**United Nations Development Programme**

**Country: Montenegro**

**Project Document**

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| **Project Title** | Scale up of response to HIV 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)* | Prevention of HIV transmission among most-at-risk populations  Improvement of quality of care and support to PLHIV  Creation of a supportive environment for HIV prevention and care  Strengthening the HIV surveillance system among most-at-risk populations  Increasing capacity and coordination of a focused response to HIV among most-at-risk populations |
| **Expected Output(s):**  *(Those that will result from the project and extracted from the CPAP)* |  |
| **Implementing Partners:** | Institute for Public Health (IPH), Primary Health Care Center Podgorica, Primary Health Care Center Kotor, Bureau for Education, State Textbook Publishing Agency, NGO CAZAS, NGO Juventas, NGO Montenegrin HIV Foundation, NGO Montevita, NGO Zastita, NGO SOS Podgorica, NGO Otvori Srce, NGO Mladi i Zdravlje, NGO Association of Private Dentists of Montenegro |
| **Responsible Parties:** | UNDP CO Montenegro |

**Brief Description:**

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 and members of the RAE minorities. 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 deleted from the Request for Renewal.

The most important elements that contributed to the successful achievements of the planned targets were establishing the Drop-in Centers for IDUs, SWs and MSM 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 Roma, Ashkalia and Egyptian (RAE) youth, merchant marines and prisoners. Strengthening the VCT network, established under the Round 5 HIV Grant, consists 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 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 and the Drop-in and Counseling Centers for IDUs, MSM, SWs and RAE. 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. 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.

YYYY AWP budget: 2012 - 2015

Total resources required 1,907,760

Total allocated resources: 1,907,760

Regular

* Other:
  + Donor \_\_\_\_00327
  + Donor \_\_\_\_\_\_\_\_\_
  + Donor \_\_\_\_\_\_\_\_\_
  + Government \_\_\_\_\_\_\_\_\_

Programme Period: July 2012 – July 2015

Key Result Area (Strategic Plan): \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Atlas Award ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Start date: July 1, 2012

End Date June 30, 2015

LPAC Meeting Date September, 2012

Management Arrangements DIM

Agreed by UNDP:

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| SECTION 1: SUMMARY OF REQUEST |

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| 1.1 | General Program Information |

Applicant CCM Montenegro

Country Montenegro

Component HIV/AIDS

Component Implementation Period 01/07/2012-30/06/2015 Cut-off date December 31st, 2011

Renewal date 01/07/2012

Current Phase/Implementation Period Currency:

Next Phase/Implementation Period Currency:

|  |  |  |
| --- | --- | --- |
| **Principal Recipient (PR) Name** | **Grant/SSF Number** | **Grant/SSF start date** |
| **PR 1 UNDP CO Montenegro** | **MNT-910-G03-H** | **01/07/2010** |

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| 1.2 | Summary of CCM Request for Renewal |

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| 1.2.1 | Summary of Request |

Please provide a brief overview of the current progress toward goals and objectives of the proposal as well as main observations, the recommendations and the rationale for the Request for Renewal.

Progress under Round 9 Phase I of program implementation has been rated as “A1”. The average achievement rate for twelve indicators as of the cut-off date (31/12/2012) was 111.4%, while the average performance rate for Top Ten indicators (including indicators related to training health and non-health staff) was 110.6%.

The Program demonstrated the potential of its impact through the achievement of impact and outcome indicators revealing low HIV prevalence among all injecting drug users, IDUs (0.3%, BSS 2011) and sex workers, SWs (0.76%, BSS 2008), as well as the potential for a possible concentrated epidemic among men who have sex with men, MSM (4.5%, BSS 2011).

The most important elements that contributed to the successful achievements of the planned targets were establishing the Drop-in Centers for IDUs, SWs and MSM 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 Roma, Ashkalia and Egyptian (RAE) youth, merchant marines and prisoners. Strengthening the VCT network, established under the Round 5 HIV Grant, consists 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 members of most at-risk populations were counseled and tested for HIV in 2011, out of them nine were found to be HIV-positive).

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 and members of the RAE minorities. 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 deleted from the Request for Renewal.

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 and the Drop-in and Counseling Centers for IDUs, MSM, SWs and RAE. 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. 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.

Outstanding activities from GFATM Round 6 Tuberculosis (TB) program will be included under government HIV/TB collaborative activities and ten health professionals from Departments for Lung Diseases within Primary Health Care Centers will be trained in VCT.

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| 1.2.2 | Proposed Changes in Programmatic, Budgetary and Implementation Arrangements |

**1. Are you proposing any changes in the Implementation Arrangements of the grant/program?** Yes (delete as applicable)

If yes, please indicate the nature of the change.

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| --- | --- | --- |
| **Reallocation of funds between PRs** | **Changes in institutional arrangements** | **Budgetary changes** |
| No (delete as applicable) | Yes (delete as applicable) | Yes (delete as applicable) |

Please describe and provide rationale and justification for each proposed change.

Changes in institutional arrangements

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.

After receipt of the GFATM invitation to apply for Phase II funds with the allowed upper ceiling of 75% of the original budget, the CCM decided to reconsider the implementation arrangements for the Phase II period. In light of resource constraints and the possible insufficient capacity of the proposed second PR, NGO CAZAS, the possibility of requesting the UNDP to stay as the sole PR was brought up. At the CCM meeting in March 2012 the NGO CAZAS decided to withdraw its candidature for PR2 and requested to be the main sub-recipient for programs implemented by the NGO sector. This implementation model permits CAZAS to further develop its capacity in program management and management of sub-recipients. This arrangement also reduces overall project costs through having one management unit and reduced transaction costs (in terms of reporting, field monitoring). This would ultimately ensure better coordination of the activities. It was therefore proposed that UNDP should remain the PR for the overall program and this was accepted unanimously by all CCM members.

Budgetary changes

In line with the new Request for Renewal submission requirements for Montenegro as an Upper Middle Income Country, the budget was reduced to 75% of the original budget and has become more focused to be within the threshold for the income classification of the country.

If you are adding new PR(s) to the grant/program, please provide name(s).

No

If you are discontinuing any PR(s) in the grant/program, please provide name(s).

No

**2. Are you proposing any changes to the scope and/or scale of the performance framework of the grant/program?**  Yes (delete as applicable)

If yes, please describe and provide rationale and justification for the proposed change.

The Mid-term Review and the GFATM both recommended that future HIV prevention activities should be strictly focused on most at-risk population groups and treatment, care and support of people living with HIV. This is in accordance with the epidemiological evidence about the main modes of HIV transmission in a low prevalence country and the GFATM threshold based on the income classification of the country.

As a result, proposed activities under SDA 1.8 on Youth education and healthy life styles dealing with HIV prevention amongst the general population of young people have been removed. However, a focus on young people most at-risk of HIV will be maintained as a component of activities focusing on most at-risk population groups. Linked with this more focused approach, two knowledge, attitudes and behavior (KAB) surveys (under SDA 4.1 on Information system and Operational research) have also been removed from the proposal: one among young people aged 15-24 years planned for Year 4 and one among the general population (aged 15-59 years) aimed to measure level of HIV related knowledge and stigma planned for Year 5.

Consequently, output indicator #6 on the percentage of young people aged 15-24 years who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission and coverage indicator #8 on the number of students reached by Healthy Education Life Styles education (in primary and secondary schools) have been removed from the performance framework.

One new impact and one new outcome indicator have been added to the performance framework: HIV prevalence among Roma, Ashkalia and Egyptian (RAE) youth and the percentage of RAE youth who correctly identify ways of preventing sexual transmission of HIV. These indicators will be measured through a bio-behavioral survey among RAE youth envisaged to be conducted in Year 3.

Round 6 of the GFATM grant on Tuberculosis (TB) is due to complete program implementation in June 2012. The CCM has decided that part of the TB/HIV collaborative activities such as the development of a protocol for HIV/TB collaborative activities and training of pulmonary diseases specialists in Voluntary Counseling and Testing (VCT) to be included in the revised Round 9 grant proposal. This would support the national health system during the transitional period after completion of the Round6 TB Grant activities and enable national institutions to be able to assume complete responsibility for the National TB program.

Do the proposed changes entail material reprogramming compared to the original proposal(s)? Yes (delete as applicable)

If yes, please indicate and explain whether the changes affect the entire program or a specific PR.

The proposed changes do not affect the entire program as they are consistent with the epidemiological evidence about population groups most at-risk of HIV and with GFATM and UNAIDS recommendations for a focused approach in low prevalence countries.

The proposed changes are the deletion of two surveys and one component SDA 1.8 on Youth education and healthy life styles. This component mainly included promotional activities on Healthy Life Styles in secondary schools in the academic 2012/13. All the major activities concerning development of the Manual for Teachers and Textbook for children as well as training of teachers have already been accomplished during the Phase I implementation, so the removal of this component is not likely to have a significant impact on the overall program results. The CCM have decided to send affected school Principals a strong letter of recommendation endorsed by the Ministers of Health and Education to promote the Healthy Life Styles within their schools. It is hoped that this action will mitigate against a reduction in the number of students who choose the subject due to the absence of promotional activities.

The two surveys that have been removed from the proposal are:

A survey among the general population planned for Year 5 to measure the level of stigma amongst the general population as well measure the impact of the stigma-related activities implemented during Round 5 and Round 9 HIV Grants. The removal of this survey will not impact the overall program.

The second survey that has been deleted is a survey among young people aged 15-24 years planned for Year 4 and to measure HIV-related knowledge, attitudes and sexual behavior. This survey would also have shown the effectiveness of activities implemented amongst the general population of young people during the implementation of Round 5 HIV as well as during Phase I of the Round 9 HIV grants.

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| 1.2.3 | | CCM Request for Renewal | | | |
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| **CCM Requested Budget for Renewal** | | | | | |
|  | | | **PR 1[[1]](#footnote-1)** | **PR 2** | **Total Program** |
| a | Adjusted TRP clarified amount for the next Phase/ Implementation Period | | 1,849,425 |  | 1,849,425 |
| *b* | *Total budget requested (after cut-off date to the end of the next Phase/Implementation Period)* | | 2,579,848 |  | 2,579,848 |
| c | * Undisbursed amount at cut-off date | |  |  |  |
| d | * Cash at cut-off date | | 578,513 |  | 578,513 |
| *e* | *= Incremental amount requested* | | 2,001,335 |  | 2,001,335 |
| f | *% of adjusted TRP clarified amount (cannot exceed 100% of adjusted TRP clarified amount)* | | 81% |  | 81% |

Has the CCM taken into account any Board-approved funding limitations? Yes (delete as applicable)

*(Please refer to the CCM Invitation Letter for further details).*

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| SECTION 2: CCM GOVERNANCE |

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| 2.1 | CCM Governance Overview |

Please refer to the CCM Requirements listed in the CCM Request Guidelines.

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| 2.1.1 When was the last Round that the CCM/RCM/sub-CCM applied for funding? Round 9  Was the CCM/RCM/sub-CCM determined compliant with the CCM requirements at this time? Yes (delete as applicable)  If the CCM/RCM/sub-CCM was not compliant when they last applied, please describe what remedial actions were taken by the CCM/RCM/sub-CCM?   |  | | --- | | At the time of the last GFATM application there were 30 CCM members. In accordance with the Rules of Procedures of CCM for implementing and monitoring HIV and TB projects (Attachment 1, Part II, which relates to CCM structure, and Articles 4 and 5, all interested parties from the NGO sector were transparently selected to become members of the CCM (Attachment 54). Minutes of the NGO sector meeting, dated May 27, 2009). For the government sector, members were selected in accordance with Articles 4, 5, 6 and 7 of the Rules of Procedures.  The CCM consists of members of the National HIV/AIDS Commission (Attachment 9, Decision on setting up the Commission from 2010), representatives of United Nations agencies in Montenegro supporting HIV/AIDS activities and programs and other constituency representatives, as per GFATM requirements.  *Attachments:*   1. *Attachment 1.* The Rules of Procedure of National Coordination Body for development and monitoring of implementation of projects in the area of HIV/AIDS and Tuberculosis; 2. *Attachment 9.* Decision on Establishing of National AIDS Commission 2010. 3. *Attachment 54. NGO Meeting Minutes 27\_05\_2009.* | |

**CCMs/RCMs/sub-CCMs should answer questions 2.1.2 and 2.1.3, 2.1.4, and 2.1.5 (not 2.1.6)**

**Non-CCM applicants should proceed directly to question 2.1.6.**

*2.1.2 CCM Membership*

a) When was the last time that changes were made in the CCM/RCM/sub-CCM membership of people living with HIV and people affected by tuberculosis and malaria? Please provide details for those changes, including the current membership of people living with and/or affected by the diseases.

