**United Nations Development Programme**

 **Country: Montenegro**

**Project Document**

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| **Project Title** | Scale up response to HIV/AIDS among most at risk population groups in Montenegro |
| UNDAF Outcome(s):  | n/a |
| **Expected CP Outcome(s):** *(Those linked to the project and extracted from the CPAP)* | Maintenance of low HIV prevalence in Montenegro |
| **Expected Output(s):** *(Those that will result from the project and extracted from the CPAP)* | Improved prevention, care and treatment of at risk and HIV affected populations through scaled up national HIV/AIDS response |
| **Implementing Partners:** | UNDP CO Montenegro  |
| **Responsible Parties:** | Institute for Public Health (IPH), Primary Health Care Center Podgorica, Primary Health Care Center Kotor, NGO CAZAS, NGO Juventas, NGO Montenegrin HIV Foundation, NGO Zastita, NGO SOS Podgorica, NGO Association of Private Dentists of Montenegro |

**Brief Description:**

Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) has been financially supporting implementation of the National HIV/AIDS Strategy in Montenegro since 2006.

GFATM Rd5 program **“Support to Implementation of the National HIV/AIDS Strategy in Montenegro” (2,424,124 EUR)** was successfully implemented in the period Aug 2006-July 2010 with UNDP as Primary Recipient of the funds (PR) and Country Coordinating Mechanism (CCM) as responsible national entity and owner of the program.

“**Scale up response to HIV/AIDS among most-at-risk populations in Montenegro”** programme,funded by GFATM within the Round 9 cycle builds up on the successes achieved and challenges faced during the implementation of the Montenegrin National HIV/AIDS Strategy 2005 – 2009.

Phase I Grant Agreement was signed in August 2010. First phase was implemented in the period July 2010-June 2012 with the budget of 2,332,012 EUR.

Activities in Phase II of the Round 9 HIV program build upon the activities established under the Round 5 program. The Request for Renewal Phase II takes into account recommendations that the focus should be on most at-risk population groups and people living with HIV (PLHIV) based on the epidemiological evidence and appropriate program responses for low prevalence countries. In Montenegro the most at-risk groups have been defined as MSM, IDUs, female SWs, merchant marines, poor RAE youth and prisoners. Therefore activities not directly linked with population groups (such as school-based Healthy Lifestyles education and surveys of young people and the general population) have been removed from the Request for Renewal.

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| Programme Period: July 2012 – July 2015Key Result Area (Strategic Plan): Mitigating the impact of ADIS on human developmentAtlas Award ID: 00060348Start date: July 1, 2012End Date June 30, 2015LPAC Meeting Date September, 2012Management Arrangements: Direct Implementation (DIM) |

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| 2012 - 2015 AWP budget: Total resources required 1,730,618EURTotal allocated resources: 1,730,618 EURRegular * Other:
	+ GFATM 1,730,618 EUR
	+ Donor \_\_\_\_\_\_\_\_\_
	+ Donor \_\_\_\_\_\_\_\_\_
	+ Government \_\_\_\_\_\_\_\_\_
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Agreed by UNDP:

Mr. Rastislav Vrbensky, Resident Representative

Agreed by the Government:

Mr. Miodrag Radunovic, Chair of the Country Coordinating Mechanism

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# 1. Situation Analysis

According to the latest data released by the Institute of Public Health of Montenegro, since 1989 (when the first person was reported with HIV), to the end of 2011, 128 people had been officially registered with HIV in Montenegro (106 males: 22 females). Out of this number, 65 persons had developed AIDS and 35 persons had died of AIDS.

During 2011, seven people were newly diagnosed with HIV, two people with AIDS cases and two AIDS-related deaths were reported to the IPH of Montenegro.

The leading mode of HIV transmission in Montenegro, so far, is through sexual intercourse (85%) – 44% heterosexual transmission and 41% homo or bisexual transmission. Sexual transmission of HIV shows a steady increase since the very beginning of the epidemic (Graph 1). Other modes of transmission are injecting drug use 3%, mother-to-child transmission 2% and blood transfusion 2%. For 8% of persons registered with HIV the mode of transmission was unknown (Annual report on HIV/AIDS in Montenegro for 2011, IPH, 2012). For two children registered with HIV, information about their serological status was collected after their mother had been diagnosed HIV-positive. Two persons were infected via blood transfusion outside Montenegro before 2005. All transfused blood in Montenegro has been routinely tested for HIV since 1987.

**Graph 1.** Mode of HIV transmission in Montenegro by year for the period 1989-2011

Out of 128 people registered with HIV in Montenegro more than half were aged 25-34 (65 people living with HIV). Detection of HIV in the children under 18 years is rare (3%, Graph 2). Information on the age of diagnosis with HIV can be misleading as information on age of HIV transmission is rarely available and many people in Montenegro seek HIV testing, or are tested for HIV when they have already developed AIDS-related conditions. For example, out of the fourteen people (13 men and one transgender) newly registered with HIV during 2010, six of them had already developed AIDS and three of them later died. This indicates the urgent need to encourage people who have engaged in HIV risk behaviour to seek HIV testing and counselling. It also demonstrates that factors such as low level of knowledge about HIV and/or stigma and discrimination may be seriously impeding efforts to increase timely HIV testing and counseling amongst people most at-risk of HIV.

**Graph 2.** Age at diagnosis of HIV infection for the period 1989-2011

The geographic distribution of people living with HIV in Montenegro is correlated with areas of HIV risk behavior in tourist areas and the capital city: 42% of people registered with HIV are from the coastal region and 37% in Podgorica.

-In the period 1989 to 2011 a total of 65 people had been registered with AIDS in Montenegro (53 males: 12 females). Out of them, 26 people were MSM, 32 were heterosexual (males and females) and two were people who injected drugs. In the same period, a total of 35 AIDS-related deaths were reported (27 males: 8 females). Out of these 63% were aged 30-49 and 20% were aged 15-29.

A decreasing trend in reported AIDS-related deaths has been noted since 2003 due to the availability of highly active antiretroviral therapy (HAART) fully covered by Republic Health Insurance Fund. At the end of 2011, 42 PLHIV were receiving HAART: all registered PLHIV who are eligible to receive HAART are able to do so.

During Rd 5 Grant network of 8 VCT centers has been established as well as outreach services for IDUs, SWs, MSM and RAE youth. It was also procured missing equipment for HIV diagnostics and monitoring of HIV status. Two additional MMT centers were opened in PHC Centre Kotor and PHC Centre Berane. Universal precautions measures were introduced and entered into regular practice of health care professionals. Set of trainings for blood transfusion health professionals were conducted in terms of increasing the blood safety and introducing the quality assurance mechanisms. Optional subject “Healthy Life Styles” was introduced to primary schools curriculum and more than 150 teachers were trained, while more than 3,500 pupils were covered with the subject.

During the Phase I of the Rd 9 HIV Grant, services established under the Rd 5 HIV Grant were scaled up in terms of opening of 3 drop in centers for IDUs, one drop in center for SWs and one counseling center for MSM. During the same period, beside existing counseling center for merchant marines within NGO Zastita in Bar, outreach services and additional counseling center for merchant marines within PHC Centre Kotor were established. Program for secondary schools’ optional subject “Healthy Life Styles” was developed as well as Textbook for Students.

