

UNGASS COUNTRY PROGRESS REPORT

SLOVENIA

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II. Status at a glance

II. (a) Report writing process

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II. (b) Status of the epidemic

Slovenia is a low-level HIV epidemic country. Less than one individual per 1000 inhabitants is living with HIV infection.

Men who have sex with men (MSM) have been most affected, but the proportion of infected has stabilized at a level of a few percent, and has consistently remained below five percent.

There is as yet no evidence of a substantial HIV infection burden among injecting drug users (IDU) and their sexual partners or any other population group at higher behavioral risk.

During the 2006 the annual reported incidence rate of newly diagnosed HIV infection cases has been 16.4 per million population, 15% lower than the reported rate in 2005.

In 2006, MSM represented 76% of newly diagnosed HIV infection cases in comparison to 82% in 2005.

A cumulative total of 13 cases of HIV infection among IDU were reported during the period from 1986 to 2006, the last one in 2001.

A cumulative total of five cases of mother-to child transmission of HIV infection were reported during the period from 1986 to 2006, the last one in 2004.

In 2006, HIV diagnosis was established very late, within three months preceding AIDS diagnosis, in 9.1% of all new diagnoses. The proportion of very late diagnoses has been decreasing recently. The diagnostic HIV testing rates have been increasing slowly to 1.3 tests per 100 population in 2006.

In 2006, five AIDS cases were diagnosed (2.5 per million population), of which one presented with pulmonary tuberculosis.

No AIDS deaths were reported in 2006.

II. (c) The policy and programmatic response

The Slovenian Ministry of Health has been leading an early and effective response together with other governmental sectors and non-governmental organizations (NGOs). Some milestones were:

- 1985
 - Working Group on AIDS was established at the Institute of Public Health
 - HIV reference laboratory was established
 - MSM NGO implemented their first AIDS campaign
- 1986
 - Red Cross and the Association of the Socialistic Youth of Slovenia implemented their first national AIDS campaign
 - blood safety was ensured (mandatory testing of all donated blood)
 - voluntary confidential HIV testing and counseling national site was established
 - health care for the first cases of HIV infection was provided
 - HIV surveillance was established
- 1987
 - anonymous HIV testing and counseling was provided
 - Guidelines for the prevention of HIV transmission in prisons were prepared
 - HIV/AIDS guidelines for health care workers were prepared and distributed
- 1988
 - the Institute of Public Health coordinated its first national AIDS campaign
- 1989
 - antiretroviral therapy was introduced
- 1990
 - first Slovenian HIV/AIDS strategy document was drafted
 - HIV prevention was introduced in prisons by the Ministry of Justice
 - methadone substitution for injecting drug users (IDU) was introduced at two sites
- 1992
 - STIGMA, an NGO for IDU started the first needle exchange programme
- 1993
 - the Ministry for Labor Family and Social Affairs started supporting programmes for the prevention of drug use and harm reduction programmes for IDU
- 1995
 - the Ministry of Health established a national network of Centers for Prevention and Treatment of Illicit Drug Use, also providing methadone substitution for IDU
 - NGO AIDS Foundation Robert started with prevention and harm reduction interventions for IDU and care and support for HIV infected
 - the national strategy for HIV prevention and care has been adopted at the multi-sector national consensus conference
- 1996
 - Highly Active Anti-Retroviral Therapy was introduced
- 1997
 - youth HIV/AIDS peer education project VIRUS run by medical students started
 - Guidelines for management of IDU in prisons were prepared
- 1998
 - psychosocial emergency hot-line integrated HIV/AIDS counseling

The national strategy for HIV prevention and care has not been revised since 1995, but is mostly still relevant. The three broadly defined objectives are:

- to prevent the spread of HIV infection,
- to reduce the personal and social impact of HIV infection and AIDS, and
- to mobilize and unify the national efforts for prevention and control.

Prevention, treatment and care have been mainstreamed into different governmental sectors' activities. Since mid-eighties, information, education and communication activities have aimed at reducing risk-taking behavior and encouraging responsible sexual behavior among youth and the general population. In addition, NGOs have been implementing preventive and harm reduction interventions targeted to groups at highest behavioral risk, for example MSM and IDU.

Everyone has access to client-initiated voluntary confidential and also anonymous counseling and testing, effective treatment for sexually transmitted diseases, and universal access to high quality clinical treatment and care for HIV infection, including highly active anti-retroviral therapy.

II. (d) UNGASS indicator data overview

In view of our low level HIV epidemic and limited resources, adequate personnel and financial resources have not been allocated for the development of a comprehensive monitoring system to evaluate HIV/AIDS prevention, treatment, and care programme. Thus, existing data sources do not provide data for most UNGASS indicators to monitor the Declaration of Commitment to HIV/AIDS.

HIV surveillance is based on:

- universal case reporting of HIV infection, AIDS and AIDS deaths,
- monitoring HIV infection prevalence in selected easily accessible groups at different behavioral risk (IDU, MSM, patients with sexually transmitted infections (STI) tested for syphilis, and pregnant women screened for syphilis) with unlinked anonymous testing, and
- behavioral surveillance in two groups at higher behavioral risk (MSM and IDU).

Additional data are available to inform policies and strategies. For example:

- national HIV and sexually transmitted infections related behavioral survey "Sexual Lifestyles Attitudes and Health" was conducted in a probability sample of the general population in 2000,
- "Health Behavior in School-Aged Children" (HBSC), World Health Organization Cross-National Study has been conducted in 2002 and 2006.

UNGASS indicator data overview:

Government HIV and AIDS Policies

1. AIDS spending

Data not available.

2. Government HIV and AIDS Policies (NCPI-National Composite Policy Index)

Provided.

INDICATORS

NATIONAL PROGRAMME INDICATORS

3. Blood safety

Data provided: 100%.

4. HIV Treatment: Antiretroviral Therapy

Data provided for 2006: 94%.

5. Prevention of Mother-to-Child Transmission

Not relevant.

Since 1986 to 2007, a cumulative total of five cases of HIV infections were diagnosed among children that resulted from mother to child transmission, the last case in 2004. Our results from the national unlinked anonymous monitoring of HIV prevalence change among pregnant women indicate very low prevalence of HIV¹. By 2007, HIV screening of pregnant women has not been introduced.

6. Co-management of Tuberculosis and HIV treatment
Data provided for 2006: 0%.
Since number of incident cases in people living with HIV was 0 AND nobody receiving antiretroviral therapy was started on TB treatment.
7. HIV testing in the General Population
Not relevant.
Slovenia has a low level HIV epidemic. By the end of 2007, less than one HIV infected person lived per 1000 population.
8. HIV testing in Most-at-risk Populations – Sex workers
Data not available.
8. HIV testing in Most-at-risk Populations – Men who have sex with Men
Data not available.
8. HIV testing in Most-at-risk Populations – Injecting drug users
Data not available.
9. Most-at-risk Populations: prevention Programmes – Sex Workers
Data not available.
9. Most-at-risk Populations: prevention Programmes – Men Who have Sex with Men
Data not available.
9. Most-at-risk Populations: prevention Programmes – Injecting Drug Users
Data not available.
10. Support for Children Affected by HIV and AIDS
Not relevant.
Not a single orphan with HIV infection has been known to have lived in Slovenia by the end of 2007.
11. Life Skills-based HIV Education in Schools
Data not available.

