Bosna i Hercegovina
Босна и Херцеговина

The Ministry of Civil Affairs

Ministry of Health, Federation of Bosnia and Herzegovina,
and
Ministry of Health and Social Welfare, Republika Srpska

UNGASS Country Progress Report

Reporting period: January 2006 – December 2007

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II. Introduction

This is Bosnia and Herzegovina's (BiH) first submission of a Country Progress Report on United Nations General Assembly Special Session (UNGASS) Indicators on HIV/AIDS. The process for data collection and preparation for the report began in mid-January 2008, therefore there was a need to simplify the preparation process indicated in the UNGASS Guidelines.

In consultation with UNAIDS, the following deadlines were agreed:

- data entry in CRIS and submitted by 8 February 2008 (accomplished)
- narrative section of the report to be submitted by end-February.

Baseline data:

BiH has a complex administrative structure, established after the war in 1995, comprising of two Entities - the Federation of Bosnia and Herzegovina (FBiH), and Republika Srpska (RS), and the Brcko District.

In the FBiH, the health system administration is decentralized, with each of the 10 cantonal administrations having responsibility for the provision of primary and secondary health through their own Ministry of Health. In the RS, authority over the health system is centralized, with planning, regulation and management functions held by the Ministry of Health and Social Welfare in Banja Luka.[1] Hence, this report presents most data disaggregated at the Entity level.

Comprehensive data in the form of population surveys or demographic health surveys do not exist on BiH. It was therefore agreed with the Entity AIDS Coordinators to utilize existing data thereby, establishing a basis for future reporting: UNICEF's Multiple Indicator Cluster Survey 3 2006, UNICEF's Rapid Assessment and Response on HIV among Vulnerable Young People in South Eastern Europe 2002, UNICEF's Biological and Behavioural survey among Injecting Drug Users 2007; and EuroHIV Surveillance in Europe, End-of-year report 2006, No 75, 2007.

Exceptionally, reporting to the European Centre for the Epidemiological and Monitoring of AIDS (EuroHIV) was done jointly by the Entities. Since Brcko District has to date not a single HIV positive case, they were not included in the above reporting.

The MICS3 2006 provided information on HIV knowledge and risk behaviour amongst girls and women aged 15-49 years. Comparable data is not available for men. The RAR 2002 provided information on youth i.e. up to 24 years, but the data is not current. In both MICS and RAR, it is difficult to compare the results as different questions are asked and they are not consistent with the data needed to report on UNGASS Indicators.

[1] The World Bank Working Paper No. 68: HIV/AIDS in the Western Balkans: Priorities for Early Prevention in a High-Risk Environment, Godinho, et.al.

As a further complication, the questions to be included in surveys to enable reporting on UNGASS indicators were changed in the Guidelines dispatched to countries in August 2007. The UNICEF survey on injecting drugs users carried out in early 2007 integrated questions into the questionnaire based on 2005 UNGASS Indicator reporting, however it was not possible to interpret all of the survey data post-facto to comply with certain indicators.[2]

In addition to existing data sets, key experts in the HIV/AIDS sector: Government institutions, UN Agencies[3], some international non-governmental organization (INGO) and local non-governmental organization (NGO) individuals were interviewed and data compiled (see details on list of people interviewed). The Entity AIDS Coordinators from the FBiH and the RS, and the EPI Coordinator from Federal Institute of Public Health (IPH), Mostar provided extensive inputs for this report. Without their input the preparation of the UNGASS country progress report would not have been possible (see Annex 1).

III. Status at a glance

According to the Population Reference Bureau, BiH's mid 2003 population was 3.9 million people (FBiH 2.5 million, RS 1.4 million), whereas UN population Division puts the 2003 population at 4.2 million.[4] Since 1991, no population and household census has been undertaken in the country, and the demographic trends and patterns in BiH have significantly changed due to the events of the 1990, respectively the war and the large migration following it.

BiH is a low HIV prevalence country with an estimated prevalence of <0.1%.[5] Due to the considered low-level of HIV/AIDS risk, the measures in the country are predominantly focused on promotion of protective behaviour in most-at-risk population groups.

Sub populations that have been identified as being at higher risk of HIV transmission are: injecting drug users (IDU), Men who have sex with Men (MSM), Sex workers and their clients, Cross-border Migrants, Migrant Workers, Internally Displaced people, Refugees, and Prisoners. Although Roma population (marginalized group) and youth (adolescents and elementary school children in rural areas) are not referred to as target groups in the national HIV/AIDS strategy, some INGOs, UN Agencies, and the UNDP/ Global Fund to Fight Against AIDS, Tuberculosis and Malaria (GFATM) programme have singled them out for attention.

[2] Croatian Ministry of Health UNGASS Indicator focal points who conducted training for data managers on CRIS ver.2.1 in Teslic, BiH during 11-14 February 2008.
[3] WHO reports an estimated range on TB and HIV/AIDS for BIH and it does not verify data directly with individual institutions in the country.
[4] The World Bank Working Paper No. 68, Godinho, et.al.
[5] Report on the Global AIDS Epidemic, UNAIDS 2006

The inclusiveness of the stakeholders in the report writing process:

Although workshops with stakeholders directly addressing UNGASS Indicators and reporting were not carried out, UNGASS reporting has been discussed at meetings of the National Advisory Board on HIV/AIDS (NAB), the Global Fund project's Country Coordination Mechanism on HIV/AIDS and Tuberculosis (CCM), and in the Joint UN Team on HIV/AIDS. Therefore, all relevant parties are fully aware of the UNGASS reporting requirements.

The UNGASS reporting requirements were discussed at two Joint UN team on HIV/AIDS meetings – in November 2007 and January 2008. At these meetings, the technical assistance needs of the reporting were discussed and agreed. A NAB meeting was held where the UNGASS process was discussed and a focal point identified within the Ministry of Civil Affairs. The UNGASS Indicator Country Progress Report was agreed to be completed on the basis of existing / officially accepted data.

Key informants interviews were conducted with:

- all three government AIDS Coordinators:
  a) Dr. Zlatko Cardaklija, FBiH
  b) Dr. Natasa Loncarevic, RS who is also the Monitoring and Evaluation Coordinator for the UNDP/ GFATM supported HIV/AIDS Programme in RS
  c) Dr. Jasna Sadic, Brcko District
- Dr. Jelena Ravlija, EPI Coordinator/Epidemiologist, Federal IPH, Mostar who is also the Monitoring and Evaluation focal point for UNDP/GFATM HIV/AIDS programme in FBiH
- Dr. Dragana Stojisavljevic, Director, Public Health Institute (IPH), RS with
- Dr. Ljubica Jandric, Epidemiologist, IPH, RS, and
- Dr. Radovan Bratic, Epidemiologist, IPH, RS
- Dr. Gordana Guzijan, Director, Blood Transfusion Institute, RS
- Ms. Deborah McWhinney, Deputy Representative, UNICEF
- Dr. Ranko Petrovic, HIV/AIDS Specialist, UNICEF
- Ms. Vesna Besirevic, HIV/AIDS Project Officer, UNICEF
- Dr. Nesad Seremet, HIV/AIDS & Tuberculosis (TB) Programme Director, UNDP
- Ms. Mirela Kadribasic, Coordination Assistant, HIV/AIDS & TB, UNDP
- Mr. Sasa Potezica, HIV/AIDS Data Collection Coordinator, UNDP, RS
- Mr. Haris Hajrulahovic, Head of Office, WHO
- Ms. Zeljka Mudrovcic, Assistant UNFPA Representative, UNFPA
- Mr. Srdjan Kukolj, Action Against AIDS (AAA) active in RS whose main targets are Men who have sex with Men and sex workers
- Mr. Albert Panjic, World Vision
- Ms. Maja Grujic, Project Manager, World Vision
- Ms. Aida Muslic, Country Director, Fondation PH Suisse - Partnerships in Health (FPH)

The State Hospital of FBiH, Treatment Centers in Tuzla and Sarajevo were also contacted for information and clarification.