# 2. Strategy

The programme seeks to scale up and strengthen the Montenegrin national response to the HIV epidemic among the most-at risk populations, building on the Rd 5 experience, successes achieved and challenges faced during the implementation of the Montenegrin National AIDS Strategy 2005–2009. It was developed in broad consultation with all key stakeholders contributing to the Montenegrin AIDS programme and is aligned to relevant WHO and UNAIDS policy guidelines and the National AIDS Strategy 2010 to 2014. The goal of the programme is to maintain low HIV prevalence in Montenegro. The programme has five objectives:

1. **To prevent HIV transmission among most-at-risk populations**

Despite some encouraging trends in behaviour detected in recent surveys implemented in 2006 and 2008 among MSM, IDU, and SW, overall surveillance results indicate a very strong need to intensify preventive interventions in all most at risk groups. Activities planned by the Round 9 proposal focus on IDU, MSM, SW, poor RAE youth, merchant marines and prisoners. They include outreach work (NEP, condom and lubricant distribution, rapid tests, counselling, distribution of IEC materials, etc.), drop in and counselling centres and peer education programmes. Sensitisation trainings are planned for key health and law enforcement professionals, police officers, prison staff and social workers with the aim of creating a more supportive environment for HIV prevention among vulnerable populations. Other trainings target physicians, nurses and dentists with the aim of enhancing HIV prevention and answering the particular health needs of the populations affected/targeted. Functioning of the 8 existing Montenegrin VCT centres is planned to be improved through additional training, strengthened supervision and improved coordination. A modest component of the programme targeted youth through an institutionalized low cost-high coverage approach due to very worrying results of a nationwide knowledge and behaviour surveys carried out in 2007 and 2009. The programme envisioned development of a high school healthy lifestyle course that will focus on sexual health and HIV.

2. **To improve quality of care and support to PLHIV**

While much has been planned for and already achieved in the field of care and support, currently present shortfalls significantly influence the quality of life of PLHIV. To this end, the programme aims to improve care and support to PLHIV through several activities: training in ARV prescribing, procurement of modest equipment for the Montenegrin Clinic for Infectious Diseases, training in provision of psychosocial support for staff of the Montenegrin infectious disease clinic who are in closest and most regular contact with PLHIV, provision of psychosocial and legal assistance to PLHIV, and through sensitization trainings implemented with the aim of creating a network of physicians, nurses and dentists willing and able to provide PLHIV with necessary medical services.

3. **To create a supportive environment for HIV prevention and care**

Activities within Phase I of the project included awareness campaigns targeted towards the general population and anti-stigmatization activities incorporated in all activities implemented under the programme. They focus on destigmatizing both PLHIV and equally important populations at risk such as MSM, IDU and SW who remain strongly stigmatized in Montenegro. In Phase II, activities related to stigma have been reduced only to activities incorporated in the other SDAs dedicated to most at risk groups due to budget reduction. Activities implemented under a separate SDA will introduce the gender sensitive approaches to the HIV response, in particular through targeting GO and NGO staff contributing to the national response to the HIV epidemic, but also through training journalists and other media representatives.

4. **To strengthen the HIV surveillance system among most-at-risk populations**

Activities are aimed at further enhancing the Montenegrin HIV M&E system with the aim of better understanding the epidemic in the country. To this end, a comprehensive information system at the national level will be implemented, which will serve as a basis for a quality recording and reporting on HIV/AIDS as well as trends in the most relevant indicators established.

5. **To increase capacity and coordination of a focused response to HIV among most-at-risk populations**

Much has already been achieved in the field of strengthening and institutional capacity building. A key feature of the round 5 grant has been developing partnerships between governmental and nongovernmental organizations and raising the capacity of all implementing organization. The round 9 programme builds on these achievements and further proposes activities with the aim of empowering Montenegrin GOs and NGOs primarily to ensure sustainability of programs upon the completion of the Grant period.

The most important elements that contributed to the successful achievements of the planned targets were establishing the Drop-in Centers for IDUs in Podgorica and Bar, SWs and MSM in Podgorica as well as the Counseling Center for merchant marines within the Primary Health Care Center at Kotor. These newly introduced services under the current Grant, as well as the continuation of successful implementation of the outreach services introduced under the Round 5 HIV Grant covering IDUs, SWs, MSM, Roma, Ashkalia and Egyptian (RAE) youth, merchant marines and prisoners. Strengthening the VCT network, established under the Round 5 HIV Grant, consisting of eight VCT Centers evenly distributed geographically should ensure coverage of the entire Montenegrin territory and has contributed to higher HIV testing rate (1,692 persons including members of most at-risk populations were counseled and tested for HIV in 2011, out of them nine were found to be HIV-positive).

Another change in the Request for Renewal relates to institutional arrangements concerning the proposed Principal Recipients (PRs) for Phase II in the original Round 9 project proposal. Instead of the originally proposed two national PRs (Institute of Public Health and NGO CAZAS), the CCM decided that UNDP should remain the sole PR. This decision reflected the new requirements of the Request for Renewal as well as some concerns about the capacity of the proposed PRs.

Most of the Phase II activities will be implemented through the NGO sector (49%) for continuing existing outreach program activities for IDUs, SWs, MSM, merchant marines and RAE and the Drop-in and Counseling Centers for IDUs, MSM, SWs. The government component of the program will include strengthening and scale-up of the methadone maintenance treatment (MMT) services at primary health care level, the network of eight Voluntary Counseling and Testing (VCT) Centers, and treatment and support for PLHIV. Two additional MMT Centers are planned to be opened in Year 3 and Year 4.

The further strengthening of VCT services will aim to increase the number of people counseled and tested for HIV and ensure the sustainability of these services through their full integration into the primary health care system. Treatment, care and support services for PLHIV will be strengthened through further training of health professionals at different levels of service delivery as well as training aimed at increasing treatment literacy and other life skills of PLHIV themselves. Psycho-social support services for PLHIV will be implemented by the recently formed first PLHIV NGO (*Montenegrin HIV Foundation*, MHF).

HIV surveillance in Montenegro will be maintained through continuous training of health professionals from the Institute of Public Health in Second Generation Surveillance. A further five bio-behavioral surveys are planned amongst merchant marines and RAE youth in Year 3, IDUs and MSM in Year 4 and female SWs in Year 5. A national database is expected to be developed and introduced by January 2013 with the aim of improving the reporting system and evidence-based decision making.

Implementation of the National HIV/AIDS strategy has been jointly financed by the GFATM and the Government of Montenegro. One of the preconditions for getting the GFATM grants for the UMIC such as Montenegro is that the major part of the activities is financed by the Government while GFATM is financing up to 30% of the overall strategy budget with the progressive increase of national share up to 95% in the final project year. Most of the activities run through the governmental sector have already been incorporated to the health and education system, such as VCT services, MMT programs and HLS subject in primary and secondary schools.

In regard to NGO part of the program, some of the services will continue to be financed through part of the State Lottery funds dedicated to NGO programs, while part of the activities are expected to be financed through other donors such as EU funds since a significant part of the funds and activities in the Rd5 and Rd 9 grant have been focused to capacity building of the NGO staff not only in terms of implementation but also fund raising and project development and management.

In terms of communication and advocacy, the PR, has initiated and issued the first issue of the GFATM Programmes in Montenegro Newsletter, which contains information on the implementation of above programmes (HIV/AIDS and Tuberculosis). The Newsletter will be issued on a quarterly basis. Also, the PR, via its Communication Department, has been working closely with SRs on preparation of communication and information material, including campaigns, preparation of audiovisual material, printed material, etc. This practice will continue in the Phase II, as well.