KNOWLEDGE AND BEHAVIOUR INDICATORS

12. Orphans: School Attendance
Not relevant.
Not a single orphan with HIV infection has been known to have lived in Slovenia by the end of 2007.
13. Young People: Knowledge about HIV Prevention
Data not available.
14. Most-at-risk population: Knowledge about HIV Prevention – Sex Workers
Data not available.
14. Most-at-risk population: Knowledge about HIV Prevention – Men Who have Sex with Men
Data not available.

14. Most-at-risk population: Knowledge about HIV Prevention – Injecting Drug Users
Data not available.
15. Sex before Age of 15
Data not available.
Data published for the indicator with a different denominator for the year 2000 (probability sample general population respondents 18 to 49 years old)².
16. Higher-risk sex
Data not available.
17. Condom Use During Higher-risk Sex
Data not available.
18. Sex Workers: Condom Use
Data not available.
19. Men Who Have Sex with Men: Condom Use
Data provided: 74.6%
20. Injecting Drug Users: Condom Use
Data not available.
21. Injecting Drug Users: Safe Injecting Practices
Data not available.

IMPACT INDICATORS

22. Reduction in HIV Prevalence
Data provided for 2006: prevalence was 0%.
Sentinel surveillance methods and overview of results for the period 1993 to 2002 were published in 2003.¹ See the chapter Overview of the AIDS epidemic for data for the period 2003 to 2006.
23. Most-at-risk Populations: Reduction in HIV Prevalence – Sex Workers
Data not available.
23. Most-at-risk Populations: Reduction in HIV Prevalence – Men Who have Sex with Men
Data provided for 2006: prevalence was 2.1%.
Sentinel surveillance methods and overview of results for the period 1993 to 2002 were published.¹ See the chapter Overview of the AIDS epidemic for data for the period 2003 to 2006.
23. Most-at-risk Populations: Reduction in HIV Prevalence – Injecting Drug Users
Data provided for 2006: prevalence – 0%.
Sentinel surveillance methods and overview of results for the period 1993 to 2002 were published in 2003.¹ See the chapter Overview of the AIDS epidemic for data for the period 2003 to 2006.
24. HIV Treatment: Survival After 12 Months on Antiretroviral Therapy
Data not available.
No AIDS death cases were reported in 2006.

III. Overview of the AIDS epidemic

Slovenia is a low-level HIV epidemic country. Less than one individual per 1000 inhabitants is living with HIV infection. Men who have sex with men have been most affected, but the proportion of infected has stabilized at a level of a few percent, and has consistently remained below five percent. There is as yet no evidence of a substantial HIV infection burden among IDU and their sexual partners or any other population group at higher behavioral risk.

For the period of last four years, Table 1 presents the results from monitoring HIV prevalence with unlinked anonymous testing for surveillance purposes in three easily accessible groups at higher behavioral risk, IDU, MSM and clients of sexually transmitted infections (STI) clinics, and also in one low-risk group, pregnant women.

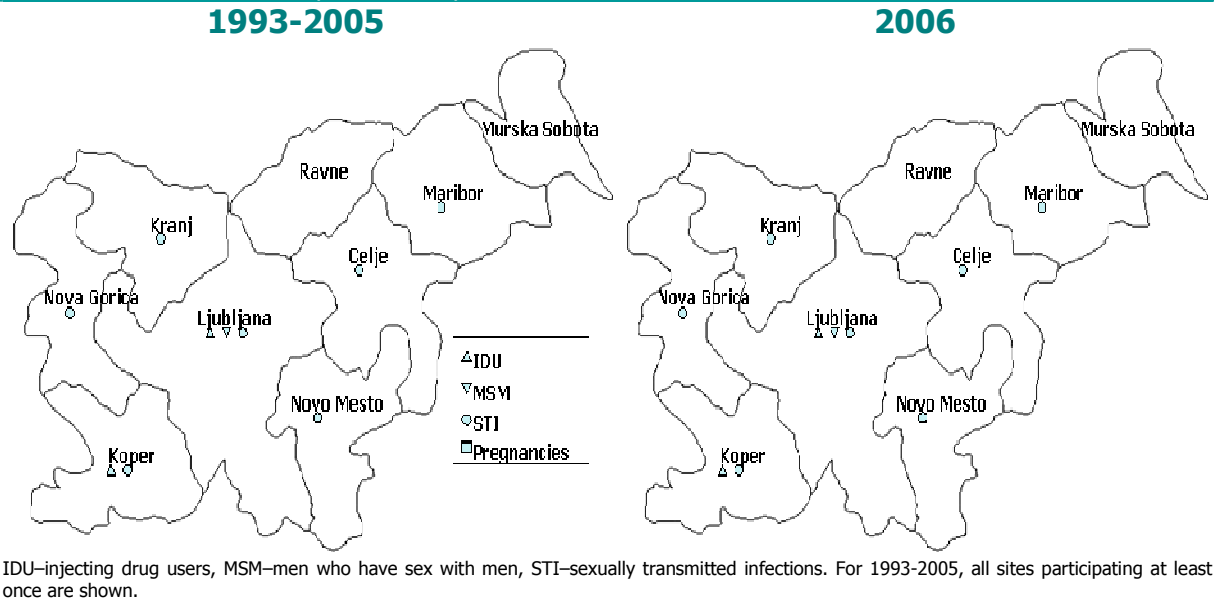
TABLE 1: PROPORTION OF HIV INFECTED AMONG INJECTING DRUG USERS, MEN WHO HAVE SEX WITH MEN, PATIENTS WITH SEXUALLY TRANSMITTED INFECTIONS AND PREGNANT WOMEN, SLOVENIA, 2003-2006						
	Year	Number of sentinel sites	Number of tested	Number of HIV infected	% HIV infected	Prevalence range*
IDU	2003	2	333	0	0	
	2004	3	233	0	0	
	2005	3	188	0	0	
	2006	2	162	0	0	
MSM	2003	1	101	1	0,9	
	2004	1	79	2	2,5	
	2005	1	82	3	3,7	
	2006	1	94	2	2,1	
STI	2003	7	613	1	0,2	0-0,3
	2004	7	489	5	1	0-1,5
	2005	7	587	2	0,3	0-1,0
	2006	7	638	10	1,6	0-2,0
Pregnancies	2003	8	7544	0	0	
	2005	8	8008	1	0,01	0-0,5

IDU – injecting drug users, MSM – men who have sex with men, STI – sexually transmitted infections. * Prevalence range between sentinel sites.

Our methods for monitoring HIV prevalence with unlinked anonymous testing for surveillance purposes were published previously.¹ In brief, residual sera from sera specimens obtained from STI patients for syphilis serology are sampled continuously in several laboratories; residual sera from sera specimens obtained from pregnant women who are screened for syphilis are sampled continuously in several laboratories every second calendar year; saliva specimens are continuously voluntarily obtained from IDU entering substitution programme at one or two sites and recently also at one or two needle exchange programmes. Once per year (one day survey) saliva specimens are voluntarily obtained from MSM in a community setting (one of their meeting sites). Figure 1 presents the sentinel sites geographical coverage. In addition to the information about the type of sentinel population, sampling period and sentinel site, all specimens are labeled only with sex and age group, frozen and stored at -20⁰ C. At the end of each sampling period, after each calendar year, all serum specimens are tested in pools of 12 for the presence of anti HIV-1/0/2 antibodies. Individual sera from reactive pools are re-tested using the same assay. Saliva specimens are tested individually for the presence of anti HIV-1/2 antibodies.

This component of our national HIV surveillance system is relatively modest in terms of numbers of tested specimens for all higher risk groups, but the results provide for crude monitoring of trends and early warning.