Considering the reporting deadline, there was no time to meet World Bank, bilateral agencies and other NGOs active within the HIV/AIDS sector in the country.

The status of the epidemic

EuroHIV data[6] for BiH to the end of 2006 show a cumulative total of 92 AIDS cases, of which 51 have died. For AIDS cases where exposure category was known, there are 14 attributed to MSM, 15 to IDU, and 45 to heterosexuals. For HIV infection 133 cases have been reported to the end of 2006, including 23 MSM, 19 IDU, 73 heterosexual, and 1 mother to child transmission.

In the early years of the epidemic most people living with HIV (PLHIV) were reported to have acquired the infection outside of BiH, either due to economic migration or as a result of displacement to other countries during the war. By 2007 this is less the case as reflected by an increase in infections acquired within BiH.[7]

The policy and programmatic response

A National HIV/AIDS strategy 2004-2009 is in place and contains five Strategic Goals to: prevent transmission and spread of HIV; ensure appropriate treatment, care and support for people living with HIV/AIDS; create a legal framework for the protection of ethic principles and human rights for people living with HIV/AIDS (PLHIV); ensure cooperation and development of sustainable capacities to combat HIV/AIDS; and encourage and strengthen links with international institutions in the fight against HIV/AIDS.

Since 2004, a small number of international agencies have been supporting governmental and non-governmental efforts to enhance HIV prevention activities in the country – namely, UNICEF, UNFPA and INGO FPH. Studies on risk behaviour have been supported and peer education, youth-friendly services and Voluntary Confidential Counselling and Testing (VCCT) models were developed, inter alia. The FBiH Ministry of Health also strengthened its HIV response by naming 10 Cantonal AIDS Coordinators in 2005 and opened VCCT centers in each Canton in 2006.

Whereas there have been valuable initiatives started in the past few years, there has also been a general lack of resources and overall political leadership to implement the HIV/AIDS strategy in the country. With the approval of Global Fund proposal, some parts of the HIV/AIDS strategy is under implementation.

Given BiH's complex legal framework, fragmented health sector (with no national Ministry of Health), and absorption capacity, the government formally asked UNDP to take on the role of the Principle Recipient for the Global Funds, and with the Ministry of Health in the FBiH and Ministry of Health and Social Welfare in the RS, to ensure the effective implementation of the Global Fund grants. In addition

[6] EuroHIV. Surveillance in Europe. End-of-year report 2006. Saint-Maurice: Insitut de veille sanitaire, 2007. No. 75

[7] Epidemiologist, Federal IPH, Mostar

to on-going projects supported by other international organizations, UNDP has in the last year provided support to BiH's national institutions, experts and NGO representatives, and through the CCM developed two successful applications to Global Fund for implementation of the comprehensive HIV/AIDS and Tuberculosis (TB) prevention and treatment programmes.

As in all Global Fund activities, the UNDP/GFATM HIV/AIDS programme in BiH are based on harm reduction principles, including community outreach, peer based education, diversified drug treatment services, condom distribution and promotion, addressing stigma and discrimination, and providing psychosocial support to PLHIV. Through the implementation of these activities, UNDP and the Ministry of Health and Social Welfare in the RS and Ministry of Health in the FBiH, together with UN partners such as UNICEF, UNFPA and WHO, seeks to strengthen and scale up the existing services to ensure country-wide coverage of effective health services, while supporting the development of a national system for monitoring and evaluation.

Multi-sectoral cooperation has significantly improved resulting in involvement of civil society in the policy-making process through civil society representatives' active role in CCM and NAB.

UNGASS indicator data in an overview table:

The UNGASS Indicator Data table includes 27 indicators, of which some have no relevance for BiH context. Below is a summary of information on each of these indicators.

Indicator 1: AIDS spending
Due to the shortage of time it was not possible to compile comprehensive data utilizing the National Funding Matrix. Therefore the expenditures stated below are not complete since information could not be collected from bilateral agencies, WHO and World Bank active within the HIV/AIDS sector during the process of writing this report.

According to the UNDP/GFATM programme report, the overall expenditure for HIV/AIDS in 2007 was reported as USD 2,160,601. INGO World Vision's contribution was indicated as USD 50,270 and an estimated BiH Government expenditure of USD 400,000 in the same report. UNICEF's expenditure for 2007 was reported as USD 424,480[8]. INGO FPH expenditure for the ongoing survey on MSM and sex workers was reported as USD 10,000[9]. And, UNFPA reported a total contribution of USD 259,586 to HIV/AIDS in 2007.[10]

The government expenditure is likely to be under-reported as the Solidarity Fond in the FBiH and Health Insurance Fund in the RS covers all treatment costs. In time, one should look at the expenditure of these funds to properly assess HIV/AIDS expenditure by public sources.

[8] UNICEF BiH
[9] INGO FPH
[10] UNFPA BiH

Indicator 2: The National Composite Policy Index Questionnaire Part A was duly completed by the two Entity AIDS Coordinators. Part B was completed by one INGO: FPH and three local NGOs: AAA (RS), Margina (FBiH), APOHA (FBiH).