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| **Intended Outcome as stated in the CPAP’s RRF:** Improved prevention, care and treatment of at risk and HIV affected populations through scaled up national HIV-AIDS response. **Related UNDP Strategic Plan focus area:** Improved social inclusion and health system for MARPs |
| **Outcome indicators as stated in the CPAP’s RRF, including baseline and targets**: Indicator 4.1: Prevalence rate kept low among affected target groups (IDUs, FSW, MSM, merchant marines) Baseline: IDUs – 0.4%; FSW - 0,76%, MSM - TBD, Merchant marines – 1.54% Target: IDUs <1%; FSW <1%; MSM <5%; Merchant marines - <1%**Related Strategic Plan focus area:** Improved social inclusion and health system for MARPs |
| **Applicable Key Result Area:** Social Inclusion |
| **Partnership Strategy:** UNDP, UN Agencies, Ministry of Health and other respective national authorities at central and local level, CSOs, etc.  |
| **Project title and ID (ATLAS Award ID):** Scale up of the national response to HIV/AIDS among most at risk populations in Montenegro; **Award ID:** 00060348 |
| **INTENDED OUTPUTS**3. Results and Resources Framework  | **INDICATORS/ TARGETS** | **INDICATIVE ACTIVITIES** | **RESPONSIBLE PARTIES** | **INPUTS** |
| **Maintain low HIV prevalence in Montenegro, trough 5 components:****Component 1**Prevention of HIV transmission among most-at-risk populations**Component 2**Improving quality of care and support to PLHIV**Component 3**Creating a supportive environment for HIV prevention and care**Component 4**Strengthening the HIV surveillance system among most-at-risk populations**Component 5**Increasing capacity and coordination of a focused response to HIV among most-at-risk populations | ***Number of IDUs reached by HIV prevention services*** Baseline: 1167 IDUs were covered by prevention services through the Phase I (July 2010-June 2012). Targets\*: Y1 540, Y2 574, Y3 647  | ACT 1.1 Behaviour change communication-community outreach: IDUsActivities consist of provision of outreach services and services within three drop in centers for IDUs (2 drop in centers in Podgorica and one in Bar). Basic package of services includes provision of sterile injecting equipment, condoms and IEC materials, while additional services include outreach worker/psychologists/medical doctor counselling and referrals to other medical services as needed. | UNDP PIU, NGOs | PIUNGO Juventas, NGO CAZAS  |
| ***Number of IDUs on methadone substitution therapy***Baseline : 284 SWs were covered by prevention services through the Phase I (July 2010-June 2012). Targets\*: Y1 152, Y2 208, Y3 290  | ACT 1.1 Behaviour change communication-community outreach: IDUsRegular provision of MMT therapy for IDUs in three MMT centres in PHC Centre Podgorica, PHC Centre Kotor and PHC Centre Berane. Additional 2 MMT centers should be opened in Y3 and Y4 of the programme. | UNDP PIU, GOs | PIU<PHCC Podgorica, PHCC Kotor, PHCC Berane |
| ***Number of MSM reached by HIV prevention services***Baseline: 479 MSM clients covered by prevention services through the Phase I (July 2010-June 2012). Targets\* : Y1 400, Y2 470, Y3 520  | ACT 1.2 Behaviour change communication-community outreach: MSMActivities consist of provision of outreach services and services within counselling services for MSM in Podgorica. Basic package of services consists of provision of condoms, lubricants and IEC material with additional services of outreach worker/psychologist/social worker/medical doctor counselling and providing referral to relevant medical services. | UNDP PIU, NGOs | PIU,NGO Juventas  |
| ***No of SW reached by HIV prevention services***Baseline: 343 SWs were covered by prevention services through the Phase I (July 2010-June 2012). Targets\*: Y1 105, Y2 122, Y3 141 | ACT 1.3 Behaviour change communication-community outreach: FSWsActivities consist of provision of outreach services and services within drop in center in Podgorica. Basic package of services consists of provision of condoms, lubricants and IEC material with additional services of providing injecting equipment, psychologists/medical doctor/outreach worker counselling and providing referral to relevant medical services. | UNDP PIU, NGOs | PIUNGO Juventas |
| ***No of merchant marines reached by HIV prevention services***Baseline: 3,273 clients were covered by prevention services through the Phase I (July 2010-June 2012). Targets\*: Y1 1,300, Y2 1,300, Y3 1,300 | ACT 1.4 Behaviour change communication-community outreach: merchant marinesActivities consist of provision of outreach services and counselling center provided by NGO Zastita and counselling centre within PHC Centre Kotor. Basic package consists of provision of condoms, IEC materials and counselling with additional referral if deemed necessary, as well as provision of different diagnostic tests within the PHC Centre Kotor. | UNDP PIU, NGOs, GOs | PIU<NGO Zastita Bar, PHCC Kotor (Counselling centre for merchant marines) |
| ***No of poor RAE youth reached by HIV prevention services***Baseline: 4,086 RAE young people were covered by prevention services through the Phase I (July 2010-June 2012). Targets\* : Y1 1,400, Y2 1,400, Y3 1,400 | ACT 1.5 Behaviour change communication-community outreach: poor RAEActivities consist of provision of outreach services. Package of services consists of individual or group counselling sessions, condoms and IEC material with RAE outreach workers.  | UNDP PIU, NGOs | PIU,NGO CAZAS  |
| ***No of prisoners reached by HIV prevention services***Baseline: 930 prisoners were covered by prevention services through the Phase I (July 2010-June 2012). Targets : Y1 400, Y2 400, Y3 400 | ACT 1.6 Behaviour change communication-community outreach: prisonersPackage of services consists of individual or group counselling and IEC material. | UNDP PIU, NGOs | PIU<NGO Juventas  |
| ***1.No of clients counseled and tested for HIV******2.No of Health professionals trained*** Baseline: 60 health professionals trained in VCTTargets : Y1 30, Y2 50  | ACT 1.7 Voluntary counselling and testingActivities consist of provision of basic and advanced trainings for VCT counsellors, training of VCT councillors in other than HIV STIs counselling and management, internal and external supervision of VCT services provision. | UNDP PIU, GOs | PIU<Institute for Public Health |
| ***No of condoms and lubricants procured*** Baseline: 120,000 condoms and 15,000 lubricants per yearTargets Y1-Y3: 120,000 condoms and 15,000 lubricants procured and distributed per yeardistributed | ACT 1.9 Condom distributionCondoms and lubricants are distributed trough each service delivery area and reported through program specific reports. Numbers are, afterwards, cumulated into the unique figure. | UNDP PIU is responsible for procurement, NGOs and GOs are responsible for distribution | PIU,Programme Manager (PM), Team Leader  |
| ***1.Number of PLHIV that received psychosocial support***2. ***No of health professional trained***Baseline: No of PLHIV covered 79Targets PLHIV: Y1 60, Y2 65, Y3 75 Targets health professionals: Y1 60, Y2 60, Y3 40 Targets PLHIV trained: Y1 20, Y2 20 | ACT 2.1 Care and support to PLHIV Package of services provided to PLHIV consists of psychologists/infectologist counselling, IEC material, condoms and referral if deemed necessary, as well as training in different aspects of ARV literacy and building of life skills. Activities also envisaged training of doctors, nurses and dentists in different aspects of HIV prevention and treatment of PLHIV. | UNDP PIU, NGOs, GOs | PIU,NGO Montenegrin HIV Foundation Clinical Centre of Montenegro |
| ***No of people trained*** Baseline: 100 GO and NGO staff as well as 25 journalistsTargets: Y1 25, Y3 25  | ACT 3.2 Strengthening the capacity of all relevant stakeholders in gender issuesActivities consist of two trainings in gender components of the HIV response for GO and NGO staff directly involved or contributing to the overall national HIV response.  | UNDP PIU, NGOs | PIU,NGO SOS Podgorica  |
| ***Bio-behavioral surveys implemented in accordance with the National M&E Plan***Baseline: relevant indicators measuring impact and outcome among surveyed populations, such as HIV prevalence, condom use, sharing of injecting equipment, HCV prevalence etc. Targets ( year 1): Bio- behavioral survey among merchant marines, Bio-behavioral survey among RAE populationTargets ( year 2): Bio- behavioral survey among IDUs,Bio- behavioral survey among MSMTargets ( year 3): Bio- behavioral survey among SWs | ACT 4.1 Strengthening HIV surveillance among most at risk populationRegular bio-behavioural survey are part of the Second Generation Surveillance system designed to actively track changes within the population at risk and are conducted in line with the national M&E framework schedule. Usually, surveys are implemented biannually. | UNDP PIU, GOs | PIU,Institute for Public Health |
|  | ***Capacity of NGO CAZAS in the area of program, SR, financial management and M&E***Baseline: Report on capacity assessment of NGO CAZASTarget (year 1): Capacity building plan implemented.Target (year 2): CAZAS to become main SR in charge of NGO part of the program | ACT 5.1 Increasing capacity and coordination of a focused response to HIV among most at risk populationCapacity development of NGO CAZAS in transition process to become a leading-umbrella organization for implementation of activities foreseen for NGO Sector.There are four functional/implementation capacity areas required for National Disease Management Programs including Global Fund NGO Umbrella organization role:**Programme Management** – successfully direct the operations of an organisation to meet its objectives. **Sub-recipient Management** (Contract / Service Delivery Management) – ensure effective oversight, management, and control of Sub-recipient activities to deliver planned results. **Financial Management & Systems** – plan, direct, and control financial resources to enable and influence the effective and efficient delivery of organisational objectives.Risk management and prevention of fraud and corruption – identify and manage risks, mitigate risks and enforce actions to prevent financial and material loss through fraud and corruption.**Monitoring & Evaluation –** collecting, storing, analysing and transforming data into strategic information to be used by management to make decisions.  | UNDP PIU, NGOs | PIUNGO CAZAS  |

\**Targets refer to the total number of unique clients expected to be covered with the services within the reporting period.*

# 4. Management Arrangements

The project will be managed and implemented by UNDP CO Montenegro within the DIM modality, in line with the UNDP Programming for Results Management User Guide.