FIGURE 1: UNLINKED ANONYMOUS HIV PREVALENCE MONITORING SENTINEL SITES AND SENTINEL POPULATIONS, SLOVENIA, 1993-2006



In 2006, the annual reported incidence rate of newly diagnosed HIV infection cases has been 16.4 per million population, 15% lower than the reported rate in 2005 (Figure 2).

In 2006, MSM represented 76% of newly diagnosed cases in comparison to 82% in 2005 (Figure 3).

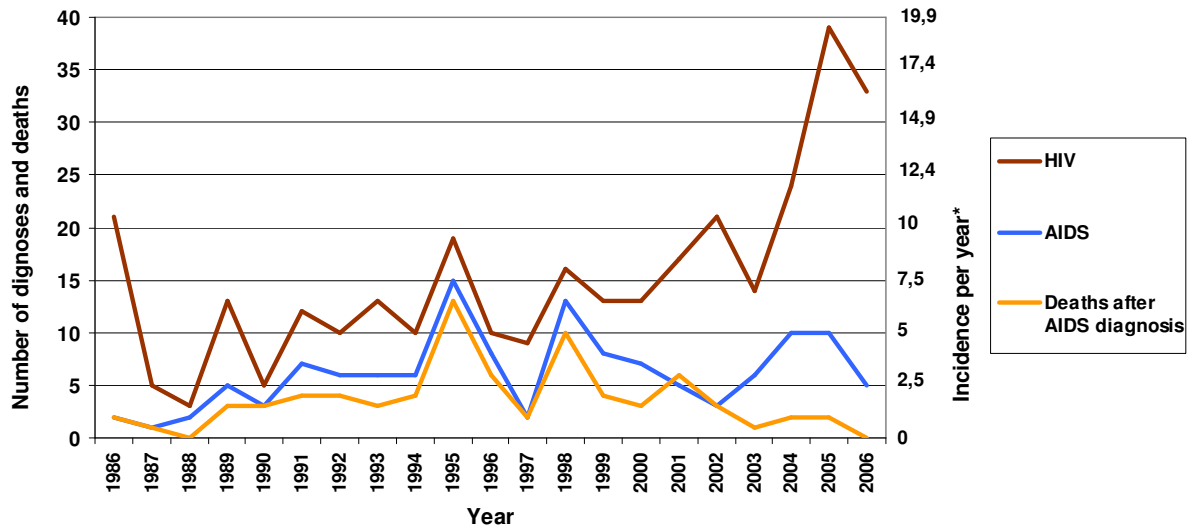
During the period from 1986 to 2006, a cumulative total of 13 cases of HIV among IDU was reported, the last one in 2001 and a cumulative total of five cases of mother-to child transmission of HIV infection, the last one in 2004 (Figure 3).

In 2006, HIV diagnosis was established very late, within three months preceding AIDS diagnosis, in 9.1% of all new diagnoses. Recently, the proportion of very late diagnoses has been decreasing (Figure 4). The diagnostic HIV testing rates have been increasing slowly to 1.3 tests per 100 population in 2006 (Figure 5).

In 2006, five AIDS cases were diagnosed, 2.5 per million population (Figure 2), of which one presented with pulmonary tuberculosis. No AIDS deaths were reported in 2006 (Figure 2).

In 2006, five AIDS cases were diagnosed (2.5 per million population), of which one individual presented with pulmonary tuberculosis (Figure 2). No AIDS deaths were reported in 2006 (Figure 2).

FIGURE 2: NEWLY DIAGNOSED HIV CASES, AIDS CASES AND DEATHS AFTER AIDS DIAGNOSIS, SLOVENIA, 1986-2006



All HIV cases reported in 1986 (except for 2 AIDS deaths) were diagnosed among haemophiliacs.