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| The latest changes made to membership of people living with HIV (PLHIV) and Tuberculosis (PLTB) of the CCM occurred at the meeting dated November 21, 2011. At that meeting, attendance of the CCM members was analyzed. In line with Article 10 of the Rules of Procedure of CCM, it was unanimously voted that the membership of a PLTB should be terminated, due to failure to attend at least two meetings in a calendar year,  There has always been a PLHIV as a member of the CCM. Initially, she was proposed by the NGO CAZAS as an individual member (in line with Article 3, Criteria for Candidacy for Appointment of PLHIV in the Rules of Procedures of CCM for implementation and monitoring of HIV/AIDS projects). This was because there was no PLHIV organization at that time. The first PLHIV organization was founded at the end of 2009 (*Montenegrin HIV Foundation*, MHF) and started to work in 2011. As the four-year CCM mandate expires in December 2012 (Article 4 of the CCM Rules of Procedures), it is proposed that the PLHIV organization be put forward to be represented on the CCM and be subjected to the transparent selection process, thereby enhancing the possibility of greater PLHIV representation in the CCM.  The population sub-group most affected by HIV in terms of the number of new HIV infections diagnosed per year is men who have sex with men (MSM). Until recently there was no formally constituted NGO of MSM. However a new NGO called *LGBT* *Progress* has been established of lesbians, gays, bisexuals and transgendered (LGBT) persons and it is expected that they will seek selection to the CCM in December 2012 in accordance with CCM Rules of Procedures (Attachment 16).  The CCM composition has been gradually changing over the last several years by introducing the new members to its core structure. Currently the CCM is composed of health professionals, representatives of government structures, NGO representatives, thus offering a broad forum for discussion on the most pressing HIV/AIDS issues with the most relevant actors in the country. |

b) When was the last time that changes were made in the representation of non-government constituencies (e.g. community based organizations, faith based organizations, private sector, private academic institutions, people living with and/or affected by the diseases, key affected populations) on the CCM/RCM/sub-CCM? Please describe how new members were selected by their own constituencies based on a documented, transparent process developed within each constituency.

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| The last changes to membership of the CCM were made at the meeting on November 21, 2011 at which attendance and participation of CCM members was analyzed. Attached are the minutes which show that eight members were replaced due to retirement, transfer to another job position or death, which caused the relevant institutions to appoint a replacement. Four organizations lost their membership because their representatives were not attending meetings (failing to meet even the minimum request, in line with Article 10) often without providing a written explanation for their absence. Two Ministries (of Internal Affairs and Tourism) failed to reply to membership renewal invitations.  Attached is the list of current CCM members. There were no changes in the representation of the NGO sector. In the course of preparing the application for Phase II of the Round 9 HIV grant, CCM received a verbal request by the new NGOs for LGBT *Progress* and people living with HIV – *Montenegrin HIV Foundation* to be included in the work of CCM. These organizations have been informed about the rules for selection of CCM members and the mandate of the CCM. They have been invited to participate in the CCM work as observers until the new selection process for CCM members planned for December 2012 is announced. |

*2.1.3. Program Oversight*

Does your CCM have an oversight plan which has been approved by the CCM? Yes (delete as applicable)

If no, explain the reasons.

N/A

If yes, describe the oversight activities which are detailed in the plan. How has the CCM been implementing this plan? How does the CCM engage program stakeholders in oversight, including the CCM members and non-members, in particular non-government constituencies and people living with and/or affected by the diseases.

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| In February 2011 the CCM established a Working Group for Program Oversight consisting of five members (four from the government sector and one from non-government constituencies, Attachment 10). The Working Group for Program Oversight has a clearly defined mandate as described in the CCM Document “The rules of procedure of the Country Coordinating Mechanism on the oversight regarding development and implementation of GFTAM grants in Montenegro”(Attachment 5).  An annual Oversight Plan has been developed by the Working Group (Attachment 47) and the Program Implementation Unit (PIU) regularly provides an update of the status of program implementation at each CCM meeting. The PIU also produces comprehensive semi-annual reports on programmatic and financial achievements for the CCM before they are submitted to the GFATM as part of the Progress Update Report. This ensures that the CCM is familiar with all programmatic achievements, challenges and issues as well as provided with financial and procurement reports.  The Oversight Plan is regularly adjusted in accordance with the reports on programmatic achievements presented to the CCM. This ensures effective oversight of any problematic areas in program implementation and provides a mechanism to resolve problems or to provide technical support as needed.  In particular, the Oversight Plan for 2011 included visiting of all eight Centers for Voluntary Counseling and Testing (VCT) (Attachment 30) as two out of three Centers in the north of Montenegro had reported managerial obstructions to program implementation. The Methadone Maintenance Treatment (MMT) Center in Berane was also visited due to delays and slow progress in providing MMT services (Attachments 29, 27).The first visit to VCT Centers was aimed to check the quality of services provided, compliance with the reporting procedures and implementation of the Unique Identifier Code (UIC). The visit was also used to advocate with managerial staff the importance of the VCT program as an integral part of the national HIV response.  The second visit to the MMT Center in Berane was initiated by the PIU since performance of this Center was poor (below target) and low number of clients was affecting the overall Grant performance and threatened to endanger the overall Grant rating. At the CCM meeting in July 07,2011 (Attachment 12) it was agreed that that the Director of the Institute of Public Health (Dr. Mugosa) and the CCM Vice-President together with two other members of the Oversight Working Group should undertake the visit.  In February 2012 upon the presentation of GFATM Progress Update Report covering the period July to December 2011, the PIU stressed that low coverage of PLHIV with psycho-social support services (one of the top 10 indicators for the program could jeopardize the overall performance of the Grant regardless of excellent performance in all other areas. The CCM was requested to take concrete steps to identify reasons for the low performance by the implementing partner (the NGO CAZAS) and to propose actions for improvement. Based on the PIU recommendation, the Oversight Working Group including the CCM member living with HIV, visited the NGO CAZAS. Their findings concluded that the NGO CAZAS did not have sufficient capacity to ensure adequate coverage according to the performance framework and that future psycho-social support activities should be performed by the NGO consisting of PLHIV representatives. |

Please include the document with the CCM Request.

*2.1.4 Managing Conflicts of Interest and Constituency Engagement*

How does your CCM manage conflict of interest among its members and/or grant implementers who sit on the CCM? What measures are in place to ensure the CCM’s conflict of interest section from your CCM governance documents is applied? How is the management of conflict of interest documented by the CCM?

The CCM Montenegro has produced an “Ethics and Conflict of Interest Policy” which regulates the management of conflict of interest of CCM members (Attachment 6). All situations where conflict of interest was noted have been recorded in the CCM meeting minutes (for example, voting on UNDP being nominated as the Principal Recipient, voting on changes to implementation arrangements for dual track financing, and the change of status of the NGO CAZAS from the proposed PR for the Phase II to main sub-recipient for NGO part of the program.

Please include the document(s) with the CCM Request.

2.1.5 In case of any proposed changes in Programmatic, Budgetary and Implementation arrangements (1.3.2), please describe the documented and transparent processes followed to ensure participation of all constituencies represented on the CCM/RCM/sub-CCM (including members and non-members) in the development and approval of these changes. Please describe the process that was used to ensure effective management of any potential conflict of interest that might have affected this process.

All relevant changes in programmatic, budgetary and implementation arrangements have been discussed at CCM meetings, meetings of CCM Working Groups and at the Annual Review Meeting held in October 2011. All decisions have been made in accordance with the CCM voting procedure with respect to all aspects of the Conflict of Interest Policy (Attachment 6).

**Non-CCM applicants only**

2.1.6 Please refer to the original proposal(s) and provide a brief update on the status of exceptional conditions for which you were last approved as a non-CCM applicant (maximum 1/2 page).

N/A

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| SECTION 3: COUNTRY CONTEXT |

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| 3.1 | Epidemiological situation |

Please describe any changes to the disease epidemiological situation that is likely to affect program implementation or strategies. (Please indicate sources of information)

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| The HIV epidemic in Montenegro is classified as low prevalence (0.01%) and data obtained through routine surveillance suggest that the epidemic is stable and well controlled. However, regional trends indicate a real potential for the rapid spread of HIV, if prevention among key target groups is not improved (Statement by Mr. Milorad Scepanovic, Permanent Representative of Montenegro to the United Nations at the High-level meeting on the comprehensive review of the progress achieved in realizing the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS in New York on 10 June 2011).  According to data obtained from bio-behavioral surveys conducted among most at-risk population groups during the period 2007 to2011 it was found that the highest HIV prevalence (4.5% - representing a concentrated epidemic) was recorded among surveyed MSM in 2011 (Attachment 45). These findings are consistent with data from the National HIV register (Attachment 36) which shows that most of the people newly registered with HIV in the past years are males who acquired the infection through sexual intercourse with other males. Survey data also show a high level of HIV risk behavior amongst the MSM population. For example, the most recent survey showed that at last anal intercourse, regardless of partner type, condoms were not used by half (50.5%) of the respondents. Also of concern is that MSM tend to delay seeking a HIV test with the result that most MSM newly diagnosed with HIV are already suffering from AIDS-related conditions. The need to focus on this particular at-risk group is now recognized as a priority in terms of containing the epidemic.  The HIV prevalence among IDUs remains stable according to the most recent data obtained from the bio-behavioral survey conducted in 2011 (0.3% in 2011, 0.4% in 2008). However, the registered Hepatitis C prevalence remains high (55% in 2011, 53.6% in 2008). There was a decrease in the percentage of IDUs who had shared injecting equipment at last injection from 10.8% in 2008 to 4.8% in 2011. A condom was used at last sexual intercourse (vaginal or anal) with a regular partner by 30.6% of IDUs showing a slight increase compared to 2008 (26.9%). (Attachments 41, 44).  HIV prevalence among surveyed female sex workers (SWs) in Montenegro, also remained low (0.76% in 2008, 1.1% in 2010), while the percentage of SWs using a condom with their most recent client in the last month increased from 72.3% in 2008 to 83.5% in 2010. |

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| 3.2 | Country Context |

Please describe the relevant key changes in the national or program context (political environment, economic situation, social situation and legal context) and the effect of these on program implementation. Elaborate on the changes adversely influencing the program performance and any strategies put in place to mitigate the negative effect on the program. (Please indicate sources of information).

**Political environment**

Since independence in 2006 and until now the political situation in Montenegro has been stable, with no major ethnic or religious tensions or social unrest. The country is focusing on European Union (EU) integration processes and implementing a number of reforms in the areas of governance and law, and in the education, health and social sectors to ensure that laws and policies comply with the EU. Alongside this, capacity is being built in Montenegro to facilitate EU accession.

The current Government led by the Prime Minister Luksic has been in place since 2009 when Parliamentary elections results confirmed the continuity of a coalition between the Democratic Party of Socialists (DPS) and the Social Democratic Party (SDP). Similarly, no major political changes have occurred in the health sector and the Minister of Health (Mr Radunovic) has been in this position since the 2006 elections.

New elections are due to take place in the coming year and by March 2013 at the latest. However, major changes in terms of possible political power shifting are not likely to occur, with no negative impact expected in terms of HIV/AIDS GFATM grant implementation.

Montenegro’s commitment to fight HIV/AIDS is embedded in the *National Strategy to Fight HIV/AIDS 2011-2015* which covers the entire GFATM grant project cycle. The National Strategy focuses on improved prevention among specific target groups, improved quality of care and support to PLHIV, a safer and more supportive environment as well as an evidence-informed, coordinated and sustainable response (Attachment 55).

Commitment to implement the *National Strategy to Fight HIV/AIDS* is strong and the major part of the Strategy (more than 60%) has been financed through national budget allocations and the CCM has been chaired by the Minister of Health since its inception. The main government counterpart in the program remains the Institute for Public Health which coordinates all other government institutions on policy making, providing an evidence based and monitoring and evaluation framework.