Specificity of GFATM funded programs is that project board is defined in advance, prior to applying for funding and it is a Country Coordinating Mechanism (CCM) together with UNDP.

Country Coordinating Mechanism (CCM) is a national body responsible for applying for funding and the overall oversight of the approved project. The CCM is composed by different constituencies, including government ministries, UN agencies, academic sector, private sector organizations, religious based organizations and non-governmental organizations. These country-level multi-stakeholder partnerships develop and submit grant proposals to the Global Fund based on priority needs defined at the national level.

Project reviews by this group are made at designated decision points during the running of a project, or as necessary when raised by the Programme Manager of the PIU.

Senior Beneficiary will be the Country Coordinating Mechanism (CCM).

CCM sessions can be regular or extraordinary and are scheduled by the Chairperson or the Deputy Chairperson of the CCM, or by Secretariat on their behalf. Regular sessions shall be scheduled at least 4 times a year, according to the dynamics of the reports of the primary recipients of funds to the GFATM on the progress of the projects activities. Scheduling of an extraordinary session of the CCM may be initiated by each member of CCM with the written consent of at least 25% of CCM members.

The CCM regularly reviews the implementation progress. There are periodic meetings of CCM for such purposes. UNDP makes sure that programmatic and financial reporting systems are established and provide regular reports to enable CCM to fulfill its oversight role in this respect.

CCM Core Functions:

* Coordinate the development and submission of national proposals.
* Nominate the Principal Recipient.
* Oversee implementation of the approved grant and submit requests for continued funding.
* Approve any reprogramming and submit requests for continued funding.
* Ensure linkages and consistency between Global Fund grants and other national health and development programs.

Country Coordinating Mechanisms are central to the Global Fund's commitment to local ownership and participatory decision-making. They play a crucial oversight role by appointing CCM working groups to conduct periodic visits to project implementation sites. The working group members can select specific implementation sites, as to minimize or avoid conflict of interests in areas where some CCM members also play an active role as implementing partners.

For each grant, the Country Coordinating Mechanism nominates one or more public or private organizations to serve as Principal Recipients.

In the original Project Proposal for the Round 9 HIV Grant it was proposed that UNDP Country Office Montenegro would act as a Principal Recipient (PR) for Phase I of the Round 9 HIV Grant implementation until such time as national organizations were able to assume these responsibilities. It was envisaged that during the course of program implementation, capacity would be built of two national organizations so that they would be able to assume responsibility as national PRs. It was assumed that the Institute of Public Health (IPH) would become responsible for the program components implemented by governmental institutions and the non-governmental organization (NGO) CAZAS would assume responsibility for activities implemented by NGOs.

The Country Coordination Mechanism (CCM) Montenegro at their meeting in October 2011 accepted the withdrawal of IPH candidature for PR1 in Phase II of the program. The IPH requested to withdraw due to uncertainties about the financial position of the health sector during the transitional arrangements linked with reforms in the health sector and of the government financial system. Given these uncertainties, the IPH requested that UNDP continue in the role of PR for the government part of the program in Phase II.

During the development of the Phase II application, CCM decided that NGO CAZAS would not be proposed as PR but to be proposed as main SR for the NGO part of the program, i.e. the umbrella SR for the grant component implemented by the NGO sector. Although not very efficient in terms of funds and management structure, this arrangement was proposed by CCM as a way to strengthen CSO capacities.

In order to ensure the proper takeover, UNDP conducted the capacity assessment of NGO CAZAS. This was done by experts from UNDP/GFATM Partnership from New York and Geneva, in July, 2012. The assessment came up with two set of activities that CAZAS should implement in order to successfully take over the role of umbrella SR. In order to secure that the CAZAS will smoothly takeover the role of the umbrella SR, the implementation of the aforementioned activities will be closely monitored by UNDP PIU. However, NGO CAZAS will be subjected to second capacity assessment after 10 months of implementation of Y3 and only upon satisfactory capacity assessment report will take over the new function. Second assessment will be done by LFA.

The Project Implementation Unit (PIU) staff will provide strategic advice and administrative support and is responsible for financial disbursements, controlling and reporting. PIU is composed of a Programme Manager/M&E Specialist, Project Officer and a Programme Assistant.

The PIU will be responsible for: reporting to LFA (Local Fund Agent) and to GFATM Secretariat, in accordance with the Grant Agreement; operational management and staff supervision; financial management; partnership collaboration and coordination; monitoring and supervision of project activities; quality assurance of the services provided and regular reporting to CCM.

The UNDP’s Team Leader for Social Inclusion will provide advisory and operational support to the programme implementation and will have Senior Supplier role as well as Assurance role.

UNDP acts as the Principal Recipient (PR) for this project. As PR, UNDP has been responsible for the financial and programmatic management of GFATM grant, as well as for the procurement of health and non-health products. In all areas of implementation, it provides capacity development services to implementing partners.

The Principal Recipient has the primary responsibility for implementing the goals and objectives of the proposal.

However, sub-recipients may also be used to implement parts of a Global Fund-supported program. Principal Recipient is responsible for assessing the capacity of the proposed sub-recipient to implement program activities.

The PR is also responsible for ensuring that such a sub-recipient has the capacity to carry out the required reporting and monitoring and evaluation activities, in order to collect the necessary data for the program’s progress towards its targets. Once selected, the Principal Recipient should enter into a grant agreement with each sub-recipient. There should be terms and conditions that will enable the Principal Recipient to meet the requirements of the grant agreement that they have signed with the Global Fund. SRs are expected to do quarterly reporting on implementation progress and monthly cash reconciliation towards the PR.

The Local Fund Agent works closely with the Global Fund, and in particular with the relevant Fund Portfolio Manager, to provide the following services:

1. Work performed before the Global Fund signs a grant agreement with the Principal Recipient. This includes assessing the Principal Recipient's capacity to implement the grant, reviewing proposed budgets and work plans and otherwise assisting the Global Fund in grant negotiations.
2. Work performed during program implementation. The Local Fund Agent is contracted to independently oversee program performance and the accountable use of funds (known as Verification of Implementation). This includes reviewing the Principal Recipient's periodic requests for funds, undertaking site visits to verify results and reviewing the Principal Recipient's annual audit report.
3. Work performed with respect to the Phase 2 review. The Local Fund Agent's review of a grant as it approaches Phase 2 (years three to five of the grant's lifespan) is crucial in assisting the Global Fund to make its decision on whether to continue funding beyond the first two years.
4. Work performed with respect to grant closure. When a grant ends, the LFA is involved in assisting the Global Fund with closure of the grant.
5. Ad hoc assignments undertaken at the request of the Global Fund, such as investigations relating to the suspected misuse of funds.

The Local Fund Agent is an important part of the Global Fund's fiduciary arrangements. However, it is not an "agent" in the true sense of the word and is not empowered to represent the Global Fund's views or make decisions regarding grants.

UNDP Backstopping Team: The UNDP Country Office in Podgorica staff will provide strategic advice and administrative support and is responsible for financial disbursements, controlling and reporting. The UNDP Social Inclusion Team Leader will provide advisory and operational support to the project implementation.