FIGURE 3: NEWLY DIAGNOSED HIV CASES ACCORDING TO TRANSMISSION CATEGORY, SLOVENIA, 1986-2006

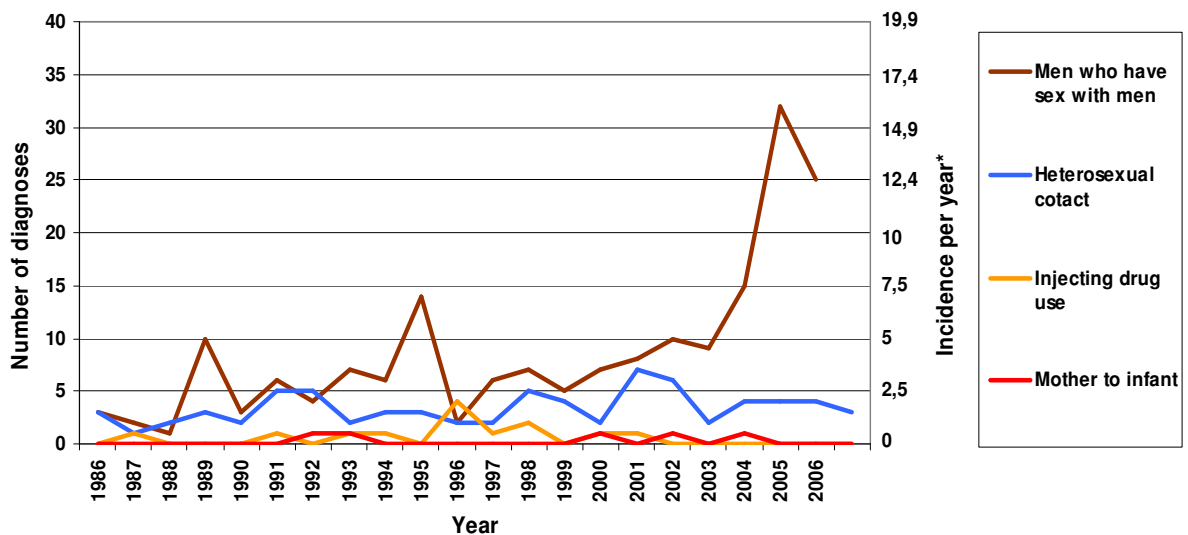


FIGURE 4: LATE DIAGNOSES OF HIV, SLOVENIA, 1996-2006

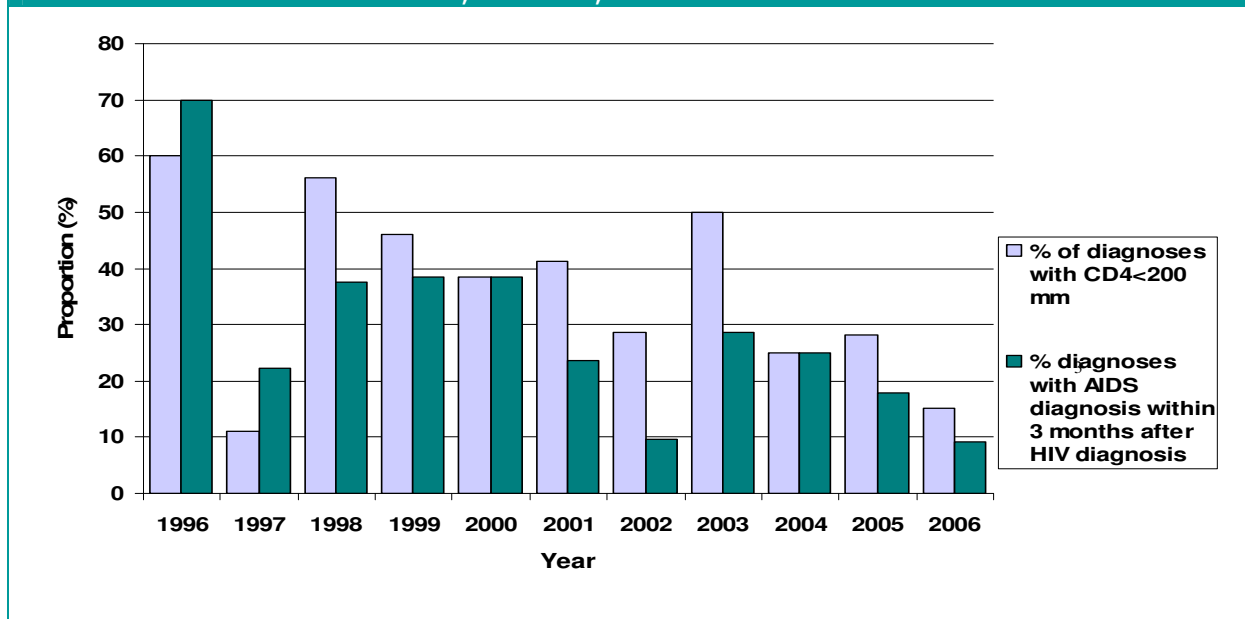
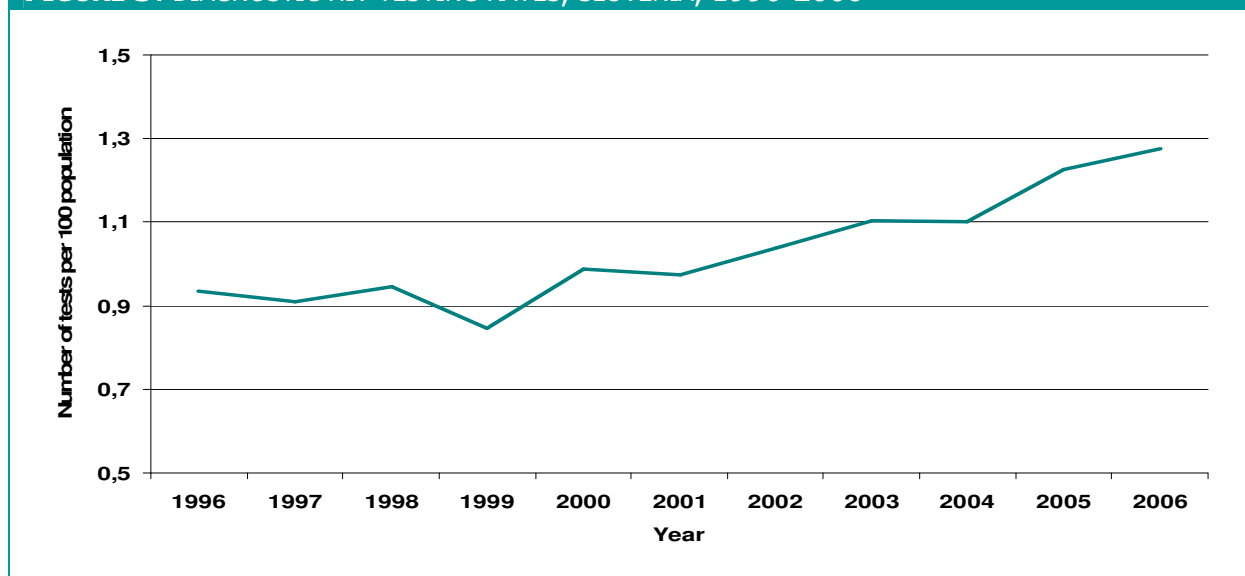
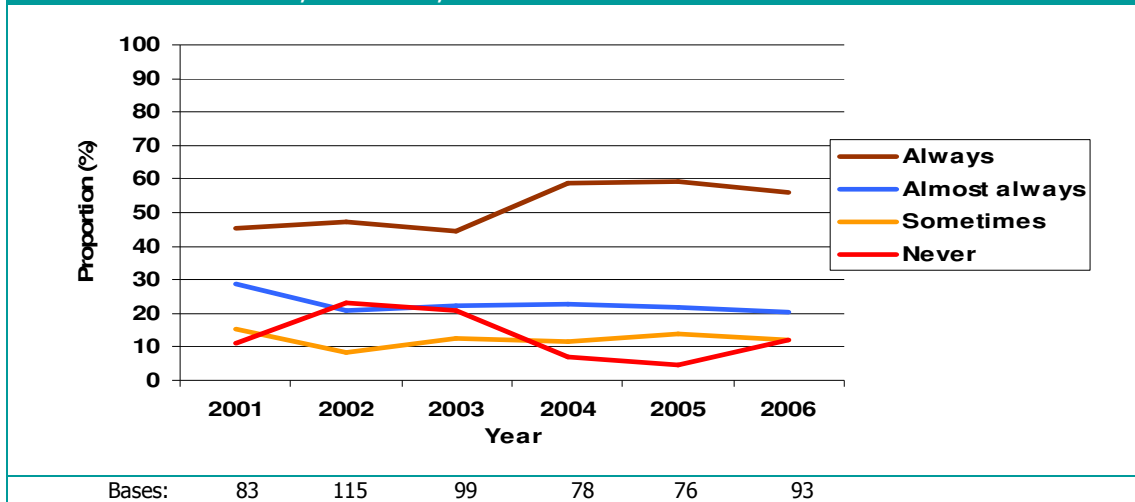


FIGURE 5: DIAGNOSTIC HIV TESTING RATES, SLOVENIA, 1996-2006



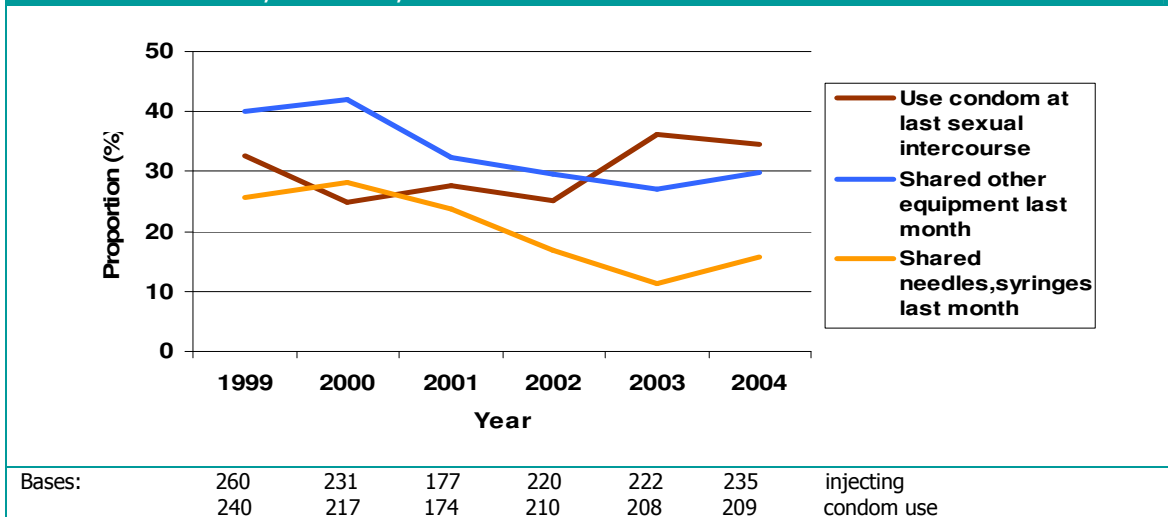
Very modest behavioral HIV surveillance has been established among MSM in 2000. It was linked to HIV sentinel surveillance described above.¹ MSM participating in one day surveys at one of the gay venues in Ljubljana who consent to contribute a saliva specimen for unlinked anonymous HIV testing are also invited to anonymously complete a self administered questionnaire about their recent sexual behavior. The results about the reported frequency of condom use at homosexual anal sex during the preceding year do not suggest recent deterioration of safer sex practices among MSM in Slovenia (Figure 6).