**Economic situation**

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| Montenegro recorded an impressive economic growth in the years following independence and Gross Domestic Product (GDP) increased by 4% in 2005, **by 8.6% in 2006, 10.7% in 2007, and 7.5% in 2008). Due to the global economic crisis in 2009 the** Montenegrin economy recorded a sharp decline in GDP by 5.7%. Economic recovery was slow in 2010 and 2011 with a growth rate of 1-1.5% of GDP growth. However, according to the World Bank classification, Montenegro belongs to the group of Upper Middle Income Countries (UMIC) with US$4.1 billion of Gross Domestic Product (GDP) in 2011 (amounting to US$6,750 per capita).  In addition to the structural reforms driven by the EU accession process, Montenegro is also undergoing economic reform, including privatization of former state owned factories, attracting foreign direct investments (FDI) and developing a new competitive market-driven economy. These measures have been introduced to counteract increases in the unemployment rate, currently at 19.5% (MONTSTAT). Nearly 40% of the unemployed are hard-to-employ groups and youth unemployment is increasing.  The country is largely dependent on external energy sources (importing some 30% of total annual consumption). The increase in energy-related prices (electrical energy, oil) has led to an increase in minimum consumer basket prices of Euro 786.30 in February 2012. At the same time the national average net salary was Euro 495 (Euro 739 including taxes and national contributions).  The 2009 economic crisis also severely affected the industrial sector and FDI inflows further limited the country’s prospects of growth. Nevertheless the budgetary deficit remained under control, mainly due to external borrowing and positive developments in the tourism-related sector. On average, Montenegro hosts around one million tourists annually, thus bringing in financial/economic benefits. As well as being important for the country’s economy, tourism represents a challenge for HIV prevention, as during the summer season there is an increase in sex work in the coastal region, as well as in the number of MSM visiting the country. A significant percentage of the foreign tourists are from Russia (18.6% in July 2011, 20.3% in August 2011, Statistical Office of Montenegro) and Ukraine (3.1% in August 2011, Statistical Office of Montenegro), both countries with high HIV prevalence rates.  In an attempt to keep the budget deficit low the Government has imposed a number of restrictions related to budgetary spending. These have not however affected expenditure on health and social services. The 2012 Budget committed to safe-guard health-related allocations; currently planned to be Euro 176 million and 12.74% of the country’s budget has been allocated for health care. |

**Social situation**

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| Despite the significant economic growth experienced during the period 2006 to 2008, the absence of pro-poor policies meant that poverty remained stable with strong regional disparities correlating with unequal economic growth in different regions. The 2009 economic crisis has led to a deterioration in the socio-economic situation in under-developed regions and as a consequence, unemployment and poverty rates were twice as high in the North as the South (coastal part) and Central regions of Montenegro. According to the National Statistics Office, poverty had increased by 40% in 2009 and unemployment by 20% since 2008. The situation improved slightly in 2010 and 2011 according to several macro-economic indicators, but regional disparities persist.  The Northern region is also characterized by high out-migration (in all of 11 municipalities in the northern part of Montenegro) had recorded a population decrease in the last decade (MONSTAT – Census 2003, 2011). Migrants are mainly young people who seek jobs in the more developed areas of the country and abroad, leaving the region without development potential. The main Balkan narcotics smuggling route crosses parts of the northern region, increasing criminal activity and contributing to potential health and human security risks in terms of drug abuse and related health and social risks.  Increasing disparities between different social groups have been noted. For example, Roma, Ashkalia, Egyptians (RAE) are the most vulnerable population group with a poverty rate of 36%; followed by displaced persons 34%, social welfare recipients 30%; pensioners 15.7%; the long-term unemployed 12.3% and people with disabilities 11.9%. Social exclusion remains concentrated within these six vulnerable groups who are reported to have the following percentages of households that are socially excluded: RAE (14.1%); social welfare recipients (11.9%); the long-term unemployed (10%);pensioners (8.9%); displaced persons (8.3%); and people with disabilities (5%) (Attachment 48).  Deepening inequalities between different social groups has the potential for social unrest and instability. In addition, some of these socially excluded groups also face stigma and discrimination (for example, the. Roma, displaced persons, and persons with disabilities) further contributing to their social exclusion and marginalization and possibly exposing them to social, economic and health risks. |

**Legal context**

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| The *Strategy for the Improvement of RAE Population Status 2008-2012* commits Montenegro to respect, protect and fulfill the rights of the RAE population. It also envisages the integration of RAE members into all spheres of social life, gender equity, the prevention of any discrimination and implementation of positive action measures.  In relation to health and HIV a set of laws was passed during the period 2006 and 2009: *Safe Blood Strategy* (2006). *Law on Blood Provision* (2007), *Law on Taking and Implantation of Human Body’s Parts aimed at Treatment* (2009), and the *Law on Treating Infertility through Assisted Reproduction Technologies* (2009). Also in 2009, the Parliament of Montenegro passed a *Law on Control of Manufacture and Placing on the Market of Substances used in the Manufacture of Narcotic Drugs and Psychotropic Substances* (law on precursors) that could be used in the production of opioid drugs and psychoactive substances. This Law should result in a reduction of drug use in the streets and reduce the number of persons that have access to drugs. In 2011, based on a request from the Ministry of Health, the *Law on Prevention of Drug Abuse* was passed. This new policy document creates a solid base for the preparation of the new Act which will regulate prevention, treatment and care relating to drug abuse and provides a framework for including substitution therapy as an important part of project activities.  In early 2010, amendments were made to the *Law on Health Care* to the *Law on Protection of the Population from Diseases.* These Laws better define disease surveillance and through respective by-laws the monitoring of diseases, including of HIV and AIDS, through separate reporting and improvements to the existing Registry. Also in 2010 the *Law on Taking and Use of Biological Sample*s and the *Law on Health Care* were passed – the latter law defines among other things, care for sick and dying patients.  In December 2010, the *National Strategic Response to HIV/AIDS in Montenegro 2010-201*4 was formally adopted. The aim of the Strategy is to maintain Montenegro as a county with low HIV prevalence, to provide a universal access to HIV prevention and treatment, and to improve the quality of life of PLHIV through a coordinated multi-sectoral response.  In July 2010, the Parliament of Montenegro passed the *Law on Prohibition of Discrimination* that should establish a comprehensive system for the prevention of discrimination. The Law prohibits any kind of discrimination including: harassment, mobbing, segregation, discrimination in the process of using public facilities and areas, discrimination in provision of public services, teaching, training and professional education, in the area of labor, faith and belief based discrimination, discrimination of people with disabilities and discrimination based on gender and sexual orientation. The post of Protector of Human Rights and Freedoms has been established and citizens can address him/her should they feel their rights have been violated.  In June 2011, the Ministry of Health prepared the *Strategy for Optimization of Secondary and Tertiary Health Care* together with an Action Plan for implementation. The section on *Provision of Services*, defines palliative care for patients who suffer from specific chronic diseases and patients in the terminal stage of disease, including patients with AIDS.  In January 2012, the Ministry of Health prepared a draft *National Strategy for Improvement of Health Care Quality and Safety of Patients which* aims to reduce inequalities in the quality of health care services, inconsistency in the treatment results and inefficient use of health technologies. The *Rulebook on Amendments to the Rulebook on Detailed Requirements Related to Standards, Norms and Manner of Achieving the Primary Health Care through a Preferred Doctor or Team of Doctors* (Official Gazette, 1/2012) was adopted in the beginning of January 2012 and permits the provision of methadone within Centers for Mental Health in Primary Health Care Centers, i.e. MMT Centers and it ensures pre-conditions for procurement of needed quantities of methadone by the Health Insurance Fund.  In February 2012, the Ministry of Health, following the proposal of the National HIV/AIDS Commission adopted the *National Plan for Monitoring and Evaluation of the Strategic Response to HIV/AIDS in Montenegro*.  There are still certain areas requiring changes to the legal framework in order to enable and/or facilitate out-reach HIV-related prevention work as well as the HIV response in general. In regard to outreach work and drop-in service provision the following changes need to be introduced into the legal framework:  1. Introduce new provisions that define "drop-in center", "outreach work" and "outreach worker" as well as the rights and obligations of drop-in centers;  2. Introduce provisions that define the medical service package to be delivered to clients of drop-in centers;  3. Introduce legal changes to protect the right to privacy for drop-in centers' employees (in the area of record keeping);  4. Introduce changes that would ensure quality in providing medical services in the area of mental health of LGBT persons (MSM included) most of which are defined within the action plan against homophobia;  5. Decriminalization of sex work;  6. Examine compliance of mandatory treatment for IDUs with the basic human rights;  7. Introduce the legal basis for beginning and continuing therapy for Hepatitis C infection and methadone;  8. Provide the legal basis for a HIV Testing and Counseling Centers within prisons. |

**Epidemiological situation**

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| According to the latest data released by the Institute of Public Health of Montenegro (Attachment 36), 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 HIV/AIDS- related deaths were reported to the IPH of Montenegro.  The leading mode of HIV transmission in Montenegro in 2011 was through sexual intercourse (85%) – 44% heterosexual transmission and 41% homo or bisexual transmission. Sexual transmission of HIV shows a steady increase since the start 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. |

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| 3.3 | Health Systems Analysis |

Please comment on the status of the HSS (Health System Strengthening) actions undertaken with the Global Fund and/or other domestic or partner support and how the identified health system constraints have been addressed.

1. **Governance and Stewardship, including Planning and Performance Management**

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| Low HIV prevalence and socially conservative values in Montenegro do not support HIV being placed high on the health and social agendas.  The *National Strategic Response to HIV/AIDS 2010-2014* advocates following the “Three Ones” principles through establishing a single action framework, one monitoring and evaluation (M&E) framework (recently adopted National M&E plan) and one coordinating body (National AIDS Commission). Health and other service providers in Montenegro continue to show high level of stigmatizing attitudes towards PLHIV and members of most at-risk groups despite significant efforts to train health, law enforcement and judiciary professionals, prison officials as well as advocacy efforts with policy makers during the implementation of Round 5 and Round 9 HIV Grants. Significant efforts by NGOs in outreach work with most at-risk populations have resulted in increased health seeking behavior by members of these groups. For example for HIV testing and counseling and MMT. During the period July 2010 to December 2011, three MMT centers in Podgorica, Kotor and Berane covered 213 clients, and 1,682 clients were counseled and tested for HIV in VCT services. Of these, nine were found to be HIV positive.  Centers for VCT have not yet been properly integrated into primary health care services under the health care reform program. The World Health Organization and UNAIDS have supported a review of these services to ensure that HIV prevention activities are firmly embedded in the reformed health care system and are currently developing indicators for quality of care.  Public health institutions are organized through a network of primary, secondary and tertiary health care facilities composed of: 18 Primary Health Care Centers (PHCC), Emergency Center, seven general hospitals, three special hospitals, Clinical Center of Montenegro, Institute for Public Health and Pharmacy Institution of Montenegro. Dental health care was removed from the primary level (PHCC level), from 1st January 2012 and was organized as a private business. More than 100 health professionals have been targeted with the sensitization trainings, while 35 specialists such as dermato-venereologists and urologists have been trained in how to respond to the specific needs of the MSM population. |