**Figure 1: Global Fund Project Organization Structure**

**PIU**

**Project Board**

**CCM**

**Executive (UNDP)**

**Senior Supplier (UNDP)**

**Project Assurance**

(SI Team Leader)

**Project Support (consultants, specialists, etc.)**

**Project Organization Structure**

**Sub-recipients (SRs)**

**GFATM Secretariat**

**LFA**

#

# 5. Monitoring framework and Evaluation

Members of PIU, M&E Specialist in particular, are responsible for regular visit of service delivery spots as well as trainings under the program. Each SRs is visited, at least, twice a year, while each service delivery spot is visited, at least, once a year. After each visit a set of recommendations are prepared and sent to SR. Data verification is done on semi-annual or quarterly basis, depending on the service delivery area. Once a year, it is being conducted also a LFA conducts on-site data verification of randomly selected indicators (selected by LFA) resulting in set of recommendations in regard to data and reporting quality.

There is also a project based supervision of certain part of the programs, such as VCT, which is being done by local experts (internal supervision as continuous process) and external (done by regional expert on annual basis).

At service delivery level each implementing entity (SR) had appointed an M&E focal person, person responsible for data collection, ensuring data quality and reporting. Depending on the implementing entity, those persons should have appropriate skills and qualifications in line with the requirements defined in National HIV/AIDS M&E Plan .

Data collection forms include all relevant parameters to be collected and aggregated such as number of clients covered with the services, number of condoms distributed, number of needles and syringes distributed, number of IEC material distributed, number of people trained etc.

Programme Manager/M&E Specialist is responsible for preparing reports of program results for GFATM, NAC, CCM, MOH and other program stakeholders (semi-annually), secondary verification of all data received from sub-recipients, at least, semi-annually (including verification visits as appropriate), analyzing the program’s M&E data and making recommendations for program adaptation to SRs and CCM and providing guidance and support in all M&E related activities to all SRs. Programme Manager/M&E Specialist will also facilitate field visits by CCM members, National HIV/AIDS Commisssion, donors and other relevant stakeholders. Each field visit will be reported using a standardized field visit report format.

Project monitoring and evaluation will be conducted in accordance with established UNDP and Global Fund policies and procedures. The indicators defined in the Performance Framework of the Grant Agreement will form the basis on which the project‘s monitoring and evaluation system will be built. Progress towards the completion of key results, will be regularly updated in ATLAS.

Over the course of a grant’s life cycle, the Principal Recipient regularly reports to the Global Fund on results achieved against targets, expenditures against budgets, and any deviations from or corrective actions to program activities.

The Local Fund Agent is contracted by the Global Fund to verify the Principal Recipient’s programmatic and financial data, and to evaluate its performance. The Secretariat’s disbursement decisions are, in turn, based on the Local Fund Agent’s recommendation and an internal performance evaluation whereby each grant is assigned a performance rating. Lack of progress triggers a request by the Secretariat for corrective action and may also result in reduced disbursement amounts vis-à-vis the original budget.

* The Principal Recipient regularly reports on the progress to date and requests a disbursement for the next period of implementation. This is done through the submission of a Progress Update/Disbursement Request form on a semiannually basis during the grant life cycle (period of reporting defined within the Performance Framework).
* The Local Fund Agent reviews the Principal Recipient’s programmatic and financial reports, verifies reported data, evaluates performance and makes recommendations to the Global Fund on future disbursements.
* On receipt of the Local Fund Agent-verified Progress Update/Disbursement Request, the Secretariat evaluates the overall performance of the grant and gives it a performance rating. The evaluation is based on the following considerations:
	1. Programmatic achievements – Have programmatic targets been reached?
	2. Financial performance – Are expenditures in line with budgets?
	3. Grant management – Are there issues related to monitoring and evaluation, procurement and/or financial management?

| **Overall grant rating** |
| --- |
| A1 | Exceeds expectations |
| A2 | Meets expectations |
| B1 | Moderate |
| B2 | Inadequate but potential demonstrated |
| C | Unacceptable |

**Annual Audit:**

UNDP‘s Office of Audit and Investigations requires completing an annual audit of the Global Fund programmes in compliance with the Grant Agreement signed with the Global Fund.

As per the requirement of the GFATM, each SRs is annually audited by the independent auditor.

**Mid Term Evaluation:**

A Mid Term evaluation of HIV prevention activities among most at risk groups will be done during the year 1 of the Phase II implementation. The purpose of the evaluation is to assess and evaluate if the project has achieved its goal, objectives and targets and recommend corrective measures if necessary.

#

# 6. Equity and Gender

No specific equity assessment was conducted. However, different aspects of equity have been discussed at the Annual Review Meetings as well as part of the other reports (such as Gender analysis, program reports). These discussions have generally focused on issues of social exclusion amongst most at-risk population groups and the measures needed to address these inequities. For example, gender disparities in providing HIV prevention services to certain population groups, such as IDUs, MSM and RAE youth, were recognized during the implementation period July 2010-December 2011. Measures to address these were contained in the recommendations of the report on “Gender equality in the context of HIV/AIDS” (see below). Equity in access to treatment, care and support services by PLHIV is also reported on.

Although no specific equity assessment was conducted, the following equity dimensions have been discussed and analyzed:

##

## 6.1 Gender

Following the initial evaluation of the Round 9 project proposal, the need to strengthen the gender component at all program levels was identified. Data on gender related to implementing the national response to HIV were missing. For example, gender disaggregated data were available on program recipients but not on health care providers, media, governmental institutions and NGO volunteers and employees. Also, there was no information on the attitudes and practices of institutions and civil society organizations on gender issues and the gender impact on HIV vulnerability amongst target groups. The absence of such data prevented the design and implementation of quality, gender-sensitive programs required by the HIV/AIDS Program within the Round 9 of GFATM Grant.

Remediating actions included:

* Research on “Gender equality in the context of HIV/AIDS” was conducted consisting of a review and analysis of international documents, existing laws, strategies and policies in Montenegro. In addition, information of knowledge, attitude and existing practices in the work of institutions and civil society organizations in relation to gender issues and their impact on HIV vulnerability of target groups was reviewed;
* Based on data and recommendations from the research, experienced gender trainers designed a gender-sensitive training program for judicial institutions, civil servants, medical professionals and NGO representatives;
* 50 representatives of government and NGO sectors were trained in how to develop gender-sensitive national HIV programs and policies.
* An additional 50 representatives from other sectors and 25 media representatives will be trained in a similar program at the end of the first phase.

A Working Group for Monitoring and Implementing Gender Policies has been established and has prepared recommendations for future gender-sensitive actions to institutionalize the principles of gender equity in the response to HIV/AIDS in Montenegro.

In the next phase of the project, existing risks in the area of gender equity will be addressed though active support from the Working Group for Monitoring and Implementing Gender Policies. All program recipients will be expected to include a gender component in all their projects and to undertake an analysis of gender roles among the project target groups.

Working group, with support from an external consultant, will do the analysis of existing training programs aimed at integrating gender issues and implementing gender sensitive trainings/education, particularly in the area of stigma and discrimination.

In order for M&E system to be strengthened, there will be developed an additional set of indicators for monitoring progress and impact of program, policies and activities within the response to HIV epidemics on women, men and transgender persons, which would provide a qualitative and quantitative monitoring and evaluation of HIV/AIDS intervention.

In addition to intense work of the group for monitoring and implementation of gender policies, in the Y4 of Rd 9 HIV program implementation another training for 25 media representatives, aimed at sensitization of general public, and media campaign will be carried out.

In order for the integration of gender based principles in the HIV response in Montenegro to provide complementary results, second phase of the project is strengthened with two two-days trainings for different stakeholders occurring in the Y3 and Y4 (50 medical and social workers, police officers, judicial representatives and NGOs).

In the second phase of the project, there have been envisaged two trainings on Gender equity in context of HIV/AIDS for CCM members and implementers, aimed at strengthening their capacities and developing gender sensitive national HIV/AIDS programs and policies. This activity will be funded from the Government budget.

##

## 6.2 Access to Services by People Living with HIV

No equity assessment for PLHIV has been conducted. Yes it is recognized that there are issues to be address related to equal access and availability of health and psycho-social support services for PLHIV.