FIGURE 6: USE OF CONDOM AT ANAL SEX AMONG MEN WHO HAVE SEX WITH MEN, LJUBLJANA, SLOVENIA, 2001-2006



Monitoring of drug use related risk behavior indicators among IDU demanding treatment for the first time was established within network of Centers for Prevention and Treatment of Drug Addiction with national coverage. Available results for the period 1999-2004 (Figure 7) suggest that the availability of clean needles and syringes in pharmacies and the gradually expanding needle and syringe exchange and distribution programmes in Slovenia had the desired impact on the reduction of sharing injecting equipment among IDU. Also, the intensive promotion of condom use targeted to general population, youth and IDU seems to have had some impact.

FIGURE 7: SELECTED BEHAVIOURAL INDICATORS FOR CURRENT IDU AT FIRST TREATMENT DEMAND, SLOVENIA, 1999-2004



To conclude, Slovenia is a low HIV epidemic country. MSM are the most affected population group, but HIV prevalence remains consistently below 5%. It seems that we have not missed the window of opportunity for promotion of safer sex, especially condom use, targeted to general population, youth and population groups at higher behavioral risk and for the development of harm reduction programmes for IDU.

IV. National response to the AIDS epidemic

Early response

The Slovenian Ministry of Health has been leading an early and effective response mounted together with other governmental sectors and NGOs. Some milestones are given below.

In 1985, the first governmental Working Group on AIDS was established at the Institute of Public Health of the Republic of Slovenia. HIV laboratory diagnosis became available and HIV reference laboratory was established at the Institute of Microbiology and Immunology, Medical School, University of Ljubljana.

Among NGOs, the gay men NGO SKUC-MAGNUS / ROZA KLUB was the first to respond to the news about the developing AIDS epidemic among homosexual men elsewhere. They launched their first campaign in 1985 in the gay club "Amerikanec" in the capital city Ljubljana. Leaflets with information about HIV infection, transmission modes and safer sex practices were distributed. Since then, safer sex promotion campaigns targeted to MSM are organized annually, during recent years also by several other MSM NGOs.

In 1986, the first national AIDS related campaign targeted to general population was launched by the Red Cross and the Association of the Socialistic Youth of Slovenia. The Institute of the Republic of Slovenia for Transfusion Medicine ensured blood safety, a national voluntary confidential HIV testing and counseling site was established at the Infectious Diseases Clinic, University Clinical Centre Ljubljana, and health care for the first recognized cases of HIV infection, then limited to treatment of opportunistic infections and malignancies was provided. The Institute of Public Health of the Republic of Slovenia started with HIV surveillance, initially based on reporting of diagnosed HIV infection and AIDS cases. The Ministry of Justice in collaboration with the Ministry of health prepared Guidelines for the prevention of HIV transmission in prisons.

In 1987, anonymous, free of charge HIV testing and counseling became available at the Institute of Microbiology and Immunology, Medical School, University of Ljubljana and HIV/AIDS guidelines for health care workers were prepared and distributed by the Institute of Public Health of the Republic of Slovenia.

In 1988, the Institute of Public Health of the Republic of Slovenia coordinated the implementation of the first national HIV/AIDS mass media campaign.

In 1989, antiretroviral therapy with zydovudine was introduced at the Infectious Diseases Clinic, University Clinical Centre Ljubljana, where all HIV infected individuals were receiving treatment.

In 1990, the Institute of Public Health of the Republic of Slovenia drafted the first comprehensive Slovenian HIV/AIDS prevention and control strategy document. The Ministry of Justice introduced HIV prevention programme in prisons. Methadone substitution for IDU was introduced at two health care sites.

In 1992, STIGMA, the NGO working with IDU in Ljubljana started the first needle exchange programme. By then, injecting drug use related harm reduction policy with HIV prevention had gained broader support and the initiation of this programme was supported by the Ministry of Health and the former World Health Organisation Global Programme for AIDS.

In 1993, the Ministry for Labor Family and Social Affairs started supporting programmes for the prevention of drug use, rehabilitation programmes and harm reduction programmes for IDU implemented by NGOs.

In 1995, the Ministry of Health established a national network of outpatient services, Centers for Prevention and Treatment of Illicit Drug Use, on primary health care level that provided different services including substitution treatment for IDU and the first NGO dedicated exclusively to issues related to AIDS, "AIDS Foundation Robert", was established in Ljubljana, as it was perceived that some HIV infected would prefer receiving psychosocial support from dedicated volunteers in a NGO setting outside governmental institutions. This NGO, in 2000 also integrated the former STIGMA and continued to provide harm reduction programme for IDU, including needle exchange. In 1995, under the lead of the Ministry of Health, the new national strategy for HIV prevention and care has been adopted at the multi-sector national consensus conference.

In 1996, first protease inhibitor saquinavir was introduced into treatment and since 1997 all patients with medical indications had access to highly active antiretroviral therapy (HAART).

In 1997, youth HIV/AIDS peer education project VIRUS was started by the Association of Medical Students of Slovenia. Guidelines for management of IDU in prisons were prepared by the Ministry of Justice in collaboration with the network of Centers for the Prevention and Treatment of Drug Addiction.

In 1998, the main psychosocial emergency hot-line at the Centre for Mental Health in Ljubljana integrated HIV/AIDS issues into their anonymous telephone counseling.

HIV prevention, treatment and care national strategy

Recognizing the need for multi-sector approach, in 1995 the Ministry of Health, lead the process to prepare the national strategy for HIV prevention, treatment and care, "AIDS Prevention and Control Programme, 1995-2000". Programme has been adopted at the multi-sector national consensus conference with the participation of civil society. This strategy document has not been revised since, however, the objectives, strategies and most interventions are still relevant in 2008.

The three broadly defined objectives of the national Programme are:

- to prevent the spread of HIV infection,
- to reduce the personal and social impact of HIV infection and AIDS, and
- to mobilize and unify the national efforts for prevention and control.

Prevention, treatment and care have been mainstreamed into different governmental sectors' activities. In addition, NGOs implement preventive interventions targeted to groups at highest behavioral risk. There is no national budget for HIV prevention, treatment and care and no earmarked budgets for HIV within the budgets of different Ministries.

Prevention of HIV infection was identified as the most important objective. Different strategies according to transmission modes were identified:

- prevention of sexual transmission,
- prevention of transmission through blood, and
- prevention of transmission from mother to child.

Five interventions to prevent sexual transmission of HIV defined in the Programme are:

- promotion of safer sexual behaviors,
- provision of condoms and lubricants,
- provision of STI health care and promotion of STI health care seeking behavior,
- provision of testing and counseling, and
- partner notification.

The prime focus of action for interrupting transmission is to promote safer sexual behavior. Five safer sexual behaviors promoted are:

- mutual fidelity,
- abstinence from sexual activity (for example for youth to delay the first sexual intercourse),
- safer sexual acts (non-penetrative rather than penetrative sex),
- decrease in the number of non-regular sexual partners,
- correct use of a condom every time an individual has a sexual intercourse at risk (e.g. sex outside a long-term relationship between uninfected partners based on mutual fidelity).