1. **Health System Financing**

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| The organization and financing of the health care in Montenegro is based on the dominant role played by the public sector, both in providing services and funds for health care.[[2]](#footnote-2) Health care financing is based on the system of mandatory health insurance, i.e. Bismarck model, with the Health Insurance Fund as the institution established by the *Law on Health Insurance* for the purpose of implementing that model guided by the principles of solidarity, equality, availability and obligation.  Mandatory health insurance provides rights to health care in public health institutions for approximately 620,000 insured persons. They are also entitled to other rights for treatment outside the Montenegrin health care system, (according to conventions), as well as rights to orthopedic instruments and support devices, remuneration for sick leave exceeding 60 days and remuneration for travel costs in exercising their rights to health care.  The main source of financing the mandatory health insurance scheme is through contributions. Besides contributions, the Health Insurance Fund receives funds from general Budget revenues, from conventions, compensation for damage incurred, interest and other sources in accordance with the law.  The total amount allocated for health care is divided into public and private. Public income is received from public funds (mandatory health insurance, capital investments and earmarked funds received by the Institute for Public Health from the state budget for programs and services provided to Fund’s beneficiaries). Private income comes from private sources, such as direct payments (and co-financing by health care beneficiaries) and voluntary, i.e. complementary insurance.  In 2010, Euro 235,414.3 and 2011 Euro 288,662.44 was spent by the Health Insurance Fund on antiretroviral therapy for PLHIV.  The proceeds of the Health Insurance Fund for 2010 amounted to Euro 168,624,943, out of which 84.8% came from earmarked funds and 15.2% from general revenue. The total health care expenditure in 2010 per capita amounted to Euro 280, and an additional Euro 264 per capita came from the private sector, according to National Health Survey conducted in 2008 by the Ministry of Health of Montenegro in 2008.  Health care expenses account for 93.1% of the Health Insurance Fund expenditure. This includes expenses for dispensary and hospital treatment in Montenegro and abroad, the cost of prescribed drugs and for drugs and medical material used during dispensary and hospital treatment.  The total transfer of funds to institutions, individual NGOs and the government sector in 2010 amount to Euro 143,418,969 out of which transfer to public health institutions for primary, secondary and tertiary health care amount to Euro 138,670,798.  In addition to funds received from the Health Insurance Fund, public health institutions are funded from the State budget and through income generated. For instance, the Institute of Public Health received Euro 2,619,115.13 from the State budget; Euro 12,025,423 from co-payment income (made available to health institutions) amounts to Euro 1,324,217; income from services provided to other beneficiaries - Euro 1,636,225; income from lease of space and equipment – Euro 197,685; transfers from state budget or Ministry of Health for programs and projects – Euro 414,430; income from Employment Agency for reimbursement of salaries for trainees – Euro 94,988; and other income of public health institutions (from other funds, compensation between health institutions, sponsorships, etc.) – Euro 1,084,882.00.  The largest share of income for health institutions comes from the Public Pharmaceutical Institution “Montefarm” and amounts to Euro 6,223,693 or 42.5 % of the total income. Funds are realized through the sale of pharmaceutical products that are not funded by the Health Insurance Fund. The remaining income (Euro 8,420,845.13) is generated by 30 health institutions, which makes 57.5 % of other income realized.  Out of a total of Euro 138,670,798 which the Fund transfers to public health institutions, Euro 83,119,666 (59.9%) goes towards gross salaries and other personal income. Primary health care receives 37.8% of the total costs, or 35.12% of total expenses and secondary and tertiary health care accounts for 53.7% of total costs, or 49.9% of total expenses. In 2010 and 2011, the Government of Montenegro invested an additional Euro 2,705,955.72 from a World Bank loan for reform of the secondary and tertiary health care system: Euro 1,027,269.33 in 2010 Euro 1,678,686.39 in 2011.  From 2012, the Health Insurance Fund is taking over the procurement of methadone. During 2009-2011, capital investment projects in the health sector amounted to Euro 15,904,507.41. Due to the economic crisis, the proposed construction of new Clinic for Infectious Diseases has been postponed from 2012 until 2015. |

1. **Service Delivery including Public Private Partnerships and community level service delivery**

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| During Phase I of the Round 9 HIV program implementation, two Drop-in Centers for injecting drug users were established. The Drop-in services are provided by local NGOs. Outreach services for IDUs, MSM, SWs, RAE and merchant marines continue to be successfully provided by NGOs.  The NGO sector has also been providing psycho-social support services to PLHIV which are currently insufficient within the formal health system. Initially this was through CAZAS and more recently by the *Montenegrin HIV Foundation* which is made up of PLHIV who are aware of the services that are required.  Methadone maintenance treatment is provided in three Primary Health Care Centers and one prison for those clients who had already been admitted to the MMT program prior to being imprisoned.  Also, one Counseling Center for Merchant Marines was established under the Round 5 HIV program in Bar run by the NGO “Zastita”. Under the Round 9 HIV program an additional Counseling Center has been established within Primary Health Care Center in Kotor. |

1. **Monitoring and Evaluation**

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| Second generation HIV surveillance was introduced under Round 5 HIV program implementation. Significant efforts have been invested to build capacity of government and NGO staff in the area of program monitoring, as well as in the implementation of survey methodologies.  At the MESS workshop held in June 2010, with the participation of all stakeholders in the national HIV response a major weaknesses in the M&E system were identified as: lack of M&E coordination at the national level; absence of population size estimates; absence of a national M&E plan; insufficient numbers of trained professionals for implementation of second generation surveys; insufficient knowledge and capacity of NGOs performing M&E functions; poor quality of programmatic reporting due to not using the unique identifier code; and the absence of a national electronic database.  The MESS workshop resulted in an Action Plan which listed the activities needed to improve the identified weaknesses, such as development of National M&E plan, defining roles and responsibilities of different M&E staff at different levels (national, institutional, NGO sector), population size estimates, further investments into systematic training of health and NGO staff involved in program implementation and M&E activities, and capacity building in conducting surveys.  During Phase I Round 9 HIV program implementation, several major improvements were achieved, namely:   1. National M&E plan developed and adopted by the National AIDS Commission, CCM and Ministry of Health in February 2012 (Attachments 39, 40). The National HIV M&E Plan is a core document outlining the key elements of the National HIV Monitoring and Evaluation System, including core indicators definitions, rationale and dynamics for data collection, methodology and responsible entities within the national system. It includes national, international and GFATM program related indicators. 2. Strengthening national and institutional structures with M&E roles and functions; developing Terms of Reference (ToR) for the Technical Working Group, for the national M&E person, for the HIV focal points for M&E activities at health care facilities level, for NGOs employees in charge for M&E. Since the National M&E plan was adopted by the MoH in February 2012, it is expected that the establishment of the M&E Technical Working Group in April 2012, as well as all relevant changes in the ToRs and appointments of persons in charge of M&E resulting from the national M&E structure defined in National M&E Plan, will considerably strengthen M&E activities. 3. Additional investments have been made to train government and NGO staff in program monitoring, as well as training of four epidemiologists from IPH in HIV Surveillance training at the “Andrija Stampar” School of Public Health in Zagreb, Croatia. A total of 14 persons from government and NGOs were trained in using the Unique Identifier Code in June 2011. All implementing partners working with members of most at-risk groups introduced the UIC in July 2012. 4. Following the *Integrating Gender into AIDS response in Montenegro* document recommendations produced in response to the GFATM requirement to strengthen the gender response within the program, all partners introduced reporting on gender. 5. Development of a National HIV M&E database - this was not initially planned and budgeted for, but a reallocation of budget was requested and approved for database development. The database should be developed and piloted by the end of 2012 and introduced into regular reporting at the beginning of 2013. The introduction of the national database will contribute to more precise programmatic monitoring, better reporting minimizing the possibility of double counting, and lead to improvements in the quality of services.   Completion of work on obtaining Population Size estimates was delayed and is now expected to be finished by the end of June 2012. |

1. **Pharmaceutical Sector**

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| The procurement of medicines was not envisaged under Round 9 HIV program activities. In Montenegro medicines and other medical products are procured from companies that follow the rules of *Good Manufacturing Practice* (GMP) and have a Certificate of Pharmaceutical Products (CPP). This is regulated by the Ministry of Health of Montenegro which is responsible by law for the registration of drugs.  The procurement and supply of goods, works and services for implementing UNDP programs (as Principal Recipient) is regulated by the terms of the *Standard Basic Assistance Agreement* between the Council of the Ministers of the State of Montenegro and the United Nations Development Program. In addition, financial assistance and procurement of goods are regulated by the *Convention on the Privileges and Immunities of the United Nations*.  All drugs and pharmaceuticals procured under the GFTAM grant have to be registered in Montenegro. However, the *Law on Medical Supplies* allows the Ministry of Health to approve the import of drugs, which are not currently registered (following an extraordinary examination by the designated Drug regulatory authority). |

***Please answer the following question if you are submitting the CCM Request for a HSS grant/program. Otherwise proceed to the next HSS question.***

In the context of the national health system strategic plan, goals and objectives, please elaborate on how the HSS grant/program has contributed to the progress towards MDGs 4, 5 and 6. Please also describe if the HSS grant/program has resulted in any demonstrable improvements in access (addressing geographic and gender inequalities), coverage and quality of services.

N/A

Please elaborate on any lessons learned and what health system gaps remain in scaling up the disease program.

The need was identified to ensure that the eight VCT Centers established under Round 9 are in accordance with health sector reform, particularly at the primary health care level. A Quality Assurance program is being developed by the Ministry of Health with external technical support. During 2012 indicators for quality HIV and sexually transmitted infection services at primary health care level will be developed that are consistent with the national Quality Assurance program.

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| SECTION 4: Program OVERVIEW |

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| 4.1 | Financial Gap Analysis, Counterpart Financing and Additionality |

***This section is not applicable for G20 UMICs that are no longer eligible for Renewals. Please continue to section 4.2 ‘Progress Towards Proposal Goals and Impact/Outcome’.***

Please provide an update of the financial needs, actual and planned sources of funding, and financial gap of the disease/HSS program.

CCMs must use the ‘Financial Gap Analysis and Counterpart Financing’ table to provide financial information pertaining to the national program that implements the national disease strategy. Detailed instructions on how to complete the Financial Gap Analysis and Counterpart Financing table are provided is in the Financial template provided with the CCM Invitation package: **Renewals\_Financial Template\_ FinancialRequest\_ResourcesAvailable.**

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| 4.1.1 | Overview of Government Financing of the National Program |

Please specify the levels of government (central, regional, local) that incur spending on the disease programs and the major agencies through which government funds are spent. Elaborate on the availability of earmarked budget line items to capture government disease spending and the extent to which these budget line items capture total government spending on the disease program.

Overall financing for the health components of the National HIV program is from the budget of the Ministry of Health. However, there is no earmarked budget line for expenditure on HIV and as a consequence HIV does not feature in the National Health Accounts. Some of HIV-related costs can be captured from the Health Insurance Fund (costs of ARV therapy, treatment of PLHIV in Montenegro including costs of therapy for opportunistic infections, treatment of PLHIV out of Montenegro, diagnostic tests for HIV, Hepatitis B, Hepatitis C. gonorrhea, syphilis, and the costs of the VCT Centers). The budget for other activities such as, measures for universal precautions, blood safety, treatment of blood borne infections, are not shown separately (Attachment 51).

The Ministry of Education is responsible for implementation of Healthy Life Styles in primary and secondary schools, the Ministry of Justice for the treatment of prisoners, and the Ministry of Finance for financial support to different programs from the National Lottery Funds and financing capital investments.

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| 4.1.2 | Estimation of Current and Anticipated Domestic and External Funding |

Describe how contributions from various sources of funds were estimated, including reference to:

1. Methodology for estimating current and anticipated funding;
2. Composition of reported government spending (part or all of government spending; programmatic costs alone or includes apportioned health system costs; recurrent costs alone or includes capital costs);
3. Whether amounts contributed by each source for the current and previous years pertain to budget, disbursement, expenditure or an estimate of spending;
4. Whether amounts forecast from each source for the future years pertain to estimation or commitment.

Current funding was calculated based on reports of the Health Insurance Fund and Ministry of Health. Exact costs were provided for 2010 since reports for 2011 are still under development. Part of the reported spending is for directly related HIV program costs, such as costs for ARV treatment, VCT program costs, in-patient treatment of PLHIV in Montenegro and out of Montenegro, diagnostic tests, methadone procurement costs, and for teachers of the Healthy Lifestyles subject (Attachment 51).

Other spending lines refer to apportioned health system costs (infectologists, IPH staff, chosen doctors, chosen gynecologists, Centers for Reproductive and Mental Health, and capital investments for the Clinic for Infectious Diseases - construction planned 2013-2015).

For 2011 exact figures were provided for some expenditure lines, while for the remaining part estimations were made based on the 2010 expenditures. Estimations for 2012-2015 were based on the previous expenditures as well as planned costs based on the official strategic documents (Attachments 49, 38).

Overall health sector spending was calculated based on the *Laws on budget of Montenegro for 2010, 2011, 2012* figures and exact revenues for IPH and other health institutions obtained from *Report of the Health Insurance Fund* (Report on *Results of the Health Insurance Fund of Montenegro for 2010*, *Annual Financial Report of the Institute of Public Health for 2010*, 2011 and *Financial Plan of IPH for 2012*, *Report of the Public Construction Agency 2009-2011*). Estimation of overall health sector spending is based on the health planning documents and loan agreement with the World Bank, as well as based on the historical budget.