No	Indicator Name		Indicator Relevance	Indicator Data
National Programme Indicators:				
3	Blood Safety	Percentage of donated blood units screened for HIV in a quality assured manner	Relevant – data available	No external quality assurance system in place therefore the result is 0%
4	HIV Treatment: ART	Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	Relevant – data available for 2006 and 2007	2006: 100% (33 out of 33) 2007: 100% (30 out of 30)
5	Prevention of Mother-to-Child Transmission:	Percentage of HIV infected pregnant women who received ARV to reduce risk of mother to child transmission	Not relevant	2006-2007: Only 1 recorded case in 2006 – mother not tested (see explanation on p.9). No other known cases.
6	Co-management of Tuberculosis and HIV treatment:	Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV	Relevant – data available from Federal IPH Mostar	2005-2007: 1 co-infection of TB/HIV in 2005 (RS), and 1 in 2006 (FBiH), 1 in 2007 (FBiH)
7	HIV testing in General Population:	Percentage of **women and men aged 15-49** who received a HIV test in the **last 12 months** and who know their results	Relevant – data only available on females from MICS3 2006	Only 2.6% of the female respondents had tested for HIV
8	HIV testing in Most-at-Risk Populations:	Percentage of sex workers populations who received an **HIV test in the last 12 months and know their results**	Relevant – data from RAR 2002	96.15% received HIV test. No information on test results.
		Percentage of Men who have sex with Men who received an **HIV test in the last 12 months and know their results**	Relevant – data from RAR 2002	10% received HIV test. No information on test results.
		Percentage of injecting drug users who received an **HIV test in the last 12 months and know their results**	Relevant – data available from IDU survey 2007	Data only from Sarajevo site used on all IDU related indicators. 53.46% received HIV test and know results
9	Most-at-risk Population: Preventive Programme:	Percentage of sex workers reached with HIV prevention programmes	Relevant – data not available	
		Percentage of Men who have sex with Men reached with HIV prevention programmes	Relevant – data not available	
		Percentage of injecting drug users reached with HIV prevention programmes	Relevant – data available	Total percentage not available as Q.2 was not asked (see Annex 2).
10	Support for children affected by HIV and AIDS	Percentage of orphaned and vulnerable children aged 0-17 whose households received free external support in caring for the child	Not relevant	Not reported for BiH.
11	Life skills based HIV education in schools:	Percentage of schools that provide life-skills based HIV education in the last academic year	Relevant – data available from UNICEF Partner Reporting Documentation 2007	All schools: 24.34% Primary Schools: 8.57% Secondary Schools: 62.41%
National Knowledge and Behaviour Indicators:				
12	Orphans: school attendance:	Current school attendance among orphans and non-orphans aged 10-14	Not relevant	Not reported for BiH
13	Young people: knowledge about HIV prevention	Percentage of young women and men aged **15-24** who **both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions** about HIV transmission	Relevant – data available on females from MICS3 2006 only	43.5% of females has comprehensive knowledge of HIV/AIDS transmission. No comparable data available on men.

14	Most-at-risk population knowledge about HIV prevention	Percentage of sex workers who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Relevant – data not available	Survey to be carried out in 2008.
		Percentage of Men who have sex with Men who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Relevant – data not available	Survey to be carried out in 2008.
		Percentage of injecting drug users who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Relevant – data available from IDU survey 2007	21.92% of respondents from Sarajevo site answered correctly to all 5 questions
15	Sex before age 15	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	Relevant – data available on females from MICS3 2006	0.6% of females reported sex before age 15
16	Higher risk sex	Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	Relevant – data available on females from MICS3 2006	8% of females reported sexual intercourse with more than 1 partner. 25.7% reported intercourse with non-regular partners
17	Condom use during higher risk sex	Percentage of women and men aged 15-49 who have had more than one partner in the **past 12 months** reporting the use of a condom during their last sexual intercourse	Relevant – data available on females from MICS 2006	71.50% of females surveyed reported condom use with non-regular partners.
18	Sex workers: condom use	Percentage of female and male sex workers reporting the use of a condom with their most recent client	Relevant – data available from RAR 2002	65.4% reported condom use
19	Men who have sex with Men: condom use	Percentage men reporting the use of a condom the last time they had anal sex with male partner	Relevant – data available from RAR 2002	6.7% reported condom use
20	IDU: condom use	Percentage of injecting drug users reporting the use of a condom the **last time** they had sexual intercourse	Relevant – data available from IDU survey 2007	Sarajevo site data utilized, and only on condom use with steady partners reported as 23.2%. Casual partners were not utilized for UNGASS indicator reporting which is higher: 48% reported condom use.
21	IDU: safe injecting practices	Percentage of injecting drug users reporting the use of sterile injecting equipment the **last time** they injected	Relevant – data available from IDU survey 2007	Sarajevo site reported 25.4%. (closest proxy used: no. of times the last needle /syringe was used before thrown away = 1 time)
National Impact Indicators:				
22	Reduction in HIV Prevalence	Percentage of young women and men aged 15-24 who are HIV infected	Not Relevant	Not reported for BiH
23	Most-at-risk populations: reduction in HIV prevalence	Percentage of sex workers who are HIV infected	Relevant – data not available	No second generation surveillance data. Survey to be carried out in 2008.
		Percentage of Men who have sex with Men who are HIV infected	Relevant – data not available	No second generation surveillance data. Survey to be carried out in 2008.
		Percentage of injecting drug users who are HIV infected	Relevant – data available from IDU survey 2007	0.1% in Sarajevo site
24	HIV treatment: survival after 12 months on ART	Percentage of adults and children with HIV still alive and known to be on treatment 12 months after initiation of ART	Relevant – data available from AIDS Coordinators	80% (8 out of 10 PLHIV survived – 2 died)
25	Reduction in Mother-to-child transmission	Percentage of infants born to HIV-infected mothers who are infected	-	Not required to report

III. Overview of the HIV/AIDS epidemic in Bosnia and Herzegovina:

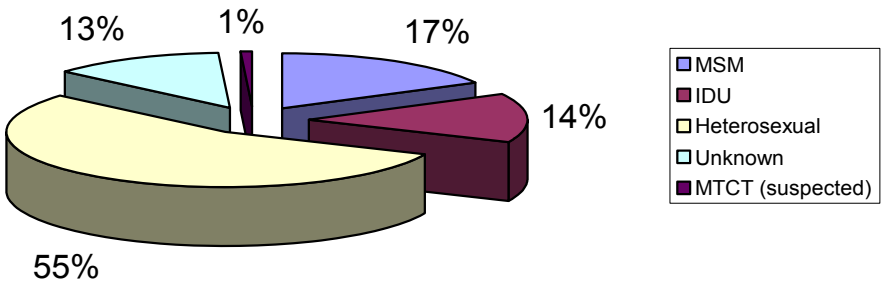
a. The first case of HIV was registered in 1986 and until end 2006 BIH has registered 134 people as HIV positive (FBiH: 81, RS: 53). Of these 103 were recorded as males, 30 females, and 1 recorded as unknown[11]. Some of them have died, and some were lost to follow-up.

   In the FBiH there are currently 35 PLHIV (24 males, 7 females) registered and 22 of them have developed AIDS symptoms and receive ART. In the RS, of the registered 22 PLHIV who developed AIDS symptoms 14 died, and 8 (6 males, 2 females) are currently receiving ART.[12]

   Although survival of PLHIV has improved from 1989 onwards, based on the data recorded from 1989-2007, the proportion of PLHIV living <1 year after AIDS diagnosis can be estimated at 39 percent, 1-2 years: 12.7 percent, 3-4 years: 6%, and >5 years: 1 percent. Therefore the median survival is approx. 1.4 years.[13]

b. With respect to probable modes of transmission, the majority of reported transmission modalities were heterosexual at 55 percent, 17 percent MSM, 14 percent IDU, 1 percent MTCT, and 13 percent where it is not known[14].