Information, education and communication activities aimed at reducing risk-taking behavior and encouraging responsible sexual behavior among youth and the general population, especially condom use, have continued. The Institute of Public Health of the Republic of Slovenia coordinates national HIV/AIDS campaigns annually, at least once per year, for the World AIDS Day (WAD). In addition, occasional campaigns are implemented at Valentine's Day and before summer holidays (Europe against AIDS – Flying condom). Most campaigns involved promotion of safer sex, especially condom use, but some also included messages aimed at countering stigmatization of people living with HIV/AIDS and gender issues. The overview of the WAD campaign messages for the period of last 10 years is given below.

Year	Target population	Messages
WAD ¹ 1998	youth general population	be aware of HIV prevent HIV transmission use condoms
WAD 1998	youth professionals (health care, education)	be aware of HIV prevent HIV transmission use condoms
WAD 1999	youth	prevent HIV - safer sex
WAD 2000	general population	gender issues involve men
WAD 2001	general population	get HIV test
WAD 2002	general population	combat discrimination
WAD 2003	general population decision makers	combat stigma and discrimination
WAD 2004	general population	decrease vulnerability of women
WAD 2005	general population decision makers	commit to HIV prevention
WAD 2006	vulnerable groups	be aware of HIV prevent HIV transmission
WAD 2007	vulnerable groups MSM	prevent HIV transmission get HIV test

1 – WAD – World AIDS Day

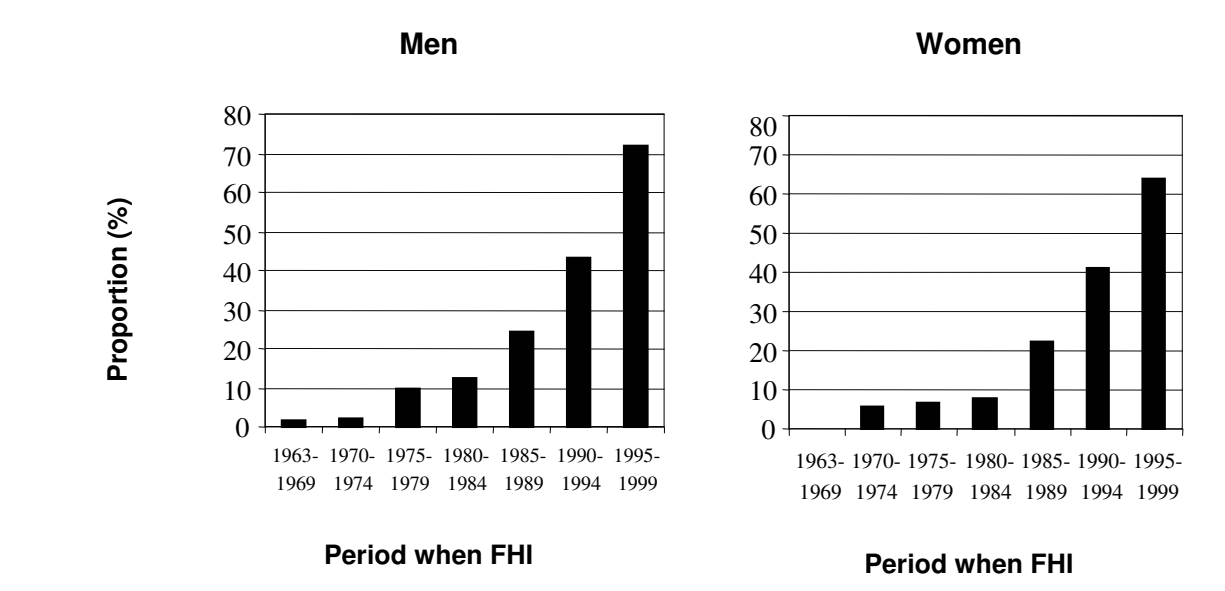
Some primary and secondary schools have been organizing different HIV educational activities, although sexual and reproductive health life skills-based education, including HIV issues, has not been integrated into the primary school curriculum. Ministry of Education and Sport together with the Institute of Education coordinates activities within the healthy schools network that also include promotion of sexual health with promotion of safer sex

including condoms promotion, e.g. through optional curriculum units, activities on WAD, and distribution of HIV educational materials.

Also, numerous governmental sector initiatives often implemented by the network of regional Institutes of Public Health as well as NGO initiatives have contributed to sexual health promotion among youth in Slovenia. These activities have not been coordinated or systematically monitored on the national level. For example, youth HIV/AIDS peer education project VIRUS that was started in 1997 by the Association of Medical Students of Slovenia, during the 10 years of its existence implemented: 1100 peer education sessions for approximately 30000 young people, two international education seminars, eight national education weeks with 320 volunteers, seven STOP AIDS WAD concerts, eight national WAD campaigns, two pre-summer campaigns, published a peer education manual, maintained a website with over 15000 visits per year and established an internet forum for HIV topics where answers are provided by experts.

The steep increase over time in condom use at first heterosexual intercourse in Slovenia suggests that HIV related condom use promotion has had an impact. Currently, the majority of Slovenian men and women use protection against HIV, other sexually transmitted infections, and unplanned conception at first heterosexual intercourse, which predicts subsequent use (Figure 8).³ Sexually active Slovenian men and women who used condom at first heterosexual intercourse were 11 and 2.5 times more likely to consistently use condoms during the month preceding the interview.³ Similarly, the Health Behavior in School-Aged Children: a WHO Cross-National Study (HBSC), implemented in Slovenian schools in 2005-2006, reported that among the sexually experienced 15 years old, 70.9% of boys and 79.0 % of girls reported to have used a condom at first heterosexual intercourse.⁴

FIGURE 8: PROPORTION OF MEN AND WOMEN REPORTING CONDOM USE AT FIRST HETEROSEXUAL INTERCOURSE (FHI) ACCORDING TO CALENDAR PERIOD AT FHI, SLOVENIA, 2000



Condom use estimates are not representative of everyone who had FHI during these calendar periods due to exclusion of individuals under 18 and over 49 years of age at time of survey. Potential bias greatest for earliest and more recent periods.