 In the period 1989 to the end of 2011 a total of 128 PLHIV persons were registered. As of March 2012, 42 PLHIV are being treated and an additional 26 are being monitored by the Clinic for Infectious Diseases. All PLHIV who need antiretroviral therapy are receiving it. The Health Insurance Fund pays ARV therapy and treatment of opportunistic infections, diagnostics and monitoring of HIV status for all PLHIV who are citizens of Montenegro. However, patients and their partners/families do not have access to a developed system of psycho-social support to enable them to make informed decisions to initiate ARV therapy, accept the diagnosis, decide with whom and when to share information about their HIV status and other issues related to their social life and well-being. The only psycho-social support services available are those provided within the VCT Center in IPH and the newly established PLHIV NGO.

PLHIV can receive psycho-social support in Mental Care Centers (part of Primary Health Care Centers) if they are referred by the infectologist or personal chosen doctor. However, these services are not being used (according to some PLHIV or their partners/family members claims) due to the fear of discrimination or disclosure of HIV status. Doctors who prescribe and monitor the effects of the ARV therapy do their best, but additional experts (psychologists, nutrition specialists, chosen doctors) need to be trained in psycho-social support so PLHIV are fully aware of the health and social consequences of living with HIV.

Concerns remain over confidentiality of data relating to PLHIV and this may delay people seeking HIV testing. In the health information system at the primary health care level, the type of infection or disease is recorded next to the person’s name so the diagnosis is visible to all medical workers and administrative staff who can access medical records. .

Complaints have been made by PLHIV relating to discrimination in health and educational institutions But these have not been systematically analyzed and acted upon. To the date, no research with a valid sample has been conducted, which would provide information on equal and fair access to services for PLHIV. It is therefore planned to conduct research among PLHIV to identify their needs for health care provision, and their perception of discrimination by service providers and the general population. This survey would enable the following key indicators defined in the National M&E Plan to be obtained in order to measure the quality of access to service to PLHIV:

1. Percentage of PLHIV who are satisfied with social relations, support and acceptance in their environment

2. Percentage of PLHIV who are receiving the therapy (HAART) in a correct manner in line with the therapy protocol in the last month (adherence to and following the therapy)

3. Percentage of PLHIV who use services provided by NGOs in the last 12 months

4. Percentage of PLHIV using condoms during last sexual intercourse (oral, vaginal or anal) with their permanent partner

5. Additional indicators regarding PLHIV experience of discrimination due to HIV status within health institutions and by other service providers.

##

## 6.3 Roma, Ashkalia and Egyptian(RAE) population

A census was conducted in 2008 among the Roma, Ashkalia and Egyptian (RAE) by the Montenegrin Bureau for Statistics (MONSTAT) in cooperation with the National Roma Council and Coalition of Roma NGOs– Roma circle. The census determined that there are 11,001 RAE persons, both native and displaced from Kosovo, now living in Montenegro.

The Law on Rights and the Law on Rights and Freedoms of Minorities (Official Gazette of Montenegro 31/06, 51/06, 38/07) introduced affirmative action to enhance the political representation and employment of minorities, and to support their educational preferences. The Law on Rights and Freedoms of Minorities only gives rights to those members of minorities with Montenegrin citizenship, which excludes the Kosovo RAE and other RAE with unresolved citizenship status. The survey revealed that only 75% had Montenegrin citizenship at the time and 11.1% had applied for it. The new Montenegrin Law on Citizenship (Official Gazette of Montenegro 28/2011) and the accompanying regulations pose numerous obstacles for the RAE in obtaining citizenship, as many lack personal documents. RAE NGOs estimate that about 25% of the RAE lack personal documents.

Montenegrin participation in the Decade of Roma Inclusion 2005-2015 resulted in adopted National Strategy for Improving the Position of RAE population in Montenegro 2008-2012 and the National Action Plan for the Decade of Roma Inclusion 2005-2015 with the goal to combat all types of discrimination and inequality that affect the RAE population.

According to the National Human Development Report (NHDR) 2009 (Source: UNDP/ISSP Social Exclusion Research 2008), in 2008, the RAE as a group still remain more exposed to poverty and social exclusion than any other vulnerable groups covered by the report. The poverty rate of the RAE population was 36%, with 14% of RAE households being socially excluded. The RAE also noted considerable tension between the rich and the poor (including within the RAE) in Montenegro. The RAE graded their level of life satisfaction at 5.38 (on a scale 1-10), compared to the national average of 6.31. Their financial situation was also perceived to be poor: as many as 65% of RAE households experienced difficulty covering their monthly expenses, compared to 49% of average Montenegrins in the same situation.

There are several reasons why RAE experience extreme exposure to poverty and social exclusion: no or a low level of formal education, high unemployment especially among RAE women, and a high level of prejudice towards them. The NHDR refers to the low percentage (17%) of RAE population engaged in some type of gainful activity with a significant gender gap – 84% men and 16% women in paid employment. Access to the labor market is particularly constrained due to their low level of educational attainment.

All levels of education, from pre-school to university, are officially accessible to the RAE (40% have no formal education and many RAE are illiterate). However, but many RAE children need additional inclusive educational assistance (Roma teachers, educational counselors, education of RAE parents on importance of education, etc) to encourage them to attend and remain in school. The school dropout rate among RAE children is high.

Due to their low education levels and harsh living conditions RAE women tend to marry early, often an arranged marriage, and have numerous pregnancies. Some still deliver their children at home and take care of the old and disabled members of the family. RAE women rarely visit the gynecologist (75% of respondents), which endangers their health and can additionally impact the mortality rates at birth.

Long-standing illnesses affect 13% of the community, while more than a third of the surveyed population has a disability (often related to their poor living conditions) that prevents them from working to their full capacity. The barriers in accessing affordable housing faced by the RAE are significant and only 38% own their houses, while 50% live in illegally built structures in the suburbs.

The RAE have limited access to social welfare support systems, due to both their illiteracy and their lack of Montenegrin citizenship. The existing policy recognizes this problem, and one of the major goals of the National Strategy for Improving the Status of Roma Population in Montenegro is to provide the RAE with easier access to the social and child welfare network. In 2008 UNICEF conducted research into HIV risk behavior amongst RAE youth and found that some young RAE men were engaged in HIV-risk behavior in the form of unprotected sex with other males.

##

## 6.4 Access to services by most at-risk populations

Montenegrin NGOs have had considerable success in increasing access to services by IDUs, MSM and female SWs. Through intensifying outreach work and establishing Drop-in Centers a total of 794 IDUs have been reached, 409 MSM, and 173 SWs. Outreach has been directed towards RAE and 3,020 have been reached. Work within prisons has reached 618 prisoners and 2, 278 merchant marines can been covered by outreach activities and the Counselling Centre in Kotor.

Despite this progress, the number of MSM reached by HIV prevention services remains low due to the intense stigma and discrimination against this group. On April 08, 2012 the LGBT Forum Progress filed a claim to the Police authorities against a former police officer from Niksic who made violent and death threats towards the members of the LGBT population through the social network site Facebook. He claimed that LGBT deserve to be beaten, tortured, tied down naked and burned to death. Since the launch of the public work of the LGBT Forum Progress in February 2011, the NGO has filed forty claims to the Police and State Prosecutors for various misdemeanours and criminal acts committed at the expense of members of the LGBT population. (www.lgbtprogres.me). Such prevailing attitudes make it an extremely hostile environment for MSM and NGOs working with them. This profoundly affects their access to HIB prevention, treatment, care and support services.

##

## 6.5 Geographical disparities

There are regional disparities in the availability of services as for the MARPS as well as for the PLHIV and general population. In northern Montenegro, only one (Berane) out of 11 municipalities is covered with the outreach HIV prevention services for IDUs implemented by the NGO CAZAS. When it comes to outreach prevention services provided to RAE youth, 80% of the clients covered were from central region (Podgorica and Niksic) while only 11% RAE youth covered with the services were from the north of Montenegro(Berane and Bijelo Polje). As far as for the services provided to SWs services are provided at the coastal region (Bar as a harbor town) and Podgorica as capital. For the MSM population services are provided also in Podgorica and at the coastal region during the summer season.