Probable Transmission routes of HIV infections in BiH (1999-2006), EuroHIV 2007



   There was only one recorded case of mother-to-child transmission between 1986 and 2007. A 5 year old child was diagnosed in 2006 as HIV positive. The mother of the child was from Ukraine and has returned back to her country and has had no further contact with the child. The treatment center presumes that the transmission was vertical but as the mother was not tested and showed no

[11] Source: Entity AIDS Coordinator, FBiH [Due to bad reporting system during former Yugoslavia]
[12] Source: Entity AIDS Coordinators from RS and FBiH, and IPH, Mostar. All figures reported in this report are based on officially registered data.
[13] Source: Epidemiologist, Federal IPH Mostar
[14] EuroHIV No 75, 2007 (see earlier footnote on EuroHIV for more details)

visible symptoms at the time of her visit, this cannot be verified. ART was begun in 2007 through the Public Health Care system with limited funding. In 2008 the Treatment Center is continuing to provide treatment to the child, however there is lack of liquid ARV drugs in the country.

c. HIV Prevalence: The VCCT center reports in 2006, out of a total of 3,464 people tested 15 were HIV positive. From the total 3,435 were informed of their HIV test results. Given the ratio of population tested in VCCT and HIV positive cases, and given the over-representation of most-at-risk populations undergoing testing in VCCT centers, this puts the likely prevalence rate of those tested at VCCT between 0.1 and 0.5%.

   The following is a report of HIV tests carried out at VCCT centers in BiH from 01.01.2006 – 31.12.2006[15]:

Population Group	Total Tested	HIV positive Cases	Informed of Test
Sex workers	51	0	51
MSM (homosexual/bisexual)	58	6	58
Injecting Drug Users	413	4	410
Non-injecting Drugs Users	65	0	63
Transfusion recipients	231	0	231
Hemophilic clients	3	0	1
Family members of HIV cases	13	2	13
Total most-at-risk population	834	12	827
Heterosexual	447	3	431
Pregnant women	1524	0	1524
Others	659	0	653
Total	2630	3	2608
Total Tested	3464	15	3435

   Note although all of these population groups were also tested for Hepatitis C (HCV) and Hepatitis B (HBV), results are not included in this table.

   Pre-testing and post-testing counseling has existed since the beginning of 2005 in two locations supported by UNICEF and was expanded in 2006 in the FBiH when VCCT centers were opened in all 10 Cantons. VCCT centers are meant to target most-at-risk population groups in the country i.e. IDU, MSM, sex workers, and Roma population with the provision of free of cost voluntary and confidential counseling and testing for HIV. With the support from UNDP/GFATM programme 8 VCCT centers in the country were reconstructed, upgraded and training to staff provided.

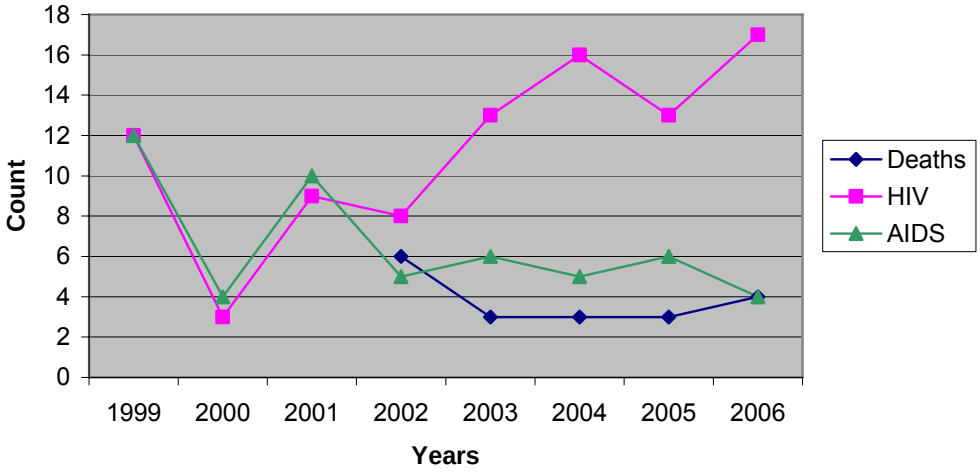
   VCCT centers have increased the number of people coming in for tests. Increased availability and use of HIV testing is a necessary pre-requisite for diagnosing and providing appropriate treatment and care to PLHIV.

d. According to BiH reporting to EuroHIV, the number of AIDS cases in BiH has stabilized since 2002. With the introduction of highly active anti-retroviral

[15] Compiled BiH report on HIV tests carried out in VCCT centers. Source: FBiH AIDS Coordinator

therapy, the number of AIDS cases and deaths from AIDS seems to have slowed down, while the number of HIV positive cases has increased. See graph below.

Annual number of people in BiH with diagnosed HIV infection, AIDS cases and the number of deaths of persons infected by HIV for the period 1999-2006



On recorded deaths, there was information available only from 2002 onwards in the EuroHIV report from 2007.

IV. National response to the AIDS epidemic:

Enabling environment:

The BiH government is bound by the constitution and other international treaties that guarantee protection of the human rights of all BiH citizens. BiH developed the "Strategy on prevention and fight against HIV/AIDS in BiH 2004-2009", which included a strategic goal to ensure that a legal framework exists to protect ethical principles and human rights of PLHIV.

The protocol from VCCT centers clearly states that in BiH mandatory testing for any purposes is not allowed. Every test must have informed consent of the client, together with the signature of the counsellor. But the law on labour regulates that the employer can ask for health check ups of employees if deemed necessary. The employee is obliged to inform the employer on the health status if that would affect and impact on his/her working ability.

Harm reduction strategies such as needle and syringe exchange programme are difficult to implement, as injecting drug use is illegal in BiH.[16] However approval

[16] FBiH AIDS Coordinator

has been given on a case-by-case basis for harm reduction programmes in different cities since 2006. Some NGOs have introduced needle/syringes distribution and collection of used needles/syringes in drop in centers in the RS with some success.[17] In 2008 UNICEF supported drafting of national strategy on supervision over narcotic drugs, prevention and suppression of the abuse of narcotic drugs in BiH aiming to provide legal framework for the implementation of harm reduction activities in BiH.

In addition to mechanisms for reporting on any form of legal violation, mechanisms for recording, documenting or treating in cases of discrimination against PLHIV or other vulnerable population groups does not exist.

According to Organization Q, an advocacy organization in BiH effective steps should be taken by representatives in BiH institutions to conform to EU anti-discrimination directives. This would involve a more accurate definition of discrimination to cover all aspects of discrimination, whether through deliberate acts, quite subjugation or exclusion.[18]

National Coordination Mechanisms:

At the National level there is one mechanism that oversees and advises on the HIV/AIDS programme in the country. The National Advisory Board for fight against HIV/AIDS in Bosnia and Herzegovina (NAB) with the Ministry of Civil Affairs as the Chair was established in early 2002 to develop HIV/AIDS strategy and to facilitate the strategic planning process at the State level. It has representations from different Ministries and international organizations. Each of the two entities, and the District of Brcko nominated Entity AIDS Coordinators facilitate and coordinate the tasks undertaken by the NAB.

The Country Coordinating Mechanism for the Global Fund projects on HIV/AIDS and Tuberculosis (CCM) has been the most active coordination body in the country since it was established in late 2003 to prepare the Global Fund proposals. The CCM is a multi-sectoral body consisting of 45 members from the government, NGOs and UN Agencies. Various sectors such as health, legal/justice, and education are represented, as are narcotics, and treatment centers. It has a mandate of 4 years, which expired on 17.12.2007, but the tenure of the CCM was extended at the NAB meeting on 4.02.2008 until the new elections of the CCM members are completed.