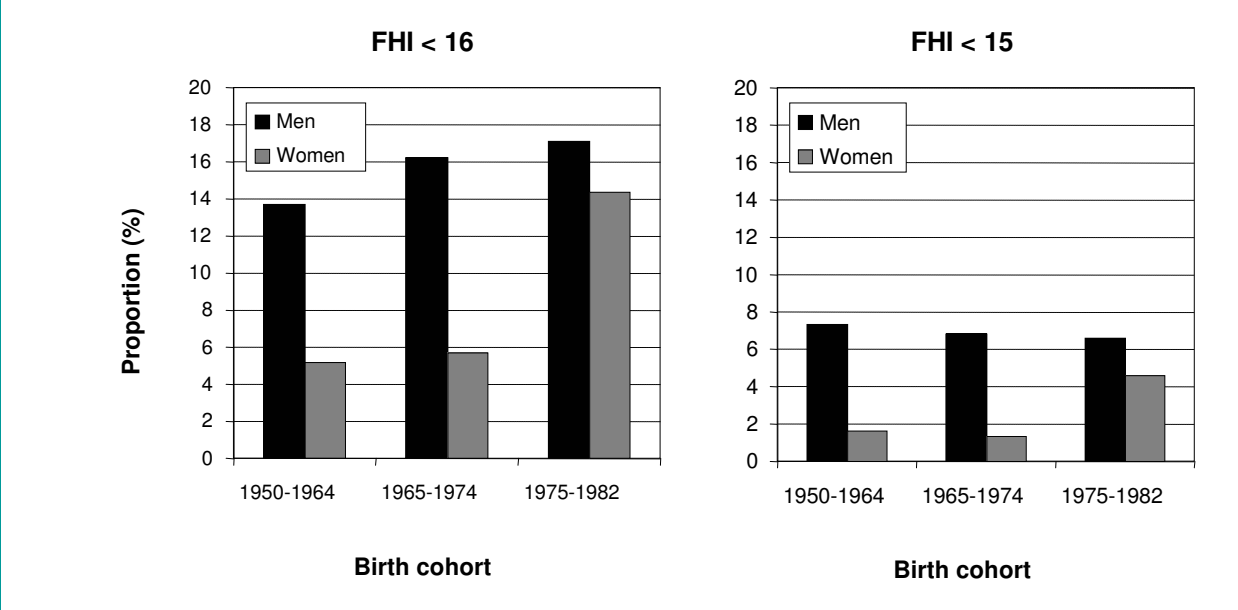
In contrast, delaying first heterosexual intercourse has proved less feasible. The proportion of young men and especially young women, who experience first heterosexual intercourse

before the age of 16 still continues to increase (Figure 9)². Similarly, the HBSC, 2005-2006, reported that 29,5% of 15 years old boys and 17,0% of 15 years old girls already had sexual intercourse.⁴

With respect to knowledge, it is unacceptable, that at the time of their first heterosexual intercourse, approximately three in four young Slovenian people perceived themselves to have been inadequately prepared in terms of information about sexual matters. "Should have known more" was reported by 76.3% of men and 71.7% of women.² Of these, a sizeable proportion felt that they should have known more about contraception, 35.4% of men and appreciably more, 47.7% of women. In contrast, more men than women felt that they should had known more about sexually transmitted diseases, 47.7% of men and 40.6% of women.²

Among men and women who claimed not to have sufficient knowledge at the time of first heterosexual intercourse, many would have liked to have learned more from authoritative sources such as parents (especially mothers), school and health care institutions. Sexual education in school was the third most preferred option for men and the second most preferred option for women.²

FIGURE 9: PROPORTIONS OF MEN AND WOMEN WHO HAVE EXPERIENCED FIRST HETEROSEXUAL INTERCOURSE (FHI) BEFORE AGE 16 AND BEFORE AGE 15, SLOVENIA, 2000



The three leading MSM NGOs in Slovenia, SKUC-MAGNUS, DIH and Legebitra, implement numerous activities aimed at promoting safer sex and HIV voluntary counseling and testing among MSM. These activities include: peer education; distribution of HIV and other STI educational leaflets, condoms and lubricants at gay venues in the community; and MSM media campaigns (radio, web, magazines). Numerous workshops for training MSM volunteers for peer safer sex promotion among MSM have been organized. Anonymous psychosocial telephone counseling including HIV issues organized by SKUC-MAGNUS (GALfon) has been operating for many years, but stopped in 2007, as the numbers of clients decreased due to new and more popular web-based communication approaches (internet chat-rooms, including an internet forum for HIV+ MSM where knowledge and experience is

shared). Also, a small self-support group of HIV infected MSM has been started by SKUC-MAGNUS and HIV manual for MSM has been published.

In 2005, AIDS Fondation Robert in collaboration with the International Organization for Migration and the Slovenian Philanthropy started a prevention programme for vulnerable mobile population groups such as commercial sex workers, victims of human trafficking, illegal migrants, and asylum seekers. Migrants and sex workers are reached through specific communication channels including bars and pimps. HIV/AIDS information leaflets, including information about access to anonymous HIV counseling and testing and access to psychosocial support in several languages (German, Russian, Serbian, Croat and English) are distributed together with condoms.⁵

HIV prevention interventions in prisons are implemented by the Ministry of Justice in collaboration of the Institute of Public Health of the Republic of Slovenia. Information and education activities are provided for the personnel and prisoners. Access to voluntary confidential HIV testing and counseling is ensured. In 2006, among 242 prisoners tested for HIV only two (< 1%) were diagnosed with HIV infection. Universal precautions to prevent HIV transmission in prisons are used and HIV infected individuals are not isolated. Safer sex is promoted and condoms are provided free of charge. IDU on substitution treatment at incarceration are either detoxicated and enrolled into abstinence programme or kept on substitution treatment.

Prevention of transmission through blood is achieved through three interventions:

- ensuring safe blood, blood products, sperm, tissues and organ transplants,
- ensuring aseptic conditions for invasive procedures, and
- promoting safe behaviors among injecting users of illegal drugs.

The safety of blood and blood products, sperm, tissues and organs for transplantation is ensured. Blood donors are voluntary and non-remunerated. All donated blood units are tested for HIV (using the fourth-generation enzyme immunoassay (EIA) and nucleic acid testing method (NAT) for HIV-1 RNA) and so are the donors of sperm, tissues and organs. For all plasma products the solvent / detergent method that inactivates viruses with lipid envelope is applied in their preparation.

Prevention of HIV transmission in the health care setting is based on careful attention to infection control procedures, including the proper sterilization of equipment used for skin-piercing, surgical and other invasive procedures. All health care institutions must provide training for and consistent use of "universal precautions" and assure availability of the necessary supplies and equipment.

Illegal drug users have access to different therapeutic and rehabilitation programmes (e.g. detoxification programme, substitution therapy, therapeutic communities). For example, a NGO Social Forum for Dependency has a therapeutic community Project Human, which is mostly funded by the Ministry of Labor, Family and Social Affairs, which also supports numerous other programmes for prevention of addiction and Caritas runs a rehabilitation programme (Comunita Incontro) in Nova Gorica. Substitution treatment is widely available to IDU in primary health care setting with currently 19 Centers for Prevention and Treatment of Illegal Drug Users operating all over the country. In addition, reducing the use of drugs by injection and reducing the use of shared or contaminated injection equipment is promoted. Clean needles and syringes are accessible for purchase in pharmacies. Needles and syringes exchange or distribution programmes, including outreach, are implemented by several NGOs (e.g. AIDS Fondation Robert and STIGMA in Ljubljana, SVIT in Koper). In addition, safer sex

is also promoted among IDU. All harm reduction activities and drug demand reduction activities are part of the Drug Use Prevention and Control National Programme and are coordinated by the Governmental Drug Committee.

The best strategy to prevent mother-to-child transmission of HIV is to prevent the sexual transmission of HIV to women of reproductive age. Our HIV surveillance results indicate very low prevalence of HIV infection among pregnant women and HIV screening has not been introduced. Since 1986 to 2007, a cumulative total of five cases of HIV infections were diagnosed among children that resulted from mother-to-child transmission, the last case in 2004. In the case of known HIV infection in a pregnant women appropriate treatment and prophylaxis is available to prevent mother-to-child transmission. Counseling, contraception, and other fertility regulation services are available to HIV infected women.

STI health care is provided by general practitioners and all gynecology outpatient services on the primary health care level and also within the dermatovenerology outpatient network (the Central Venerology Dispensary at the Dermatology Hospital of the Clinical Centre and regional venerology dispensaries); STI outpatient service at the Gynecology Hospital of the University Clinical Centre Ljubljana; urological outpatient service at the Urological Hospital of the Clinical Centre Ljubljana and the urological outpatient services network; and STI outpatient service at the Infectious Diseases Clinic, University Clinical Centre Ljubljana.