In northern Montenegro there is lower awareness in regard to HIV/AIDS, higher level of stigma and discrimination towards all population groups different from the mainstream as well as for the absence of service provision or with very limited services (VCT in Berane, Bijelo Polje and Pljevlja, MMT in Berane) should be subject of scale up of all the outreach services aimed to reach moat at risk populations in Montenegro. There has also been noted the higher level of reluctance to introduction of HIV specific services in the northern part of Montenegro even among health professionals, such as delayed opening of the MMT center in Berane, lower HIV testing in the VCTs in Berane, Bijelo Polje and Pljevlja.

During the phase II, scale up of outreach activities towards north of Montenegro has been envisaged.

# 7. Legal Context

This document, together with the CPAP signed by the Government and UNDP, by reference constitutes together a Project Document as referred to in the SBAA and all CPAP provisions apply to this document. The CO will play the role of implementing partner/executing agency and the overall project will be executed in DIM modality within existing UNDP internal rules and procedures by the CO.

* The overall project execution, implementation and the project administration
* Maintaining the project’s conceptual clarity and comparable standards regarding data collection, monitoring, project evaluation at different stages etc.
* Exchange of information, knowledge codification and application
* Consultancy and expert support necessary at phases of the project implementation
* Maintaining working contacts with the partners
* Application of the commonly agreed standards and procedures regarding data collection
* regular monitoring and reporting

#

# Annex 1: Risk Analysis

|  |  |  |
| --- | --- | --- |
| **Project Title: Scale up of the national response to HIV/AIDS among most at risk populations in Montenegro** | **Award ID: 00060348** | **Date: 19/10/2012** |
| **#** | **Description** | **Date Identified** | **Type** | **Impact &****Probability** | **Countermeasures / Management response** | **Owner** | **Submitted, updated by** | **Last Update** | **Status** |
| 1 | Fulfillment of the financial commitment of the Government of Montenegro related to financing of National Response to HIV/AIDS in Montenegro  | 08/08/2012 | Institutional | Due to economic crisis and constant shrinking of the state budget it could happen that the Government is not able to cover its part of the financing of the HIV response, which is strictly defined.*Medium* | Each year, UNDP needs to obtain the report from the Government on their participation in the a/m financing. This report is then forwarded to GFATM. | UNDP, CCM, GoM | Programme Manager |  |  |
| 2 | Changes in management of GO implementing partners and relevant ministries caused by parliamentary elections  | 15/09/2012 | Institutional | Potential changes in the management structure of the ministries and institutions involved in the programme, such as MoH, PHC centers, IPH, State Prison. *Medium* | No influence by the UNDP can be expected. However, if changes occur, PIU will immediately approach the new management in order to establish contacts in order to get them familiarized and aware of the HIV response. | UNDP, CCM, PM | Programme Manager |  |  |
| 3 | Staff turnover in NGO CAZAS | 08/08/2012 | Organizational | Capacity of CAZAS depends on personnel engaged. Given the high turnover of staff within the organization, the capacity may go significantly up and down and will substantially influence the pace and quality of implementation.*Medium* | UNDP PIU insisted on budgeting remuneration for CAZAS staff involved in GFATM programme implementation, which is higher than the national average and which hopefully would be an incentive for staying with CAZAS. | UNDP, CAZAS, PM | Programme Manager |  |  |
| 4 | Coordination and communication within the NGO sector.  | 08/08/2012 | Organizational (execution capacity) | NGOs see each other as competitors for funds and there is no clear distinction of areas of work. Since NGO CAZAS has been planned as an umbrella SR for NGO sector, a correct communication and coordination is critical for the success of such an implementation arrangement. *Medium* | UNDP PIU will closely monitor and support establishing of a proper communication and coordination between CAZAS and other NGOs. | UNDP, NGO CAZAS and other NGOs | Programme Manager |  |  |
| 5 | Coordination among the public sector and NGOs. | 08/08/2012 | Organizational  | Different perspectives on how to reach certain goals may lead to deeper misunderstands and delays in programme implementation.*Low* | UNDP PIU will monitor and facilitate coordination between sectors.  | UNDP, GO and NGO sector | Programme Manager |  |  |
| 6 | Sustainability of NGO part of the programme once the GFATM funding ends. | 08/08/2012 | Financial | Certain minor NGOs are completely financed from the GFATM funds.*Medium* | UNDP is fully committed to support capacity building of NGOs working as SRs in terms of project development and fund raising as well as to advocate within Government structures in terms of financing NGO services.  | UNDP, CCM | Programme Manager |  |  |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Annex 2 : Annual Work Plan** |            |  |  |  |  |  |  |  |  |  |
|