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| 4.1.3 | Financial Gap and Counterpart Financing Data Sources |

Please answer the following questions below:

1. Cite the sources used to complete the financial gap analysis and counterpart financing table;
2. Provide an assessment of the completeness and reliability of financial data reported, include any assumptions and caveats associated with the figures;
3. Provide details of how the country plans to improve data quality consistent with the guidelines for reporting of program financial data to technical partners; and
4. If applicable, state if the CCM Request includes a budget for an expenditure tracking study and/or measures to strengthen financial data collection and reporting during the next Phase/Implementation Period.

All 2010 and 2011 expenditures have been drawn from the Health Insurance Fund, Ministry of Health, Clinical Centre of Montenegro, Ministry of Education, Institute of Public Health and Institute for Blood Transfusion, as well as of the Public Construction Agency 2009-2011. Some financial data for 2011 was not available and was estimated based on 2010 expenditures (Attachment 51).

Tracking of HIV-related costs in Montenegro is complicated since there are neither National Health Accounts nor an earmarked separate budget line that would enable follow up of exact costs. However, in the process of developing the application for Phase II, CCM Montenegro requested special reports on HIV-related expenditures from the relevant institutions within health and educational system.

National Health Accounts are planned to be introduced through the Health Sector Reform financed by World Bank Loan as well as through the development and introduction of the integrated health information system, introduction of diagnostic related groups system in the secondary and tertiary level of health care institutions. This information will all contribute to more precise tracking of HIV-related expenditure.

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| 4.1.4 | Compliance with Counterpart Financing Requirements |

Describe whether the counterpart financing requirements have been met as listed below. If not, provide justification which includes actions planned during the next Phase/Implementation Period to move towards reaching compliance.

1. Minimum threshold for counterpart financing  
   🡪*Percentage in Line M of the ‘Financial Gap Analysis and Counterpart Financing’ table must be greater than or equal to the minimum threshold that applies to the applicant’s income level.*
2. Increasing government contribution to national disease program over the next Phase/Implementation Period  
   *🡪 Figures in Line B of the ‘Financial Gap Analysis and Counterpart Financing’ table must increase over time.*
3. Increasing government contribution to the overall health sector over the next Phase/Implementation Period  
   🡪 *Figures in Line I of the ‘Financial Gap Analysis and Counterpart Financing’ table must increase over time.*

As a UMIC country as per World Bank classification, the State contribution to the National HIV program should constitute not less than 65% in the Year 3 up to 90% in Year 5 and the funds requested for Phase II should not constitute more than 35% of the National HIV/AIDS program in Year 3 and not more than 10% in Year 5.

According to figures from the *Action Plan for Implementation of the National Strategic Response to HIV* which defines financial needs for the implementation of the National HIV program for the period 2010-2014, funds requested for Year 3 represents 25.9% of the needs for 2013, for Year 4 represents 12.7%, while funds for Year 5 represent 5.9% of the total.

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| 4.2 | Progress towards Proposal Goals and Impact/Outcome |

Please refer to the results reported by the PR(s) for impact/outcome indicators included in the Performance Framework and provide additional updates if recent information is available (e.g. survey reports, impact assessment studies, etc.)

| **Impact/Outcome Indicators** | **Baseline** | | **2010** | | **2011** | | **2012** | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date** | **Baseline** | **Target** | **Result** | **Target** | **Result** | **Target** | **Result** |
| HIV prevalence among IDUs | 2008 | 0.4% |  |  | <1% | 0.30% |  |  |
| HIV prevalence among MSM | N/A | N/A |  |  | <5% | 4.5% |  |  |
| HIV prevalence among SWs | 2008 | 0.76% | <1% | 1.1% |  |  | <1% | In progress |
| % of IDUs reporting the use of sterile injecting equipment the last time they injected | 2008 | 89.2% |  |  | 90% | 95.2% |  |  |
| % of IDUs reporting the use of a condom the last time they had sexual intercourse | 2008 | 40.1% |  |  | 50% | 41.8% |  |  |
| % of MSM who used a condom last time they had anal sex with the male partner | N/A | N/A |  |  | N/A | 49.5% |  |  |
| % of sex workers reporting use of a condom with their most recent client in the last month | 2008 | 72.3% | 90% | 83.5% |  |  | 85% | In progress |
| % of young people aged 15-24 who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission | 2007 | 22.1% | 60% | 27.2% |  |  | 40% | In progress |

Please confirm if the method of data collection and data source is consistent with the M&E framework agreed at the time of signing the Grant/SSF Agreement(s).

Methods of data collection are in accordance with the methods of data collection proposed in the M&E framework agreed at the time of signing the Grant Agreement as well as with the *National M&E Plan* adopted by National AIDS Commission and Ministry of Health in February 2012 (Attachments 39, 40). The *National M&E Plan* developed under *the Monitoring and Evaluation System Strengthening Action Plan* implementation during the Phase I of the current Grant defined the methods and dynamics of data collection for all target groups.

Is there a recent report analyzing information regarding heath impact and outcome available? Yes (delete as applicable)

If yes, when was it conducted? 2012, March

Please summarize the main findings and include a full copy of the report with the CCM Request.

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| Under Rounds 5 and 9 of the HIV program bio-behavioral surveys have been conducted among merchant marines, female SWs, IDUs and MSM, which provide the evidence-base for HIV risk behaviors amongst these population groups. These data are used to design appropriate HIV prevention and treatment services which respond to the needs of most at-risk population groups.  Results of the 2008 study conducted among merchant marines showed that HIV prevalence in this population is low at 1.5%. Low HIV prevalence has also been recorded among female sex workers (0.8% - one woman in the 2008 survey and 1.1% - two women in the 2010 survey). The 2010 survey included more subjects (176) compared with 131 in 2008 and the results indicate continuing low HIV prevalence and positive changes in behavior. For example, 72.3% of respondents in 2008 used condoms during their last sexual intercourse with a client in the last month, compared with 83.5% in 2010.  In 2011, the second bio-behavioral survey among IDUs in Montenegro was conducted and the results can be compared with the previous 2008 survey. HIV prevalence amongst the sample of IDUs is remains very low (0.3%) and remains almost unaltered compared with the data obtained in 2008 (0.4%). Hepatitis B, i.e. HbsAg was not found in either the 2008 or 2011 samples, but the prevalence of Hepatitis C was very high in 2011 (55%), similar to what it was three years ago (53.6%). The fact that there was no significant increase of HIV and HCV prevalence suggests that the reduction in shared drug injection equipment (3.3% in 2011 compared with 10.8% in 2008) had mitigated against an increase in HCV and HIV prevalence.  In 2011 the first bio-behavioral survey among MSM was conducted in Montenegro. According to the survey, HIV infection was found at five men, i.e. 4.5% of the sample of 111. The higher HIV prevalence amongst MSM is consistent with the national registration data and indicates that the HIV epidemic amongst MSM is approaching a concentrated epidemic. However, the results of the survey, based on the snowball sampling, have to be taken with caution, as this method could not ensure a fully representative sample that would produce data representative of the overall MSM population. However, this study does provide baseline data for analyzing the situation in relation to HIV infection among MSM and justifies the intensification of HIV prevention activities amongst this population group. |

Do you consider the program is making progress towards the goals and objectives of the proposal? If not, provide justification and explain how you intend to address the issues.

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| 4.3 | Program Effectiveness |

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| 4.3.1 | Aid Effectiveness |

Did you discuss within the CCM how to improve the aid effectiveness of implementation arrangements of Global Fund financing? Yes (delete as applicable)

If no, please explain why no discussion took place, and then proceed to Section 4.3.2.

N/A

If yes, was the process inclusive of key stakeholders, including those involved in donor coordination activities in your country? Please indicate the key stakeholders who participated in the discussion.

The Global Fund resources contribute towards almost 30% of the *National HIV/AIDS Strategy* implementation; the remaining portion (70%) is mainly funded by the State budget.

The process of Strategy Development was fully consistent with the principles of aid effectiveness: it was inclusive with representation of all relevant Governmental organizations (mainly from the health sector) civil society including NGOs, and representatives of the international community including the World Health Organization (WHO) and other UN Agencies working in the country. Lessons learned in program implementation from neighboring countries were used during the development of the national strategy.

The CCM in Montenegro is responsible for overseeing the implementation of GFATM funded programs. The Round 9 HIV Program was designed to cover programmatic and financial gaps in *the National HIV/AIDS Strategy 2010-2014*, adopted by the Government of Montenegro in December 2010.The national strategic response to HIV is the overall action framework and all other HIV-related activities should be aligned with its programs and objectives. Therefore the Round 9 HIV Phase II Proposal is completely in line with the objectives of the National program and identifies the most at-risk and vulnerable populations to be reached with HIV prevention interventions to contain the spread of HIV and other STIs in the country.

The oversight function of each CCM member should ensure that there is no double financing of activities proposed within the sector that the CCM member represents. Discussions concerning further improvements in aid effectiveness were held at a number of CCM meetings that took place during the first half of 2012. Also broader consultations were held with Government institutions such as, the Health Insurance Fund, thus ensuring that Government funding of HIV/AIDS related activities will complement with those activities specified in the GFATM application. The NGO members of the CCM also used meetings to discuss outreach activities and sustainable solutions. The presence of UN agencies and UNAIDS at CCM meetings has enabled both the UN and national counterparts to build a consistent approach to address HIV/AIDS-related issues.

Also, an Annual Review Meeting has been held every year in October, from Year 2 of the Round 5 HIV Grant up until today. The purpose of the meeting is to present program achievements for the previous implementation period, to discuss issues that have arisen during the current period and to propose strategies for the improvement of program activities. The Annual Review meeting involves participation of CCM members, representatives of all implementing partners as well as other stakeholders including representatives of the UN agencies.

All CCM members contribute to the governance of GFATM funds and additionality of GFATM funds to the national program investments and other donor contributions. A separate section of the meeting is dedicated to all other activities in the implementation of the national strategic response, apart those financed under the GFATM funded programs.

The UN Country Team has a Technical Group (TG) on HIV/AIDS consisting of representatives of all UN agencies operating in Montenegro. Regular meetings of the TG are used to harmonize financing activities as well as to decide on priority funding for activities not already covered by state or GFATM funds. Since UNDP is the PR, the GFATM HIV Program Manager/M&E Specialist is the member of the TG on behalf of UNDP taking care to ensure additionality within the UN sector as well as to provide direction of the priorities to be financed.

Please comment on the main findings.

The UN agencies are the only international agencies contributing to the HIV response in Montenegro. Therefore the CCM also serves as the donor coordination mechanism for HIV/AIDS. The presence and active participation of UN agencies in the CCM minimizes the risk of aid duplication. Moreover, the presence of the UN ensures that international standards and quality assurance in provided in program implementation.

The main contribution of UNICEF has been to the prevention of mother-to-child transmission of HIV and in HIV prevention amongst the RAE population (focusing on young people). UNAIDS has supported activities in the National strategy that were not financed either from the Government or through GFATM funding. Other UN agencies do not currently financially contribute to the National HIV response (although they have done so previously).

Complementarity in the HIV response has been ensured by including all relevant national partners in discussions and agreements concerning the development of the Phase II application. The roles and responsibilities of all the actors (both governmental and NGOs) have been identified and agreed. The final mechanism that would further strengthen aid effectiveness would be the rapid implementation of the recently adopted national M&E framework.

Based on your discussion did you identify any major risks? If so, please describe them and how you plan to address and monitor each in the next Phase/Implementation Period.

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| The major risks identified are connected with the economic crisis and ability of Montenegro to continue providing adequate support to HIV/AIDS related activities. In the course of Phase II application preparation this issue was discussed among CCM members. Assurances were given by CCM members representing Governmental institutions that no budget cuts in financing the HIV/AIDS Strategy implementation are envisaged. So far, Montenegro has successfully responded to the effects of the financial crisis. According to macro-economic forecasts GDP is expected to increase by 2.5% in 2012, and the economy is expected to further strengthen in the future. The State budget will be monitored on regular basis, mainly through direct communication with the representatives of the Ministry of Health participating in the CCM (Minister and Deputy Minister of Health) as well as representatives of other Governmental institutions dealing with HIV/AIDS.  UNDP has partnered with the GFATM since 2003 to support implementation of HIV, TB and malaria programs in low and middle income countries and has global agreements on rules and regulations to be applied in implementing GFATM Grants. UNDP-Sub-recipient Agreements for Government and Civil Society Organizations (CSO) for UNDP-Global Fund Programs have been recently revised and contain several changes aimed at improving risk management and streamlining UNDP’s relationship with Sub-recipients. For instance, Art. XI contains more elaborated and clear reporting obligations and according to Art. XXIX (7), the Sub-recipient now has an obligation to report other donor funds targeting similar activities or objectives as those set forth by the Project. Art. XXVI regulates engagement of Sub-sub-recipients.  The new templates stipulate conditions that must be met by the Sub-recipient before the Sub-sub-recipient can be involved.  These conditions include the need for a positive capacity assessment by the Sub-recipient and prior written approval by UNDP. |

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| 4.3.2 | Equity |

Did you conduct an equity assessment, or was an equity assessment conducted by the national program or other stakeholders, in the current Phase/Implementation Period? No (delete as applicable)

If no, please explain why an assessment was not conducted.

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| 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. |

If yes, please comment on the process for developing the equity assessment.

N/A

Please comment on the main findings of the assessment and include additional data, if available, which supports your findings (e.g. disaggregated data by relevant population groups for key indicators, findings from qualitative research, grey literature, etc.).

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| Although no specific equity assessment was conducted, the following equity dimensions have been discussed and analyzed:  **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.  **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.   **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.  **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](http://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.  **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. |

Based on your discussion did you identify any major risks (e.g. gaps in data availability or data use to assess equity, inequities in service coverage and impact/outcomes, gaps or weaknesses in planning, programming or implementation, or structural barriers)? Yes/No (delete as applicable)

If yes, please list and describe the following: (a) how you plan to address those risks in the next Phase/Implementation Period; (b) how progress will be monitored in the next Phase/Implementation Period; and (c) how the M&E system may need to be strengthened to provide data to monitor results.

The main data gap is the absence of population size estimates for IDUs, MSM and female SWs. These data should be available after June 2012 and will enable better targeting of resources to these population sub-groups as well as scale-up of existing activities.

Progress will be monitored through the electronic National HIV M&E system to be developed during the next phase. Information about proposals to strengthen the M&E system are shown in section 6.1.1

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| 4.3.3 | Value for Money |

Please comment on the three dimensions of value for money listed below, demonstrating how the program is maximizing the health impact that can be achieved with available resources.

**Economy:** is the program minimizing the cost of resources and inputs whilst maintaining quality of services?

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| The 67% resources are focused on providing services to the most at-risk population groups. This is a labor intensive activities and 49% of the budget is allocated to human resources (government and NGOs). Salaries for personnel working on the program have been calculated using the national average scale. According to the National Bureau for Statistics (MONSTAT) the average national net salary for February 2012 was EURO 495. Salaries for sub- recipient staff were based on part-time according to the specific Terms of Reference.  The costs for accommodation during training are calculated on the average price for a room within a three-star hotel during the period when the training is planned. Per-diems are not paid to training participants. All training costs are reduced to the minimum and all training is clearly targeted toward the appropriate group needing the education and skills.  During the Round 5 project implementation NGO outreach worker requested that only branded condoms be procured as they were recognized as the quality brand among the targeted population. However, the retail price of branded condoms is too expensive and not affordable by the target population. Previous distributed condoms have led to concerns about quality. It is therefore strongly recommended that branded condoms be procured as this will increase the condom use among the target population. |

**Efficiency:** is the program maximizing the output that can be achieved from available resources and achieving its results at the lowest possible cost?

Yes

**Effectiveness:** was the program approach and activities well designed to achieve the objectives and correspond to what needs to be done given the disease and local context?

Yes – full implementation of the national M&E plan will further improve efficiency.

Have any major risks been identified related to value for money? No (delete as applicable)

If yes, describe how you plan to address those risks and monitor progress in the next Phase/Implementation Period.

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| 4.4 | Quality of Services Assessment |

***This section is not applicable for a cross-cutting HSS grant/programs. Please continue to section 4.5 ‘Partnerships’ if you are submitting the CCM Request for a cross-cutting HSS grant/program.***

Please comment on systems to manage quality (quality improvement/quality assurance) that ensure adherence to national guidelines and Standard Operating Procedures (SOPs).

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| There are national guidelines for ARV treatment, VCT service provison, Universal Precautions Measures and Safe Blood. All of them were developed under the Round 5 HIV Program and are in compliance with European standards.  During the Phase I of Round 9 HIV Grant 103 health professionals from the Clinic for Infectious Diseases and doctors from the PHC level institutions were trained on ARV therapy. External supervision has been provided by an expert from the Clinic for Infectious Diseases “L.Spallanzani” in Rome, Italy.  Quality control and quality assurance of VCT services has been provided through continuous quaterly internal control, as well as annual external supervision provided by experts from the Clinic for Health Care of Students in Belgrade, Serbia. |

Please comment on major quality of services risks which have or could have a negative effect on performance, if any. Describe how you plan to address those risks and monitor progress in the next Phase/Implementation Period.

Quality issues in the provision of outreach services and services within Drop-in Centers for most at-risk population groups will be improved and monitored when national HIV M&E database is functioning. The national database will enable precise tracking of all the services being provided to the client. Field visits to the services provided will be further increased to provide better insight to the quality of services in the service delivery spots.

External evaluation of the program will include the component of the Rapid Service Quality Assessment and is envisaged for Year 3.

Under the Health Sector Reform program the government is developing quality indicators for all health services. The WHO is supporting the development of specific indicators for quality of care with the National HIV and Sexually Transmitted Infection program. This should be completed by the end of 2012.

***If the RSQA (Rapid Service Quality Assessment) assessment was not conducted in your country, please continue to section 4.5 ‘Partnerships’***

Please refer to the latest available information on quality of services annexed to the CCM Invitation Letter and provide updated information (updated national guidelines/protocols), if available.

N/A

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| 4.5 | Partnerships |

Using the table below, please indicate the technical assistance (TA), if any, already received in the current Phase/Implementation Period or confirmed to be conducted in the next Phase/Implementation period by the PR(s) and /or SR(s).

| **TA source/TA category** | **Current Phase/Implementation Period** | **Next Phase/Implementation Period** |
| --- | --- | --- |
| Bilateral | □ | □ |
| Multilateral | □x | □x |
| CSO | □ | □ |
| Private Sector | □ | □ |
| Academic Inst. | □ | □ |
| Mixed/other (specify) | □ | □ |

Describe any current gaps and/or needs in the capacity building that are not being met by the existing TA providers.

The main requirement for technical assistance is in developing the methodology for and conducting the population size estimates. The lack of such estimates is the main impediment to having realistic targets for coverage of most at-risk populations, especially for men who have sex with men.

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| SECTION 5: CURRENT PHASE/IMPLEMENTATION PERIOD PERFORMANCE (PR 1)[[3]](#footnote-3) |

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| 5.1 | Programmatic Achievements and Management Performance |

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| 5.1.1 | Programmatic Achievements |

Provide an overall assessment of the progress of the PR during the current Phase/Implementation Period based on the key programmatic indicators in the Performance Framework.

At the CCM Meeting in February 8th, 2012 the overall performance of the Phase I of the Round 9 Program “Scale up of response to HIV among most at risk population groups in Montenegro” was assessed as “A1” performing grant. It was noted that the Principal Recipient had managed to achieve and sustain solid progress in achieving program results despite two month delay with the first disbursement at the beginning of the grant implementation.

The average achievement rate for twelve indicators as of cut-off date (31/12/2012) was 111.4%, while the average performance rate for Top Ten indicators (including indicators related to trainings of health and non-health staff) was also above 100%, namely 110.6%.

The Program also demonstrated the potential of its impact through the achievement of impact and outcome indicators revealing the low HIV prevalence among all IDUs (0.3%, BSS 2011) and SWs (0.76%, BSS 2008), as well as potential for possible concentrated epidemic among MSM (4.5%, BSS 2011).

Most important elements that contributed to successful achievements of the planned targets were establishing the Drop -in Centers for IDUs, SWs and MSM as well as the Counseling Center for merchant marines within the Primary Health Care Center in Kotor. These newly introduced services under the current Grant, as well as continuation of successful implementation of the outreach services introduced under the Round 5 HIV Grant covering RAE youth, merchant marines and prisoners. Strengthening the VCT network, established under the Round 5 HIV Grant, consisting of 8 VCT Centers geographically evenly distributed should ensure coverage of the entire Montenegrin territory and has contributed to higher HIV testing rate (1,692 members o most at-risk populations were counseled and tested for HIV, out of them nine were found to be HIV-positive).

One of the areas where it has been recognized that improvement measures should be taken is the provision of psycho-social support services to PLHIV within the NGO sector. It has been also noted that reporting of clients using the specific outreach services should be improved in order to decrease and avoid the possibility of double counting. The introduction of the national electronic database will address this in future.

Please provide a description of the related actions the CCM/RCM/sub-CCM will take, in its oversight capacity, to address these identified performance issues?

In the beginning phase of Grant implementation one of the three MMT Centers located in the north of Montenegro had some difficulties with service provision (due to reluctance o managerial staff to provide such services) and with attracting clients (due to the high level of stigma present in the north of Montenegro).This issue was discussed several times at the CCM meetings during the first semester of 2011 as well as with the Minister of Health. The CCM Oversight Team visited the MMT Center in Berane (Attachment 29) as well as requested the Ministry of Health for their support in overcoming the initial problems. Finally, MMT center in Berane started to function in July 2012.

In 2012, after submission of the reports from sub-recipients to the Principal Recipient, it was recognized that the NGO sector coverage of psycho-social support services for PLHIV was very low. This issue was raised at the CCM meetings in February and March (Attachments 15, 16, 19). As a solution it has been proposed to change the implementing NGO CAZAS with the NGO consisting of PLHIV themselves (NGO *Montenegrin HIV Foundation*).

According to data obtained from the bio-behavioral survey among IDUs conducted in 2011, a discrepancy was noted between number of IDUs reporting to be provided with sterile injecting equipment through the outreach NEX programs and number of IDUs reported to be provided with this equipment by the NGO implementing outreach work. This issue has been discussed at the Annual review Meeting and it was agreed that monitoring of the NGO activities should be increased.

Please summarize the current challenges in M&E systems and capacity based on any recent assessment undertaken during the current Phase/Implementation Period, and provide an update on status of implementation of M&E systems strengthening recommendations supported through Global Fund grant/SSFs and other partners during the current Phase/Implementation Period. Please also comment on the expenditures on M&E (variances, if any) against approved funding under the Global Fund grant/SSF during the current Phase/Implementation Period.

At the MESS workshop held in June 2010, major weaknesses of the National M&E system were identified as: absence of a National M&E plan; inadequate capacity of NGO staff involved in program reporting and M&E activities; insufficient capacity of government staff to implement the HIV surveillance studies; inadequate reporting of the clients (no Unique Identifier Code, no database, high possibility of double counting); absence of a database containing staff already trained in different aspects of the HIV response; absence of o population size estimates: lack of a functioning M&E Unit at the national level in the Institute of Public Health; no developed ToRs for M&E staff at the national and institutional level; and the lack of a Technical Working Group (TWG) on HIV M&E.

During the Year 1 of the Round HIV Grant implementation within the implementation of the MESS action plan, several major improvements and strengthening actions were achieved:

1. ToRs for the TWG were developed;

2. ToRs for M&E person at the national level were developed;

3. ToRs for the focal points for HIV related M&E activities at health care facilities level were developed;

4. ToRs for the NGOs employees in charge for M&E were reviewed;

5. 14 persons from government and NGOs were trained in using of Unique Identifier Code (UIC);

6. All implementing partners working with members of MARPs introduced the UIC as of July 2011, as well as reporting in regard to gender in line with the CCM document “Integrating gender into the national AIDS response”;

7. National M&E plan has been developed and adopted by the National AIDS Commission, CCM and Ministry of Health (Attachments 39,40);

8. Four epidemiologists from IPH have been trained in HIV Surveillance training courses organized by “Andrija Stampar” School of Public Health in Zagreb, Croatia;

8. The process of development of National HIV M&E database is ongoing.

Although development of the National HIV M&E database was not initially planned and budgeted it was requested that savings from the MESS activities be reallocated for the purpose of the database development. Savings had been made in SDA 4.1. Strengthening surveillance among MARPs) as well from the SDA 5.1. Increasing capacity and coordination of the focused response to HIV among MARP.