Everyone has access to client-initiated voluntary confidential counseling and testing through their general practitioners and, if requested, also to anonymous counseling and testing without referral at one national HIV counseling and testing site at the Infectious Diseases Clinic, University Clinical Centre Ljubljana. In addition, special HIV testing and counseling services exist in many regions within hospitals, regional Institutes of Public Health or blood transfusion centers or stations. The Ministry of Justice provides resources for voluntary testing of prisoners. Laboratories that conduct HIV testing are available in all regions of Slovenia either in regional hospitals, regional transfusion stations or Institutes of Public Health. External laboratory testing quality control is ensured by the Reference Laboratory at the Institute of Microbiology at the Medical Faculty.

Universal access to high quality clinical care for HIV infection, including highly active anti-retroviral therapy is ensured at the Infectious Diseases Clinic, University Clinical Centre Ljubljana. Many asymptomatic HIV infected patients are followed-up on outpatient basis. Since Slovenia is rather small and there were less 200 individuals with known HIV infection by the end of 2007, treatment and care is available on this one location only. Psychosocial HIV counseling including safer sex promotion is available to all HIV infected followed-up. Everyone also receives a self help manual for HIV infected that was published by AIDS Fondation Robert. Social outreach workers provide support as necessary.

V. Best practices

Slovenia seems not to have missed the window of opportunity for the development of treatment and harm reduction programmes for IDU. Two examples, a governmental and a NGO approach are given.

1. National network of Centers for the Prevention and Treatment of Drug Addiction

In January 1995, the Ministry of Health established the national Network of Centers for the Prevention and Treatment of Drug Addiction under the coordination of the Centre for the Treatment of Drug Addiction at the Mental Health Centre in Ljubljana to provide preventive programmes and free of charge treatment for drug users at the primary health care level. The financial resources were provided by the Institute of Health Insurance of Slovenia within the mandatory insurance scheme resources. Guidelines for treatment of drug addiction adopted by the Health Council at the Ministry of Health in 1994 and Guidelines on clinical management adopted at the Symposium on Methadone Maintenance in 1994. In addition, numerous technical guidelines for managing drug users within the health care system were prepared (for general practitioners, psychiatrists, physicians treating personnel in military service, physicians treating prisoners, for emergency in-hospital treatment of drug users, for treatment of diseases linked to drug use and for other situations in which medical personnel encounter drug users). The network that currently involves 19 centers located all over the country, provides preventive programmes; individual, group and family therapy; counseling services for drug users and their relatives; community health programmes; substitution treatment (mostly methadone maintenance); assistance in rehabilitation and social reintegration; and consultations concerning health, social and educational services. They work closely with other health care services, NGOs and self-help groups. Evaluation and research are important elements of their work. The establishment of the Network was a major step towards the universal access of drug-dependent individuals to treatment.⁶

2. STIGMA/AIDS Foundation Robert–NGO providing harm reduction for injecting drug users, preventive interventions for prisoners and support to people living with HIV

STIGMA (NGO) was established in 1992 to implement harm reduction activities for IDU to reduce the negative health and social consequences of drug use and was integrated into the AIDS Foundation Robert in 2000. Its main activities were: outreach programme to contact IDU who were not in contact with treatment services and who did not seek medical assistance and social support services; syringe and needle exchange at the premises and through outreach work; secondary syringe and needle exchange with the participation of IDU from other Slovenian cities; drop in center for IDU; maintenance of needles and syringes vending machines in Ljubljana; counseling for imprisoned drug users in Ljubljana prison, and practical support after their release from prison (employment and housing). In addition, a self-help group for people with HIV/AIDS was initiated and peer education for students and volunteers was provided.⁷

VI. Major challenges and remedial actions

Because of low level HIV epidemic in Slovenia, HIV prevention and care is not very high on political agenda and resources for prevention activities that can not be integrated in routine health care services and activities of other governmental sectors are scarce. Also, necessary resources for the revision of the now a bit out-dated national HIV prevention strategy have not been ensured.

The most important public health priority for HIV prevention activities in Slovenia remains to ensure the national coverage of MSM with good quality interventions for prevention of sexual transmission of HIV among MSM and promotion of HIV testing for early HIV diagnosis. In addition, national coverage with good quality harm reduction interventions for IDU to increase access to clean injecting equipment should be ensured now, while rapid HIV transmission among IDU has not started yet. Thus, sustainable and sufficient funding of NGOs working in the field of HIV prevention among most vulnerable populations such as MSM and IDU should be ensured.

Finally, since Slovenians have expressed demand for receiving information about sexual matters in school and since sex and HIV education programmes have been shown not to increase sexual activity and some programmes have been shown to decrease sexual activity and increase condom or contraceptive use, safer sex promotion should be incorporated in the elementary school curriculum to cover all generations of young people before a substantial proportion becomes sexually active.

VII. Support from the country's development partners

Not applicable for Slovenia.

VIII. Monitoring and evaluation environment

In view of our low level HIV epidemic and limited resources, comprehensive monitoring and evaluation of HIV prevention, treatment, and care was not developed. Thus, existing data sources do not provide for reporting data for most UNGASS indicators to monitor the Declaration of Commitment to HIV/AIDS. Our HIV prevention, treatment, and care policies are informed from the results of the national HIV surveillance system and some research results.

Adequate resources should be allocated to most essential monitoring and evaluation of HIV prevention treatment and care. Priorities are: monitoring of a few key behavior indicators and HIV testing uptake among high-risk groups, at least MSM and IDU. Existing small scale behavioral surveillance among MSM and IDU should expand to larger scale cross-sectional repeated behavioral surveys with the inclusion of several biological markers, HIV, other STI and hepatitis B and C. Finally, preventive interventions among MSM and IDU should be monitored for quality and coverage.

IX. Appendix 1: Report writing process

This report was prepared according to guidance published by UNAIDS.⁸

Preparation of this report was coordinated by:

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All members of the National AIDS Committee at the Ministry of Health were invited to contribute any relevant information. The following members contributed:

Evita Leskovsek, MD, Unit of Mental Health, Security & Other Key Issues, Center for Health Promotion, Institute of Public Health of the Republic of Slovenia, contributed to chapters National response to the AIDS epidemic, Best practices, Major challenges and remedial actions and to the completion of the Part A for the National Composite Policy Index;

Prof. Janez Tomazic, MD, MSc, PhD, Infectious Diseases Clinic, University Clinical Centre Ljubljana, provided information for the national programme indicator HIV Treatment: Antiretroviral Therapy;

Snezna Levicnik Stezinar, MD, Institute of the Republic of Slovenia for Transfusion Medicine, provided information for the national programme indicator Blood safety.

Part B for the National Composite Policy Index was completed by:

Miran Solinc, Social Worker, SKUC-MAGNUS (men who have sex with men non-governmental organization), member of the National AIDS Committee at the Ministry of Health.

The information for the national program indicator Co-management of Tuberculosis and HIV Treatment was provided by:

Damjan Erzen, MD, Tuberculosis Registry, University Clinic for Respiratory Diseases and Allergy Golnik.

Most of the information presented in the report had been available at the Institute of Public Health of the Republic of Slovenia. Most of the data presented in the chapter Overview of the AIDS epidemic have been already published in Slovene⁹ and are accessible at the website of the Institute of Public Health of the Republic of Slovenia (<http://www.ivz.si>).

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