The main achievement of the CCM has been the development and subsequent approval of the proposals on HIV/AIDS and TB by GFATM. Some of the specific tasks carried out by CCM during the reporting period beside the proposals for GFATM were: strengthening of NGOs in terms of profiling and specializing in their work related to HIV/AIDS issues, inclusion of PLHIV, cooperation with other donors, and raising awareness among the various relevant sectors especially amongst policy makers.

[17] UNDP/GFATM HIV/AIDS Programme Progress Report, 2007

[18] Partners for Justice: The Status of Lesbian, Gay, Bisexual and Transgender rights in Bosnia and Herzegovina, A Shadow Report

Diagnostic and HIV/AIDS reporting: [19]

a. **FBiH**: Most infectious diseases are diagnosed at the primary health care level in the Health Centers. For diseases that require obligatory notification by law, the diagnosing physician has to complete a general reporting form. These reports are collected by the epidemiologist at the Health Center and forwarded to the IPH for the canton of residence and they in turn forward them to the Federation IPH. For cases diagnosed at the hospital, the reporting form goes to the municipality public health centre, and is then forwarded to the Cantonal IPH.

   Case definition for HIV infection is a positive ELISA anti-body test confirmed by Western Blot method. Since 2004, use of code for reporting HIV/AIDS cases (not including patients' identification i.e. name or initials) with a network of 10 HIV/AIDS coordinators from each Canton is in place to promote and conduct active HIV/AIDS surveillance and reporting at the Federation level. The 10 Coordinators carry out data collection at Cantonal levels and send information vertically to the FBiH AIDS Coordinator.

   There are anecdotal reports of HIV positive persons being diagnosed and treated outside the public health care system and who are therefore not included in the FBiH data. For example, private medical care practitioners do not report cases, nor is there information from people seeking diagnosis, including HIV testing outside the country. Laboratories also do not report infectious disease results to the IPHs as the results are only sent to the requesting physician.

   Regular notifiable disease bulletins for the FBiH are produced monthly. Annual Health Statistics are also produced by the IPH but with a delay of 2 years. Since recently analysis of HIV/AIDS data was included in the Annual Health Statistics produced by the Federal IPH. There is concern about data quality issues as a fairly high figure is recorded under "other infectious diseases".

b. **RS**: There are five regional IPH and one central IPH in Banja Luka. Two epidemiologists in the central IPH are mainly working on data collection and analysis of infectious diseases. In their reporting system 50 diseases are surveyed and reported. If one of the blood test in VCT is reactive, the suspected case is generally referred to Clinic for Infectious Disease (CID) in Banja Luka. HIV/AIDS cases are reported by physicians to the epidemiologist at the regional offices of IPH who then reports to the Entity AIDS Coordinator and central IPH in Banja Luka. Private clinics are expected to report notifiable diseases to IPH but to what extent this is formalized is not clear. Laboratories also do not report to IPH for infectious diseases.

   Monthly reports on notifiable diseases are produced including reports of HIV and AIDS cases. These reports are produced at central IPH and disseminated out to regional IPH offices and then to health centers and physicians.

[19] Source: Entity AIDS Coordinators of FBiH and RS, Federal IPH Mostar, and IPH Banja Luka

Annual health statistics are produced and shared by the IPH. IPH officials recognize that they need improved surveillance data, data on HIV prevalence and risk behaviours to more effectively guide HIV prevention and care programmes. They are working with active NGOs to obtain such data from vulnerable, high risk population groups.

c. **Brcko District**: It has three health centers that provide primary health care services and a hospital that delivers secondary health care. For tertiary care people are usually referred outside Brcko. Because of its small size, the AIDS Coordinator Dr. Sadic also manages a VCCT providing pre and post-test counseling. Her position allows her to collect data on tests for various notifiable diseases.

Treatment and care:[20]

Treatment and care in both the FBiH and the RS are provided free of charge to PLHIV. Payment of medicines for opportunistic infections in the FBiH depends on whether the medicines are on the list of essential cantonal drug list, which is different from canton to canton. The costs for treatment are covered from the Solidarity Fund (FBiH) in accordance with agreed list of medicaments (12+1 combination of anti-retroviral medicines) in accordance with Essential Drug List[21], and the Health Insurance Fund (RS) respectively.

HIV treatment is available in Sarajevo, Mostar, and Tuzla for the FBiH, and Banja Luka in the RS. Treatment therapy is centralized in the RS therefore all PLHIV must obtain treatment in Banja Luka at the CID. In the past few years there has been a significant in-flow of funds, which has improved conditions for HIV treatment and medicine supply. Departments for providing such services in clinics were reconstructed and psychosocial counselling centers for supporting PLHIV were opened with professional staff.

So far most HIV cases are diagnosed at a stage when individuals already exhibit symptoms of full-blown AIDS. The average age of people registered with HIV is approx. 37 years, reflecting late health care seeking practices.[22] In 2006 BiH reported 4 deaths to EuroHIV. All 4 had been receiving ART.

In 2006, 33 PLHIV received ART. The data is disaggregated as follows: 25 males, 8 females, and one under the age of 15. Of the total, 25 PLHIV were registered in the FBiH and 8 in the RS. One PLHIV who had been under treatment in the RS died, and one new PLHIV started ART treatment.

In 2007, 30 PLHIV received ART. The data is disaggregated as follows: of 8 PLHIV receiving ART in the RS, 6 are males, 2 females and all of them in 15+ age group. Of the 22 PLHIV receiving ART in the FBiH, 16 are males, and 6 females. Of the total 30 PLHIV in BiH, 29 are in 15+ age group, and 1 under 15.[23]

[20] Source: Entity AIDS Coordinators of FBiH and RS, Federal IPH Mostar, IPH Banja Luka
[21] ART WHO revision April 2003
[22] Epidemiologist, Federal IPH Mostar
[23] Source: Entity AIDS Coordinators of FBiH and RS

In Brcko District till date no HIV positive cases have been identified.

Opportunistic infections:

There are plans to introduce HIV tests to all TB patients in the RS. The RS has one anecdotal incident as reference i.e. in 1997 a 20 year old woman from Roma community (marginalized population group) had arrived with advanced AIDS symptoms (mouth full of sores, constant diarrhoea). Her test results were HIV positive. As per her case record she had received 3 months pulmonary treatment. Her husband had (according to her) died of AIDS although his case report had recorded cancer as cause of death.

Co-infection with HIV and TB has been recorded in BiH since 1996. By the end of 2006, 18 cases of co-infection (13.5 percent) of all cases had been recorded, 78 percent of them in men. Co-infection recorded for FBiH: 1 in 2007, 1 in 2006, and RS: 1 in 2005. The age range of PLHIV infected with TB is estimated to be between 23 to 56 years.[24]

No information is available on annual estimates of the number of incident TB cases in PLHIV.

According to Global Fund proposal of 2006, BiH register approx. 2700 new cases of TB each year.

In the FBiH all TB patients are tested for HIV.

Reduction in HIV prevalence

Second-generation surveillance data on HIV prevalence amongst MSM and sex workers are not available. There is also an issue of considerable under-reporting. In the opinion of many, sexual orientation and modes of transmission may be falsely reported due to stigma and discrimination associated with being bi-sexual or homo-sexual.

This region has been used by human traffickers both as a destination and as a major transit route to Western Europe although it is known that the number of women trafficked to and through BiH has reduced significantly in the past few years. Information on HIV on trafficked women could not be gathered due to time constraint. No information was available also on the extent of HIV infection amongst prison in-mates, military, displaced persons, refugees, and children living and working on streets or in institutions.

UNICEF's Biological and Behavioural Survey among IDU 2007 (BB survey among IDU) reported that the very low number of IDU who tested positive for HIV (0.1 percent for both Sarajevo and Banja Luka, and none for Zenica) and syphilis is challenging to interpret in the context of the presence of substantial levels of high risk injecting, sexual behaviours and high prevalence of HCV i.e. 44 percent in Sarajevo, 50 percent in Banja Luka and 23 percent in Zenica.

[24] Epidemiologist, Federal IPH Mostar

Knowledge on HIV prevention

According to MICS3 2006 overall 98.4 percent of children of primary school age attend primary school, including 98.3 percent of children in the FBiH and 98.7 percent in the RS. A total of 86.6 percent of children complete primary school at an appropriate age. Transition rate to secondary education is 92.7 percent, while the net enrolment rate for secondary school in BiH is 79.3 percent.

Education regarding sexual and reproductive health and HIV/AIDS prevention in the school curriculum exists through life-skills based education and in other ad-hoc modules supported by international organizations. UNICEF through its Participation in Good Governance Programme supports life-skills based HIV education in primary and secondary schools, which included HIV prevention information. The life-skills programme is a comprehensive behavioural change approach that concentrates on the development of skills needed for life such as communication, decision making, thinking, managing emotions, assertiveness, self-esteem building, resisting peer pressure, and relationship skills. In 2007, UNICEF reported 241 schools out of 990 in the country were reached with life-skills based education. The figures are higher in secondary schools - 181 out of 290 - and lower in primary schools - 60 out of 700.[25]

UNFPA Youth Sexual and Reproductive Health Programme (SRH), including peer education programme makes linkages between HIV/AIDS and other SRH issues, particularly sexually transmitted infections (STI). The programme focus is on HIV prevention and behaviour change, but also on promoting HIV testing, and dealing with HIV/AIDS, including reducing stigma attached to HIV.

Peer education is a methodology whereby peers transmit information to peers using a set of tools that develop life-based skills. Although HIV/AIDS prevention is a key programme focus, peer education results go far beyond improving HIV/AIDS situation. This programme managed by the INGO FPH, implemented by 4 youth NGOs have provided a number of peer presentations for youth in 287 locations – 27 primary schools, 235 secondary school and 27 other locations - in 2006 and 154 – 25 primary schools, 111 secondary schools, 18 other locations - in 2007.[26]

Youth and Roma population were not specifically included in the national strategy, although access to information in rural areas on sexual reproductive health including HIV/AIDS prevention and protection are limited. The INGO World Vision together with partner NGO XY targets elementary school children in rural areas and Roma population through peer education programmes. According to World Vision more attention needs to be directed towards behaviour, behaviour change and higher responsibility, as well as basic education programmes for the population that are just entering adolescence.

MICS3 2006 reports that only 2.4 percent of females aged 14 to 49 have never heard of HIV and AIDS. Of the respondents 43.5 percent of the 15-24 year olds

[25] UNICEF Partner Reporting Documentation, 2007
[26] UNFPA BiH

has comprehensive knowledge of HIV/AIDS transmission (identifying three ways of prevention and rejecting major misconceptions), and 84.3 percent know that the use of condom during intercourse is one of the most important methods to prevent transmission of the HIV virus.

There is no comparable data available on men.

a. Sex workers and MSM: A biological-behavioural survey initiated in 2007 on sex workers and MSM may provide results for future UNGASS reporting. These are hidden populations that due to stigma and discrimination are to a large extent inaccessible.

   The NGO Action Against AIDS (AAA) in the RS has had only limited access to sex workers for their programme, and considers approaching them fairly dangerous for the researcher as well as the sex worker since the official closure of nightclubs in 2003. The NGOs XY, PROI, Margina active in the FBiH has had more success.

   NGOs AAA in the RS and PROI, Margina in the FBiH working with MSM are trying to reach MSM and sex worker using internet portals, snowball and network techniques. According to INGO FPH the NGOs have over the past years built trust and relationship with these target groups and are therefore optimistic that they will reach their target sample for the survey.

b. IDU: The majority of the respondents to the UNICEF's BB survey among IDU had good knowledge of the ways HIV can be transmitted through sexual contact and injecting drugs use. However, it should be noted though that slightly more than a third in Sarajevo, and a half in Banja Luka and Zenica perceive themselves at no or low risk of HIV infection.

   Of the total sampled population of 260 in Sarajevo, only about 20 percent answered correctly to all five questions on knowledge and behaviour. On individual questions: condoms use during every sex as an effective means of HIV prevention was reported by 82.9 percent in Sarajevo 92.7 in Banja Luka, and 88.2 percent in Zenica, while use of already used needles and syringes was recognized as an HIV transmission route by 93.2 percent of the respondents in Sarajevo, 96.5 percent in Banja Luka and 93.2 percent Zenica. In Sarajevo only 38.8 percent of the respondents answered correctly to the question whether HIV can be transmitted by sharing food with an infected person. In Banja Luka and Zenica the figures were slightly higher at 55.6 percent and 51.6 percent respectively.

   More efforts need to be directed towards the promotion of a range of harm reduction services included in outreach programmes to the community. In all three sites, only a minority of IDUs had received sterile needles and syringes from NGOs and governmental institutions. Similarly NGOs and outreach workers as providers of condoms were mentioned only by one respondent in Sarajevo and Zenica, and two in Banja Luka.

Risk behaviour and behavioural practices:

According to MICS3 2006 over 34 percent of females aged 15-24 years in the RS and 18 percent in the FBiH report having sex with a non-regular partner in the 12 months prior to the survey. The overall percentage for BiH is at 25.7. Out of all the females surveyed who reported having sex with non-regular partners, 71.5 percent reported condom use during sex with such partner.

The RAR 2002 on "young people who do not do drugs" states that 24.8 percent of the population surveyed had reported sex with more than one partner (FBiH 24.6 percent and RS: 25.6 percent). The majority of young people reported that they did not use condoms and significant numbers believe condoms are primarily of value for contraception, not for prevention of sexually transmitted infections and HIV. The reported condom use by young people who do not use drugs was 47.7 percent (FBiH 47.4 percent and in RS 48.7 percent). The average age of first sexual intercourse was reported as 16.5 years for males and 17.4 years for females.

a. Baseline data is available from the RAR 2002 on the other two most-at-risk population group sex workers and MSM but not specifically relating to UNGASS Indicators. From the sampled population of sex workers 65.7 percent reported "always" used condom during sex whereas only 6.7 percent of MSM reported always used condom during sex.

b. IDU: According to the UNICEF BB survey among IDU, more than half i.e. 62.1 percent of the sampled IDU population in Sarajevo site had had two or more sexual partners in the previous year. The figures are similar to other two city sites: Banja Luka: 63.3 percent, and Zenica: 58.3 percent.