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PLANNED ACTIVITIES** | **EXPECTED OUTPUTS** | **TIMEFRAME** | **RESPONSIBLE PARTY** | **PLANNED BUDGET** |
| *List activity results and associated actions*  | *And baseline, indicators including annual targets* | Start | End | Funding Source | Budget Description | Amount in EUR |
|   |   | Year 1 | Year 2 | Year 3 |
| **ACT 1.1 Behavior change communication-community outreach:IDUs** | Output: | 1-Jul-12 | 30-Jun-15 | NGO CAZAS, | GFATM | 72100 Contractual services - Companies |  90,890.00  |  95,240.00  |  90,240.00  |
| **1 Number of IDUs reached by HIV prevention services** | NGO Juventas, |
| ***Baseline1****: 794* | PHCC Podgorica |
| ***Targets ( year 1):540***  |   |
|   |   |
| ***Targets (year 2):574*** |   |
| . |   |
| ***Targets ( year 3):647***  |   |
|  |   |
| ***Output 2:*** |   |
| ***2 Number of IDUs on methadone substitution therapy*** |   |
|   |   |
| **Baseline 2: 213** |   |
| ***Targets ( year 1):152***  | UNDP | GFATM | 72330 Medical products |  21,000.00  |  21,000.00  |  21,000.00  |
|   |
| ***Targets ( year 2):208***  |
|  |
| ***Targets ( year 3): 290*** |   | GFATM |   |   |   |   |
|  | UNDP | GFATM | 75100 Facilities and Administration |  7,832.30  |  8,136.80  |  7,786.80  |
|  |   |   | **TOTAL** |  **119,722.30**  |  **124,376.80**  |  **119,026.80**  |
| **ACT 1.2 Behavior change communication-community outreach:MSM** | Output: | 1-Jul-12 | 30-Jun-15 | NGO Juventas | GFATM | 72100 Contractual services - Companies | 48,690 | 48,050 | 48,690 |
| Number of MSM reached by HIV prevention services |
| ***Baseline****: 409* |
|  |
| ***Targets ( year 1):400*** |
|   |
| ***Targets ( year 2):470*** |
| . |
| ***Targets ( year 3):520*** |
|   |
|   |
|   |
|   |
|   |
|   |   |   |   |   |   |   |
|   | UNDP | GFATM | 75100 Facilities and Administration | 3,692 | 3,647 | 3,692 |
|   |   |   | **TOTAL** | **52,382** | **51,697** | **52,382** |
| **ACT 1.3 Behavior change communication-community outreach:FSWs** | Output: | 1-Jul-12 | 30-Jun-15 | NGO Juventas | GFATM | 72100 Contractual services - Companies | 66,510 | 68,190 | 68,190 |
| No of SW reached by HIV prevention services |
| ***Baseline: 173*** |
|  |
| ***Targets ( year 1):105*** |
| . |
| ***Targets ( year 2):122*** |   |   |   |   |   |   |
|   | UNDP | GFATM | 75100 Facilities and Administration | 4,656 | 4,773 | 4,773 |
| ***Targets ( year 3):141*** |   |   | **TOTAL** | **71,166** | **72,963** | **72,963** |
| **ACT 1.4 Behavior change communication-community outreach:merchant marines** | Output: | 1-Jul-12 | 30-Jun-15 | NGO Zastita,PHCC Kotor | GFATM | 72100 Contractual services - Companies | 24,540 | 24,540 | 24,540 |
| No of Mearchent Marines reached by HIV prevention services |
|   |
| ***Baseline: 2,278*** |
|  |
| ***Targets ( year 1): 1,300*** |
|   |
| ***Targets ( year 2): 1,300*** |
|   |
| ***Targets ( year 3):1,300*** |
|   |   |   |   |   |   |   |
| Baseline not included. | UNDP | GFATM | 75100 Facilities and Administration | 1,718 | 1,718 | 1,718 |
| Program indicator #14, National M&E Plan. |   |   | **TOTAL** | **26,258** | **26,258** | **26,258** |
| **ACT 1.5 Behavior change communication-community outreach:poor RAE** | Output: | 1-Jul-12 | 30-Jun-15 | NGO CAZAS | GFATM | 72100 Contractual services - Companies | 15,340 | 20,340 | 15,540 |
| No of poor RAE youth reached by HIV prevention services |
| ***Baseline: 3,020*** |
|  |
| ***Targets ( year 1): 1,400*** |
|   |
| ***Targets ( year 2): 1,400*** |
|   |
| ***Targets ( year 3): 1,400*** |
|   |   |   |   |   |   |   |
| Baseline not included. | UNDP | GFATM | 75100 Facilities and Administration | 1,074 | 1,424 | 1,088 |
| Program indicator #26, National M&E Plan. |   |   | **TOTAL** | **18,340** | **24,332** | **19,196** |
| **ACT 1.6 Behavior change communication-community outreach:prisoners** | Output: | 1-Jul-12 | 30-Jun-15 | NGO Juventas | GFATM | 72100 Contractual services - Companies | 8,190 | 8,190 | 8,190 |
| No of prisoners reached by HIV prevention services |
| ***Baseline: 618*** |
| ***Targets ( year 1): 400*** |
|   |
| ***Targets ( year 2): 400*** |
|   |
| ***Targets ( year 3): 400*** |
|   |   |   |   |   |   |   |
| Baseline not included. | UNDP | GFATM | 75100 Facilities and Administration | 573 | 573 | 573 |
| Program indicator #11, National M&E Plan. |   |   | **TOTAL** | **8,763** | **8,763** | **8,763** |
| **ACT 1.7Voluntary counseling and testing**  | Output: | 1-Jul-12 | 30-Jun-15 | IPH | GFATM | 72100 Contractual services - Companies | 15,365 | 21,930 | 6,600 |
| No of clients tested and counseled in 8 VCT |
| No of Health professionals trained on Basic and Advance VCT Training |
| No of health professionals trained on training in STI testing and counseling |
| ***Baseline:*** | UNDP | GFATM | 72330 Medical products | 6,000 | 6,000 | 6,000 |
| ***Targets ( year 1): 15 Health professionals trained on Basic And Advanced VCT Training*** |   |   |   |   |   |
| ***Targets ( year 2): 30 Health Professionals trained on training in STI testing and counseling*** | GFATM | 75100 Facilities and Administration | 1,496 | 1,955 | 882 |
| ***Targets ( year 3):*** |   | **TOTAL** | **22,861** | **29,885** | **13,482** |
| **ACT 1.9 Condom Distributions** | Output: | 1-Jul-12 | 30-Jun-15 | UNDP | GFATM | 72342 Condoms | 16,200 | 16,200 | 16,200 |
| No of condoms and lubricants procured |
| ***Baseline:*** |
| ***Targets ( year 1): 120,000 condoms and 15,000 lubricants procured*** |   |   |   |   |   |
| ***Targets ( year 2): 120,000 condoms and 15,000 lubricants procured*** | GFATM | 75100 Facilities and Administration | 1,134 | 1,134 | 1,134 |
| ***Targets ( year 3): 120,000 condoms and 15,000 lubricants procured*** |   | **TOTAL** | **17,334** | **17,334** | **17,334** |
| **ACT 2.1 Care and support to PLHIV** | Output: | 1-Jul-12 | 30-Jun-15 | NGO Montenegrin HIV Foundation, | GFATM | 72100 Contractual services - Companies | 27,405 | 25,940 | 17,725 |
| Number of PLHIV that received psychosocial support | Clinical Centre of Montenegro |
| No of health professional trained |   |
| ***Baseline: No of PLHIV 60*** |   |
| ***Targets ( year 1): Number of PLHIV that received psychosocial support 60; No of health professionals trained 60*** |   | GFATM | Total Activity  | 27,405 | 25,940 | 17,725 |
| ***Targets ( year 2): Number of PLHIV that received psychosocial support 65; No of health proffesionals trained 40*** | UNDP | GFATM | 75100 Facilities and Administration | 1,918 | 1,816 | 1,241 |
| ***Targets ( year 3): Number of PLHIV that received psychosocial support 75;No of health professionals trained 60*** |   |   | **TOTAL** | **29,323** | **27,756** | **18,966** |
| **ACT 3.2 Strengthening the capacity of all relevant stakeholders in gender issues**  | Output: No of people trained in training regarding gender sensitive issues for GO and NGO organizations | 1-Jul-12 | 30-Jun-15 | NGO SOS | GFATM | 72100 Contractual services - Companies | 6,820 | 1,260 | 4,760 |
| No of media campaign implemented |
| ***Baseline:*** |
| ***Targets ( year 1): One campaign designed and implemented*** |
| ***25 people trained in training regarding gender sensitive issues for GO and NGO organizations*** |
|  |
| ***Targets ( year 2):*** |   |   |   |   |   |   |
|  |   | GFATM | 75100 Facilities and Administration | 946 | 88 | 333 |
| ***Targets ( year 3): 25 people trained in training regarding gender sensitive issues for GO and NGO organizations*** |   |   | **TOTAL** | **14,466** | **1,348** | **5,093** |
| **ACT 4.1 Strengthening HIV surveillance among most at risk population** | Output: No of bio-behavioral survey conducted | 1-Jul-12 | 30-Jun-15 | IPH | GFATM | 72100 Contractual services - Companies | 51,770 | 99,575 | 39,300 |
|  Evaluation of program activities |
|   |
| ***Baseline:*** | UNDP | GFATM | 71200 International Consultants | 9,000 |   |   |
| ***Targets ( year 1): Bio- behavioral survey among merchant marines, Bio-behavioral survey among RAE population*** | GFATM | 72330 Medical products |  3,150  |  18,725  |  2,700  |
|  |   |   |   |   |   |   |
| ***Targets ( year 2): Bio- behavioral survey among IDU-s,Bio- behavioral survey among MSMs*** | GFATM | 75100 Facilities and Administration | 3,624 | 6,970 | 2,751 |
| ***Targets ( year 3): Bio- behavioral survey among SW*** |   | **TOTAL** | **67,544** | **125,270** | **44,751** |
| **ACT 5.1 Increasing capacity and coordination of a focused response to HIV among most at risk population** | Output: Establishment of NGO umbrella organization | 1-Jul-12 | 30-Jun-15 | NGO CAZAS | GFATM | 72100 Contractual services - Companies | 45,850 | 55,450 | 55,450 |
|
|
| GFATM | Total Activity  | 45,850 | 55,450 | 55,450 |
| GFATM | 75100 Facilities and Administration | 3,210 | 3,882 | 3,882 |
|   | **TOTAL** | **49,060** | **59,332** | **59,332** |
| **ACT 6.1 PR1 Programme management costs** | Output: Programme management costs | 1-Jul-12 | 30-Jun-15 | UNDP | GFATM | 71400 Contractual Services-Individual | 67,200 | 67,200 | 67,200 |
| GFATM | 71600 M&E related travel | 4,500 | 4,500 | 4,500 |
| GFATM | 73120 Utilities | 16,800 | 16,800 | 16,800 |
| GFATM | Total Activity  | 88,500 | 88,500 | 88,500 |
| GFATM | 75100 Facilities and Administration | 6,195 | 6,195 | 6,195 |
|   | **TOTAL** | **94,695** | **94,695** | **94,695** |
|   | TOTAL |   |   |   |   |   | **560,755** | **632,803** | **537,060** |

 |            |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |