledge and learning.

The SEE Collaborative Network will contribute to solving specific problems related to the health and rights of at risk population in SEE and will achieve individual and collective results at the regional level through sharing information and best practices, establishing different task forces and committees and developing cross-country projects.

The goal of the project **"Support Network for HIV Prevention among IDUs in SEE"** developed with financial and technical support from UNICEF Romania is to increase the capacity building of Romanian Harm Reduction Network to offer support for other national harm reduction coalitions in order to strengthen the regional response for maintaining a long term, viable HIV prevention, treatment and care services. This goal will be achieved through sharing experiences, lessons learned and best practices at the regional level, through identifying and documenting the needs related with HIV and drug use and through promoting the HIV prevention and specific treatment services for most at risk adolescents (MARA) priorities in the Balkans.

As part of this project, in January 10-14, 2006, one country mission will be performed in Kosovo. Reasons for choosing Kosovo:

- few data about IDUs and HIV,
- the estimates of HIV prevalence in Kosovo have lacked accuracy,
- huge quantities of narcotics pass through Kosovo on their way to European and North American markets,
- drug use among the youth is rapidly increasing (UNAIDS/WHO, 2004).

Objectives:

The main objectives of the country mission are:

- to collect data about most at-risk adolescents (MARA)
- to map the existent services for MARA, with focus on drug used and IDUs
- to assess the availability of international and national funds for HIV services
- to elaborate a general overview of the situation and the needs of at risk populations from Kosovo.

Key tasks:

- Prepare and facilitate a plenary meeting with main local counterparts is planned to happen during the first day of each country mission. At the meeting will participate representatives of governmental institutions, nongovernmental organizations and international agencies from Kosovo. The meeting will be organized with local support

from NGO "Labyrinth" (member of SEE Collaborative Network) and UNICEF Country Office in Kosovo.

- Prepare and conduct meetings on the field with stakeholders, representatives of NGOs and beneficiaries (IDUs) in order to collect accurate and relevant data about HIV/AIDS and harm reduction services in Kosovo.
- The information collected will consist of demographic and behavioural data about MARA (IDUs), number and type of YFHS in place at the community level, the coverage of MARA, the response of YFHS to MARA's specific needs (according to their age and gender), number and types of HIV prevention interventions for MARA etc. All this data will create the baseline for the development of the national evidence-based interventions (including advocacy).
- Prepare and deliver the report of country mission in Kosovo. The report will include the results of the mission, as well as recommendations for national/local advocacy strategies (see the template for the report).

Deliverables:

- Agenda for the country mission;
- Materials to be used during the country mission;
- Resource materials collected during the country missions (e.g. national reports, national statistics etc – list of resource materials and copies, if possible)
- Final report of the country mission

Appendix 2: Agenda of Kosovo mission

Day 1 – Wednesday, January 11, 2006

Time	Name/organization	Place/contact person
10.00-12.00	Plenary meeting with different stakeholders	UNICEF office: Contact person Dren Rexha
12.00-12.45	NGO ABC123 (working with drug users in Prizren)	Eroll Shporta
13.00-14.30	Lunch with UNICEF	Dren Rexha
15.00-16.00	UNFPA (45 minutes)	Rachel Hand, Visare Nimani
16.30-17.30	Partnerships in Health	Irid Bicaku

Day 2 – Thursday, January 12, 2006

Time	Name/organization	Place
9.00-11.00	Ministry of Health, UN Theme group (UNAIDS Focal Point); VCCT Coordinator	Institute of Public Health: Edona Deva, HIV/AIDS Officer – Ministry of Health Xhevat Jakupi, UN TG National Advisor / UNAIDS Focal Point Laura Berzati
12.00-12.30	CSGD (NGO working with MSM)	Arber Nuhiu
11.00-12.00	WHO Liaison Office	Dr. Skender Syla
12.15-13.00	WHO expert on mental health (works at University of Kosovo)	Aliriza Arenliu
15.00-16.00	USAID	Dr. Urim Ahmeti

Day 3 – Friday, January 13, 2006

Time	Name/organization	Place / contact person
10.00-11.00	Infectious Disease Clinic	Ilir Tolaj, doctor for infections disease
11.00-12.00	Prison Health Authority (UN and National)	Anibale Petrone Milazim Gjoci

Day 4 – Saturday, January 14, 2006

Time	Name/organization	Contact person
10.00-11.00	INTEGRA (NGO working with HIV/AIDS awareness among young people)	Kushtrim Koliqi
11.00-12.00	ANTIDANS (NGO working with VCCT)	Izet Sadiku
13.30-17.30	Labyrinth	Safet Blakaj

Appendix 3: Contact list for Kosovo mission

Name, position	Organization, position	Contacts	Email
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Appendix 4: Major International Stakeholders

UNICEF – remains the biggest supporter of activities in AIDS field. Focuses on supporting activities targeting youth and youth at risk, as well as advocacy and building commitment for HIV/AIDS.

UNAIDS – supported three projects during 2004-2006. Youth campaign in Kosovo in December 2004 (implemented by the Kosovo Youth Council and NGO Integra), prevention of HIV infection among SW and IDU, support in establishment of the M&E system of the AIDS program in Kosovo and care coordinator services for the PLWHA.

USAID – Currently funds a research on biological and behaviour indicators among injecting drug users, sex workers and MSM in Kosovo towns. Results of this research will be used for planning next steps together with other stakeholders and further advocacy. Earlier they supported condom marketing campaigns and KAP research.

UNFPA – In the past, they were supporting targeted interventions among sex workers. UNFPA provides condoms free of charge. However, in the future they do not plan to allocate substantial resources for HIV and will focus on reproductive and sexual health.

WHO – AIDS issues are not as high in the agenda as earlier but their commitment remains high -- they are leading the UN Theme Group on HIV/AIDS in 2005.

Partnership in Health – in 2005, was one of main funding channels for preventive services for most at-risk populations. They expect to have opportunity to support services also in 2006 and maybe beyond.

Other international stakeholders, including Swiss Red Cross and local branch of the International Red Cross Committee are not currently active in the field. Medicines de Monde used to work in the country (they made testing on TB and still their representative name is indicated in the list of CCM at the GFATM website) but according to experts they reduced their activities.

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Project developed and implemented
with financial support from UNICEF Regional Office in Geneva
and technical support from UNICEF Country Office in Romania

Printed in 500 copies with financial support from UNICEF

ISBN: 973-8411-54-8