   The characteristics of sexual behaviours found in these studies indicate considerable levels of vulnerability and risk-taking behaviour. Early sexual intercourse before the age of 15 was reported by an estimated 54.1 percent of respondents in Sarajevo, 43.3 percent in Banja Luka, and 26.4 percent in Zenica.

   The data analysis report for the BB survey among IDU states that sex with casual partners in the previous year was common and reported by slightly more than half the respondents in Sarajevo and Zenica and 67.4 percent in Banja Luka. Condom use during the most recent sexual intercourse with a casual partner in the previous month of reporting was 48 percent in Sarajevo site, 34.2 percent in Banja Luka, and 54.6 percent in Zenica. The majority of the population sampled reported having sex with steady partners in the past year, but condom use during the last sex with steady partner was low as reported by 23.2 percent of respondents in Sarajevo, 38.8 percent in Banja Luka, and 21.7 percent in Zenica.

   Similarly on safe injection practices, about a third have shared needles/syringes with one or more persons in the last month prior to the survey, and the most commonly reported last time that this took place was between one and seven days (23.1 percent). Sharing practices usually occur

among close friends (62.2 percent). Re-using needles was common as reported by 74.6 percent of respondents in Sarajevo, 55.6 percent in Banja Luka, and 61.9 percent in Zenica.

HIV testing:[27]

Anecdotal evidence exists that people tend to travel outside the country to obtain HIV testing as a result of high levels of stigma and discrimination. One proof of this is that many PLHIV present for the first time at the IPH / Hospital in BiH with very advanced form of AIDS related diseases rather than in the earlier stages of infection.

HIV testing is only provided for pregnant women when requested ("opt-in"). According to MICS3 2006, in BiH coverage of antenatal care (by a doctor, nurse, or midwife) is almost universal, with almost all women receiving antenatal care at least once during the pregnancy.

a. **FBiH**: HIV testing is free and non-mandatory except for patients requiring transfusion or transplantation, and it is based on code system. Anonymous and confidential testing is optional as the clients are free to make their own choices. If the test result is positive, the client provides identifying information including names and contact addresses. Clients are then referred to appropriate HIV/AIDS prevention, care, treatment, and support services

   Rapid tests are not recommended therefore it has not been used in medical institutions in the FBiH. The initial HIV test performed is the screening ELISA test, which is usually done at laboratories at the canton level. If this screening is positive on two different ELISA tests, then it is sent for confirmatory testing by Western Blot method at the laboratory of the University of Sarajevo, the only laboratory that can do confirmatory testing. The results are sent to the ordering physician who is expected to report the case to IPH if the result is positive. Tests may be carried out in private laboratories in the FBiH but these are not reported to the IPH.

   All donated blood units are tested for HIV, HCV, HBV, and syphilis by the laboratory at the Institute of Transfusiology. The Institute tests approx. 40,000 blood units received annually by ELISA methods only.

b. **RS**: HIV testing is free. It is hoped that with free testing and free treatment services people might be more willing to access the VCCT centers for testing. Beside the VCCT in CID, in 2007 VCCT centers were established in IPH and in an Infectious Hospital (3 VCCT centers are now fully functional and operating in RS). HIV tests are carried out at the central IPH laboratory, VCCT centers, and the Blood Transfusion Institutes. The reference laboratory for the RS is the CID.

   People across the RS come to Banja Luka for HIV testing for the increased sense of confidentially and anonymity. On two consecutive blood reactive tests

[27] Source: Entity AIDS Coordinators of FBiH and RS, Federal IPH Mostar, IPH Banja Luka

at VCCT center, the CID carries out two more ELISA tests from different manufacturers as per WHO protocol.

All donated blood units are tested for HIV, HCV, HBV and syphilis by the Blood Transfusion Institutes. In the RS approx. 24,000 blood units were received and tested in 2006.

c. **Brcko District**: As in the two Entities, HIV testing in Brcko is free of charge. To date there have been no reports of HIV positive infection or AIDS cases in Brcko. The Institute of Transfusiology collected approx. 3000 blood units in 2006 and all were tested for HIV, HBV, and HCV.

Voluntary blood donation, low prevalence of HIV infection, and mandatory blood products screening has contributed to the absence of transmission through blood or blood products.[28] But, there is no reference laboratory service in BiH, which means no formal quality assurance programmes for laboratory testing exists – either in general or for HIV, internally or with laboratories outside the country.

According to EuroHIV 2007, BiH in 2006 performed 20,904 HIV tests (5.3 / 1000 population).

HIV testing amongst most-at-risk groups in BiH:

The RAR 2002 provides baseline data for BiH but it does not relate specifically to the UNGASS indicator.

a. Sex workers: The RAR 2002 survey was administered on 26 sex workers (2 Males and 24 females) in Banja Luka, and 96.2 percent of the sex workers surveyed reporting having tested for HIV. This is a very high figure but the assumption made here is that it might have been in the interest of owner of the nightclubs to carry out the test. There is no data available on whether they received the test results or what the results were.

b. MSM: The RAR 2002 surveyed a sample population of 30 MSM with mean age recorded as 21.3 years. The reports states only 10 percent of the MSM respondents had tested for HIV.

c. IDU: The UNICEF's BB survey among IDU reported that an estimated 20 percent of the respondents from Sarajevo site did not know where they could get an HIV test and 40 percent had never been tested. In Banja Luka half of the respondents did not know where they could get tested for HIV, and slightly more than half 60.9 percent had never had an HIV test. In Zenica 54.4 percent of the respondents did not know where they could get an HIV test and 75.5 percent had never been tested.

[28] Entity AIDS Coordinators

V. Best practices:

Global Fund HIV/AIDS programme:

In 2006 BiH was awarded the Global Fund grant of USD 11,042,257 for five years. The comprehensive Global Fund HIV/AIDS programme is based on the BiH HIV/AIDS strategy and has the following objectives: Scaled IEC/behaviour change, communication, prevention education among youth; Scaled up IEC/behaviour change, communication in populations with increased risk for HIV/AIDS infection; Improved access and quality of VCCT centers; Reduced number of HIV co-infections with TB; Improved access and quality of harm reduction services; HIV prevention in Roma communities and former displaced persons; Universal free access provided for PLHIV to ARV, treatment of opportunistic infections, hospitalization, psychosocial counselling, and palliative care.

The activities regarding prevention have been sub-contracted to NGOs/INGOs who work with high risk population groups in the country. NGOs have had an important role from the beginning of the process: in preparing the strategy on HIV/AIDS, in CCM, NAB, development and implementation of different programmes.

Cooperation between NGOs and state institution is being strengthened through the UNDP/GFATM programme. NGOs dealing with these issues are making significant efforts in the area of HIV prevention, work with PLHIV, and vulnerable populations. Counselling centers provide information and support to the general public and to PLHIV. Although HIV may not be their main focus, there are also other NGOs addressing prevention programmes through youth education.