There are still some activities that have been postponed such as Population Size estimates that are expected to be finished by the end of June 2012.

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| 5.1.2 | Grant/SSF Risk Management |

Please comment on the major grant/SSF management risks and issues, if any, including those attached to the CCM Invitation Letter. Describe how you plan to address those risks and monitor progress in the next Phase/Implementation Period.

The key challenge in the Phase I of the Round 9 HIV Grant was capacity building of the two proposed national PRs (IPH and CAZAS). Taking into consideration the changed requirements for applying for Renewal, CCM Montenegro decided to change the proposed implementation arrangements.

UNDP remains the Principal Recipient (PR), while NGO CAZAS which was previously proposed for the second PR was proposed to be main Sub-Recipient for the NGO part of the program and as such to be in charge of the NGO sector implemented part of the program. This new implementation arrangement carries new challenges and risks in terms of the adequate selection and management of the Sub-sub-recipients (SSRs), adequate monitoring and evaluation, timely disbursements of funds and timely reporting to PR.

In terms of mitigating these risks PR will implement the following:

1. Prior to contracting NGO CAZAS as main SR, capacity assessment of the proposed NGO will be performed using the UNDP methodology in terms of institutional and programmatic management, financial, M&E and sub-recipients capacities.

2. UNDP procurement rules apply to SRs, including the selection of SSRs. NGO CAZAS will advertise the part of the program for NGO sector, and selection of NGOs will be done according to precisely defined criteria. As a control mechanism to avoid conflict of interests, one member of the PR Project Implementation Unit and one CCM member from the Oversight Working Group will be full-fledged members of the selection panel, while Local Fund Agent, namely representatives of Price Waterhouse Coopers Auditing Company, will be invited as the observer.

In case that there are two or more NGOs applying for the activities that have been implemented by the umbrella organization itself, a different modality will be applied in accordance with the UNDP procurement rules and regulations, as well as the CCM document regulating conflict of interest policy.

3. NGO CAZAS as main SR should perform the capacity assessment of the prospective SSRs in line with the UNDP capacity assessment requirements and with one of the PIU members as team member and only upon positive assessment will sign the Agreement with them.

4. The SSRs Agreements will carry the same terms as main SR Agreement.

5. PR team will increase intensity of the monitoring activities of the main SR with continuing field visits and regular meetings with the managerial and program staff. Since UNDP maintains the overall responsibility for all SSRs, PR will also increase the number of field visits to SSRs.

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| 5.1.3 | Grant Performance Rating |

***Please answer the following questions if you are submitting the CCM Request for a Phase 2 or RCC Phase 2. If you are submitting the CCM Request for Periodic Review, proceed to section 5.2 ‘Financial Performance’.***

Grant Performance Rating for the current Phase (Phase 1/RCC Phase 1)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **X** | **A1** |  | **A2** |  | **B1** |  | **B2** |  | **C** |

Please provide a rational and justification for the rating.

At the CCM meeting on February 08th, 2012, CCM of Montenegro assessed the overall performance of Phase 1 of Round 9 Program “Scale up of HIV response among most at risk populations in Montenegro” at “A1”.

Overall, UNDP as Principal Recipient has managed to achieve significant progress in implementation of planned activities and very good programmatic results as of December 31st 2011, including demonstrated the potential for impact as per the evidence by the achievement of impact and outcome indicators (*Attachment XXX. CCM Montenegro Meeting Minutes dated February 08th 2012).* The PR demonstrated strong capacity in the area of program management, as well as in the areas of program monitoring and evaluation and procurement.

The successful implementation of the Round 5 program “Support to implementation of the National HIV/AIDS Strategy in Montenegro” implemented during 2006-2010 provided the basis for the sound implementation of the Round 9 program which is a more focused program which will scale-up activities for most at-risk population groups and PLHIV established in the Round 5 program implementation.

Results to support the A1 rating include:

1) Establishment and functioning of two Drop-in Centers for IDUs;

2) Establishment and functioning of Drop-in center for SWs;

3) Establishment and functioning of Counseling Center for MSM;

4) Establishment and functioning of a Counseling Centre for merchant marines within institutional setting (Primary Health Care Centre, Kotor);

5) Well functioning outreach programs for IDUs, SWs, MSM, RAE youth and merchant marines;

6) Well functioning network of eight VCT centers;

7) Development of the new curriculum for Healthy Life Styles optional subject for secondary schools;

8) Well-designed campaigns for the rights of the MSM population, stigma reduction and condom promotion;

9) Functioning network of three MMT centers within primary health care institutions;

10) Strengthening of the national M&E system through unifying of reporting systems, introduction and regular use of UIC when reporting clients and specific services including successfully implemented regular bio/behavioral surveys among MARPs and young people 15-24;

11) A total of 450 health and 554 non-health professionals engaged in program implementation were trained in different aspects of the HIV response.

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| 5.2 | Financial Performance |

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| 5.2.1 | Financial situation at cut-off date |

**Cash at cut-off date**

***Please note that the financial information required for this section is in the Financial template provided with the CCM Invitation package* Renewals\_Financial Template\_FinancialRequest\_Cash-at-cut-off-date *– the CCM must paste a screenshot of the information to this section in the CCM Request template (Word document) by selecting the relevant cells in Excel and using Paste option in Word to insert as a picture. Financial Request must be filled out in the Excel file only. Do not edit the table after pasting it here!***

|  |  |  |  |
| --- | --- | --- | --- |
| Cash at Cut-off date |  |  |  |
|  | **PR** | **SRs** | **Total** |
| a. Disbursed to PR to cut-off date | 2098811 | N/A | 2098811 |
| b.   Less: Disbursed from PR to SRs | -82760 | 82760 | 0 |
| c. Less: Expenditure incurred to cut-off date | -1526854 |  | -1526854 |
| d.  Add: Interest received | 6556 |  | 6556 |
| e.  Add: Other income - please specify |  |  | 0 |
| **f.   Equals: Cash at cut-off date** | 495753 | 82760 | 578513 |

Please include a **Liabilities summary at cut-off date** with the CCM Request(goods and services received/ordered but not yet paid for).

|  |  |  |  |
| --- | --- | --- | --- |
| Entity | Description | Amount  EURO | Due date |
| Audit company TBD | Audit of all SR-s for period July, 2010-Dec,2011 | 28,000.00 | 20-Apr-12 |
| Institute for Public Health | SUB-RECIPIENT AGREEMENT for implementation of project activities within the SDA: 1.7 Voluntary counseling and testing 4.1 Strengthening HIV surveillance among most at risk population | 78,950.00 | 30-Jun-12 |
| NGO Montevita | SUB-RECIPIENT AGREEMENT for implementation of project activities within the SDA: 3.1 Stigma reduction in all settings | 10,000.00 | 30-Jun-12 |
| Primary Health Care Centre Podgorica | SUB-RECIPIENT AGREEMENT for implementation of project activities within the SDA: 1.1 BCC Community outreach IDU-s | 7,000.00 | 30-Jun-12 |
| Clinical Centre of Montenegro | SUB-RECIPIENT AGREEMENT for implementation of project activities within the SDA: 2.1 Care and support to PLHIV | 7,050.00 | 30-Jun-12 |
| NGO Juventas | SUB-RECIPIENT AGREEMENT for implementation of project activities within the SDA: 1.2 BCC Community Outreach MSM 1.6 BCC Community outreach prisoners | 11,920.00 | 30-Jun-12 |
| State textbook publishing agency | SUB-RECIPIENT AGREEMENT for implementation of project activities within the SDA: 1.8 Youth education in Healthy life styles | 6,200.00 | 30-Jun-12 |
| Osmi red & Meditas | Health products PCR tests for HCV | 18,245.00 | 30-Apr-12 |
| Procurement of HIV rapid test and HCV and HBS antigen tests for  survey among SW and prisoners | The reason for postponing these procurements is to align the  number of tests with survey respondents as well as because of the shelf life of tests | 10,700.00 | 30-Apr-12 |
| Institute for Public Health | Finalization of MESS action plan | 21,125.00 | 30-Jun-12 |
| Development of national HIV data base TBD | Development of national HIV data base | 42,500.00 | 30-Jun-12 |
| Institute for Public Health | Capacity building of IPH | 30,000.00 | 30-Jun-12 |

Have all liabilities at cut-off date been taken into account in the post-cut-off date budget? Yes/No (delete as applicable)

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| 5.2.2 | Analysis of expenditures versus budget |

With reference to the latest available EFR at cut-off date, please summarize the main reasons for any under-spending or over-spending against budget.

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| There was no over-spend in the implementation period referring to the Enhanced Financial Report as of cut-off date.  The reason for under-spending is because advances transferred to SR in amount of Euro 82,760.00 have not been reported and entered into the financial system yet and as such are still not considered as expenditure as well as due to liabilities contracted with SR amounting to Euro 271,690.00 to be implemented by the end of phase I. |

Please comment on whether the overall % expenditure versus budget variance at the cut-off date is in line with the average % achievement against all indicators in the performance framework. If not, please explain the reasons.

|  |
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| Overall expenditure percentage is in line with the average achievement against all indicators in the performance framework.  The only delay in spending refers to the budget line which are not directly related to the indicators, but to capacity building of the two proposed national PRs. |

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| SECTION 6: CCM REQUEST FOR RENEWAL (PR 1)[[4]](#footnote-4) | | |
| 6.1 | Programmatic Proposal |

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| --- | --- |
| 6.1.1 | Program Objectives, SDAs, Indicators and Targets |

Please provide a Performance Framework for the next Phase/Implementation Period and comment on whether indicators and targets are aligned with the national program strategy, plans and systems.

The recently adopted National M&E Plan (Feb 2012) was developed involving participation of all the stakeholders involved in the national response to HIV/AIDS. The National M&E Plan is based on the priority areas defined in the *National Strategic Response to HIV/AIDS* s *in Montenegro 2010-2014* supported by national and GFATM funding. The national M&E Plan is based on the results of the bio-behavioral and other surveillance surveys realized in the period 2006-2011, as well as based on data and suggestions obtained from program implementing partners and key stakeholders involved in the implementation of the National strategy through a thorough consultation process. Consultations included MoH, IPH, GFATM PIU and representatives of NGO sector and all other institutions involved in the national HIV response.

The National M&E plan includes a revised set of national impact, outcome and program indicators defined in the National AIDS Strategy as well as program indicators related to GFATM funded program activities with clearly defined rationale, indicator type, data collection frequency and data collection methodology, as well as responsible entity for each indicator. Indicators have been designed to fulfill national needs as key and/or recommended indicators, or to fulfill needs at international level such as UNGASS or GFATM program indicators.

UNDP as PR will harmonize data collection system under the GFATM Round 9 HIV Grant with the National M&E Plan requirements in order to be easily transferred to the future unique national database and reporting system. Therefore, all the Phase II indicators within the Performance Framework have been completely in line with the national M&E plan.

Based on the identified gaps and challenges under section 5.1.1 “Programmatic Achievements” please summarize the key M&E systems strengthening activities, including any planned operations research or evaluations to be undertaken during the next Phase/Implementation Period. Does the CCM propose reallocation of resources to support the above stated M&E strengthening initiatives? If yes, comment on the budgetary and programmatic implications, if any, on the overall request.

During the Round 5 HIV program and Year 1 of Round 9 HIV program implementation clients of outreach and drop in services were not registered using the UIC and, consequently the possibility of double counting was high. Due to very high level of stigma and discrimination in the country in a very traditional and closed community, it was very hard at the beginning of these activities to reach the members of MARPs and even harder, if not impossible, to request them for the code. Therefore, the introduction of UIC was gradual as NGOs working with MARPs began to gain their trust. After training of all program implementers in the use of the UIC in June 2011, all of them were required to use UIC as of July 2011.

During the MESS workshop in June 2010 as well as during development of the MESS implementation action plan (2010-2012) one of the main findings was the absence of a national electronic database. Savings from MESS action plan implementation were requested and approved by Fund Portfolio Manager for reallocation for the national database development (in process) which was not planned and budgeted at the original budget.

The recently approved National M&E plan precisely defines the process of registering clients and data flow among key actors. Registration of clients at the service provision spot through standardized reporting forms using the unique identifier codes provide accurate data on service coverage thus avoiding double counting and will contribute to improvements in quality of service provision. Data obtained at service delivery points will be stored in archives of each implementing entity and also be available through the on-line national data base system. The national database will be under responsibility of the Institute of Public Health. Data entry will be directly performed though web-based application by all entities involved in program activities with reporting forms for each service delivery area. The Institute of Public Health and UNDP as PR will have direct access to reports and overall data, while other users will have limited access depending on the level defined.

General coordination for surveillance studies and other operational research remains the responsibility of the Institute of Public Health. Research protocols for surveys conducted within same population groups will remain compatible in order to ensure comparison between repeated surveys. The M&E Working group will discuss implementation requirements for each survey and any needs for technical assistance.

For the Phase II period 5 surveys have been planned: among RAE youth and merchant marines in Year 3, among IDUs and MSM in Year 4 and among SWs in Year 5. Continuation of capacity building in second generation surveillance for two relevant health professionals per year has been envisaged. Survey data will also serve as basis for data triangulation and for evaluation of the quality of services provided by NGOs to specific target groups.

It has been recommended that IPH takes over the role of national coordination body for M&E to ensure more efficient monitoring of the M&E plan. The M&E Working Group will be established within CCM and consist of experts from governmental institutions and representatives of the NGO sector. The group will have the mandate to plan and monitor proposed M&E documents for the National AIDS Commission (NAC), as well as to prepare the final M&E report with the recommendations for the improvement of the National HIV response. Further capacity building of health professionals in the area of HIV/STIs prevention, treatment and care is needed to ensure continued collection, processing and dissemination of high quality HIV/STIs related data.

The PR will increase the number of field visits and meetings with SRs to ensure quality of the services provided. This has no implications for the planned budget.

External evaluation of the prevention programs for all MARPs is planned for Year 3. The findings will serve as basis for better tailoring of the programs in Years 4 and 5.

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| 6.1.2 | Pharmaceutical and Health Product Management (if applicable) |

***Please complete this section only if procurement of Pharmaceutical and Health Products is planned in the next Phase/Implementation Period. Otherwise, continue to section 6.2 “Financial Proposal”.***

Based on the key risks and challenges in the PHPM area in the current Phase/Implementation Period as identified under section 5.1.2 “Grant/SSF Management”, please summarize the measures and/or mechanisms that have been put in place or are proposed in the PSM plan (or the Country Profile if this is already in place) for the next Phase/Implementation Period. Please include an assessment of the risk of treatment interruptions at the health facilities in the next Phase/Implementation Period and a list of the possible underlying causes related to PHPM activities that may have a negative impact on the continuous availability/access to key health products (such as stock outs, diversion and theft of health products).

UNDP as PR has been responsible for the overall procurement under the Round 5 and Phase I Round 9 HIV Grant without any procurement risk or issues identified for the period of Aug 2006- Dec 2011. Procurement is performed in accordance with the UNDP overall procurement rules and guidelines in order to ensure transparency, competitiveness and best value for money.

UNDP is also recognized as the representative office of the international organization by the Ministry of Foreign Affairs of Montenegro and as such is exempted from taxes and duties, including the procurement of goods during the program implementation and so far has not encountered difficulties in obtaining tax exemptions.

In the Phase II of the Round 9 HIV Grant the PR will be responsible for the overall procurement of health products such as urine tests, rapid tests for HIV for VCT Centers and bio-behavioral surveys, PCR tests for HCV, HCV and HBS antigen tests, kits for safe injecting (needles, syringes, cookers, filters, distilled water, hepathrombin cream), condoms and lubricants.

Through regular communication with program implementing partners, a desired expiry date is obtained for each type of the test to be procured. Also, in the previous implementation period a system to monitor the stock has been developed in order to avoid stock out situations.

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| 6.2 | Financial Proposal |

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| 6.2.1 | | Resources available to finance the grant/SSF after cut-off date |
| ***Please note that the financial information required for this section is in the Financial template provided with the CCM Invitation package* Renewals\_Financial Template\_FinancialRequest\_Resources-available *– the CCM must paste a screenshot of the information to this section in the CCM Request template (Word document) by selecting the relevant cells in Excel and using Paste option in Word to insert as a picture. Financial Request must be filled out in the Excel file only. Do not edit the table after pasting it here!***   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  |  | **Year 3** | **Year 4** | **Year 5** | **Total** | | a. TRP clarified amount allocated to PR |  | 771890 | 883040 | 811115 | 2466045 | | b.  Any Board mandated adjustments |  | -153484 | -212878 | -250258 | -616620 | | c. Adjustment +/(-) for (borrowing) and/or staggered commitments not yet committed |  |  |  |  |  | | **d. Adjusted TRP clarified amount** |  | 618406.5 | 670162.4 | 560856.6 | 1849425 | | e.  CCM reallocations +/(-) (implementation arrangements) |  |  |  |  | 0 | | **f. Adjusted reallocated amount** |  | 618406.5 | 670162.4 | 560856.6 | 1849425 | | g.  + Undisbursed amount at cut-off date |  |  |  |  |  | | h.  + Cash at cut-off date |  |  |  |  | 578513 | | **i.   =Total Resources available** (after cut-off date for the next Phase/Implementation Period) |  |  |  |  | 2427938 |   ***Please note that TRP Clarified Amount must take into account Global Fund Board mandated adjustments based on Income level as follows:***  ***• 90% for LICs and LLMICs***  ***• 75% for ULMICs and UMICs***  ***Please refer to your invitation letter for your income level. Further guidance can also be found in the Financial template.*** | | |
| |  |  | | --- | --- | | 6.2.2 | Summary funding request from cut-off date to end of next Phase/Implementation Period |   ***Please note that the financial information required for this section is in the Financial template provided with the CCM Invitation package* Renewals\_Financial Template\_FinancialRequest\_FundingRequest** ***– the CCM must paste a screenshot of the information to this section in the CCM Request template (Word document) by selecting the relevant cells in Excel and using Paste option in Word to insert as a picture. Financial Request must be filled out in the Excel file only. Do not edit the table after pasting it here!***   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | **Year 2 after cut-off date** | **Year 3** | **Year 4** | **Year 5** | **Total** | | a. Total Budget required (after cut-off date for the next Phase/Implementation Period) | 730423 | 618406.5 | 670162.4 | 560856.6 | 2579848 | | b.   - Undisbursed amount at cut-off date |  |  |  |  | 0 | | c. - Cash at cut-off date |  |  |  |  | 578513 | | d.  = Incremental amount requested |  |  |  |  | 2001335 | | e. % of adjusted TRP clarified amount (cannot exceed 100% of adjusted TRP clarified amount) |  | | | | 81% | | | |
| 6.2.3 | CCM Budget Request for the next Phase/Implementation Period |

Please explain how lessons learned from the current Phase/Implementation Period have been factored into this funding request (e.g. budget reallocations, under-spending leading to more realistic budget estimates, reflection of price changes).

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| In developing the budget for Phase II all previously experienced budget variances have been fully taken into consideration. Lessons learnt from the Phase I period include ensuring more precise budgeting of goods based on the prices obtained in the tendering procedures during the Phase I, as well as using more competitive prices for hotel accommodation.  Activities that have been shown to be not realistic were removed (VCT services in prison), while some activities were removed because of the possibility to fund them from other resources (campaigns against homophobia, campaigns for condom promotion). Taking into consideration that during the negotiation process for the Round 9 HIV grant, the originally proposed budget was reduced by 8% for all 5 years in an effort to find efficiency gains in line with the GFATM recommendations. However, it was not possible to reduce the budget for Phase II unit costs in line with Global Fund Board mandated adjustments. Therefore in effort to conform to the adjusted budget it was necessary to take out from the Phase II all the activities which are not directly related to the MAR-s. Detailed analysis of savings is provided in Attachment 53.  cid:image001.png@01CD1643.1DFF4160 |

Does the budget request reflect the average programmatic performance in the current Phase/Implementation Period? If not, please provide an explanation.

Yes. This is an “A1” Grant allowing applying for 90-100% of the upper limit being set to 75% of the originally budgeted amount for Phase II. Therefore, based on the programmatic achievements and financial expenditures in the Phase II, CCM Montenegro applied for 75% of the originally budgeted amount for Phase II of the Round 9 HIV program.

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| 6.3 | Compliance with Focus of Proposal Requirement |

***This question is not applicable for Low Income Countries.***

Describe whether the focus of proposal requirement has been met per the threshold based on the income classification for the country.

Round 9 HIV Program “Scale up of the national response to HIV/AIDS among most –at-risk population groups in Montenegro” was, from the very beginning, focused mainly on HIV prevention activities among most at-risk groups. Based on the new requirements for submission of Request for Renewal all activities that are not directly focused on most at-risk population groups have been removed. These include a survey among young people aged 15-24 planned for Year 4 (Objective 4), all related activities for promotion and evaluation of Healthy Life Styles subject in secondary and primary schools (Objective 1) and a survey among general population aged 15-59 to measure HIV-related awareness and level of stigma (Objective 4).

Most-at-risk populations defined in the *National strategic response to HIV/AIDS* are IDUs, SWs, MSM, prisoners, RAE youth, merchant marines and PLHIV. Small scale activities targeting TB/HIV collaborative activities have been newly introduced in order to support the smooth transition from the end of the Round 6 TB grant and State assumption for all TB related activities.

Under Objective 1 “To prevent HIV transmission among most-at-risk populations” primary focus has been put to direct work with clients belonging to MARPs through outreach activities and service provision in specialized drop in and counseling centers and provision of methadone maintenance treatment (SDA 1.1 – SDA 1.6). Activities under SDA 1.7 include strengthening quality of VCT services through training of new counselors. Modest funds have been allocated to promote condom use planned for Year 4.

Under Objective 2 “To improve quality of life and support to PLHIV” activities aimed to strengthen NGO provided psycho-social support to PLHIV have been slightly scaled-up in comparison to the original proposal. Other activities under this objective include sensitization trainings for health professionals aimed to raise the general knowledge related to HIV prevention and transmission and to influence their willingness to provide necessary health care to PLHIV and members of different MARPs since this remains a problem amongst heath care providers.

Under Objective 3 “Stigma reduction in all settings” there are two SDAs. In SDA 3.1 primary focus has been given to training of judges, lawyers, public prosecutors and other judiciary staff, as well as to train student journalists and young politicians to reduce HIV-related stigma and discrimination and sensitize them to work with MARPs. Modest funds have been allocated to anti-stigma and anti-discrimination activities to create e a more supportive environment.

Activities within SDA 3.2 “Strengthening the capacity of all relevant national stakeholders in gender issues related to the national response to HIV/AIDS” have been slightly scaled up and include activities as priority within the document “Integrating gender into national AIDS” response developed in 2011 (Attachment # XXX. Integrating Gender into National AIDS Response”), such as training 25 relevant national stakeholders in the HIV response from government and the NGO sector as well as 25 media representatives. Modest funds have been allocated to a media awareness raising campaign in Year 3.

Under Objective 4 “To strengthen the HIV surveillance system among most-at-risk populations” five surveys have been planned: among RAE youth and merchant marines in Year 3, among IDUs and MSM in Year 4 and among SWs in Year 5. Continuation of capacity building in second generation surveillance for two relevant health professionals per year is envisaged.

Under Objective 5 “To increase capacity building and coordination of a focused response to HIV” advanced training in public relation in regard to HIV and MARPs for 25 key stakeholders in the HIV response that have already been trained in Years 1 or 2 is included since public relation skills of the key stakeholders have been recognized as insufficient and sometimes even harmful for the effective creation of a supportive environment. Regular three-day Annual Review Meetings for CCM members, implementing partners and key stakeholders serve as a platform for annual evaluation of program activities, and are one of the mechanisms for controlling the additionality of GFATM funds as well as informing a broader audience on the impact and outcome of the overall program. External evaluation of the program involving engagement of the international expert of the HIV prevention programs among MARPs has been planned for Year 3.

1. Total amounts for each Principal Recipient. [↑](#footnote-ref-1)
2. The health care system in Montenegro is informed by two laws: the *Law on Health Protection* and the *Law on Health Insurance*. [↑](#footnote-ref-2)
3. Please fill out the section separately for each PR. [↑](#footnote-ref-3)
4. Please fill out the section separately for each PR. [↑](#footnote-ref-4)