NGOs / INGOs implementing the UNDP/GFATM HIV/AIDS programme are:

RS	Action Against AIDS (AAA)	MSM, sex workers, psychosocial support to PLHIV
	UG Viktorija	IDU, sex partners of IDU, prisoners
	Poenta	IDU (drop in center, needle/syringes exchange programme)
FBiH	INGO Fondation PH Suisse – Partnerships in (FPH)	PLHIV, MSM, IDU, sex workers
	INGO World Vision With partner NGO – Association for sexual and reproductive health XY)	Elementary school children in rural areas, and Roma population
	Consortium of UG PROI/ XY / Q in Sarajevo	MSM, IDU, sec workers, prisoners, Roma youth
	UG PROI Sarajevo	Sex workers in Mostar and Sarajevo
	Margina	IDU together with Viktorija, MSM in Tuzla and Zenica, sex workers in Zenica
	APOHA (with support from FPH)	Psychosocial support to PLHIV

In addition to the HIV/AIDS programme a complementary grant for control of TB was awarded to the country in 2007 that makes linkages between interventions to prevent both HIV and TB.[29]

Public Sector:

Progress has also been made in the public sector. On the basis of established networks of Cantonal HIV/AIDS Coordinators, the FBiH now identifies needs per region and accordingly prepares targeted plans. In the next few years, training is planned in IEC skills (to be implemented by INGO FPH and NGO XY), and harm reduction measurements in several areas where cooperation is highest.

Since 2007, the RS has initiated training for primary health care professionals working on HIV/AIDS as a step towards mitigating discriminatory practices. The plan is to complete training of medical staff in primary health protection. Plans have also been initiated in 2007 to reach uniformed personnel with HIV prevention activities, which will be implemented in 2008.

VCCT centers:

Between 2005 and 2007, UNICEF supported a pilot project in Zenica-Doboj Canton that combined out-reach advocacy programmes and support for testing implemented by NGO Margina. The pilot project targeted most-at-risk adolescents (MARA) and one of project's purpose was to refer MARA to VCCT center for testing. Although this was not replicated it was considered one of the best-practices.

Since 2003, to improve testing rate in BiH, UNICEF donated a number of test kits to the VCCT centers through out the country. In 2005, the FBiH opened 11 VCCT center of which 9 were functional. Centers were also established in Brcko District and in the CID in the RS. Under the UNDP/GFATM programme, 8 of these existing centres were rehabilitated (3 in RS[30], 4 in FBiH, 1 in Brcko). Currently 14 VCCT centers are fully functional in BiH, although they do not all uphold the principles of confidentiality. HIV testing is provided free of charge and PLHIV in BiH who need anti-retroviral therapy are currently provided with free treatment assuming that they have insurance.

Second-generation surveillance:

An important step forward for evidence based policy making is the UNICEF funded biological and behavioural study conducted on injecting drugs users during the period May – July 2007.

Another study among sex workers and MSM is currently ongoing managed by INGO FPH with funding from multiple donors. The report is due in 2008.

[29] UNDP/GFATM HIV/AIDS Programme

[30] VCCT centers in the RS: Center for Infectious Disease in Banja Luka, Public Health Institute in Banja Luka, Hospital Doboj – Ward for Infectious Disease, Hospital Bijelina – Ward for Infectious Diseases.

The three studies will provide baselines useful for the purposes of second generation surveillance data on the most-at-risk population groups in the country.

VI. Major challenges and remedial actions:

a. Institutional capacity within the Government: Health protection is not regulated at the State level therefore except for the development and monitoring of the national strategy, operational planning and coordination are being conducted at the Entity level. Lack of a functional HIV/AIDS secretariat within the State level government, resulting in weak coordination of HIV related activities, a dependency on NAB and lack of funding sources are some of the main challenges indicated by the Entity AIDS Coordinators. This specifically relates to the lack of a functional M&E system (see specific recommendations under VII).

   Surveys/studies are usually undertaken by international agencies as the government at national and entity level lacks capacities in those areas. There is a need to support capacity building to strengthen data quality, for disaggregated data collection, data analysis and interpretation, report writing and dissemination, use of results and evidences for programming and policy making, and the provision of regular feedbacks to those who collect surveillance data and other relevant stakeholders. It is also important to integrate laboratories within the reporting system.

b. HIV Testing: In order to avoid stigma and discrimination, the coding system enables PLHIV to remain anonymous. However, this makes follow-up difficult.[31] It is difficult to keep track of the patients progress in terms of survival and duration of therapy received. Hence, there should be a system developed that better accommodates both considerations. This relates to regional cooperation to facilitate follow-up of patients with laboratories in Croatia and Serbia, countries that people in BiH travel to frequently. So far, feedback and sharing of results are based on personal relationships with the laboratories and the requesting physician.

c. Blood testing: Currently all blood samples are tested for HIV, HCV, HBV, and syphilis but due to lack of external quality assurance scheme in place, the UNGASS indicator on blood safety i.e. percentage of donated blood units screened for HIV in a quality assured manner amounts to zero value. Hence, procedures for testing of blood samples should be strengthened with the requirements of the UNGASS Guidelines in mind. The following information is required to measure this indicator: how many blood center/blood screening units have both: 1) followed documented standard operating procedures, and 2) participated in an external quality assurance scheme.

   In the RS, in January 2008 the Blood Transfusion Institute was de-linked from the Ministry of Health and Social Welfare. Based on the recommendations of the World Health Organization and the directive of the European Parliament

[31] Epidemiologist, Federal IPH Mostar

and the Council of Europe, the RS developed a blood safety strategy until 2015, which was approved by the RS Government. Once the autonomous status has been established, the strategy will be adopted and major changes in terms of infrastructure, equipment, and training including the implementation of the strategy are expected to take place.

d. Broader considerations on discrimination and stigma: Action is necessary to remove structural reasons for excluding certain groups of people from HIV/AIDS-related health services. For example most Roma people do not have identity papers, which they need to show to qualify for general social security programs. Children are eligible to obtain free health care services provided they are registered in the school system. Similarly, unemployed people need to be registered at the unemployment bureau.[32]

   Similar to other countries stigma and discrimination against PLHIV, populations most-at-risk of HIV exists in the country. According to MICS3 2006, 64.2 percent of women and girls in BiH unfortunately support at least one of the discriminatory attitudes towards people with HIV/AIDS. In rural areas there is even higher level of stigmatization and prejudices expressed towards most-at-risk population group. Care should be taken that providing activities only towards one population group does not further stigmatize them as "vectors of disease".

Support from the country's development partners (excluding UNDP):

a. The Joint UN Team on HIV/AIDS with UNICEF as the Chair provided technical assistance in compiling existing information / data sets within the country to prepare the UNGASS country progress report.

b. UNICEF has been working towards supporting the development of a national monitoring and evaluation system and strengthening the second generation surveillance systems related to HIV/AIDS. Special considerations have been given to improving the evidence base on the most-at-risk adolescents and on enhancing the understanding of the legislative environment for service provision to adolescents.

   This orientation is in line with BiH's obligation to report on implementation of the Declaration of Commitment on HIV/AIDS.

   UNICEF carried out Biological and Behavioural Survey among Injecting Drug Users in 2007, which provided data sets for UNGASS indicator reporting.

c. WHO has been providing assistance in HIV/AIDS area through:

   - Capacity building: WHO supported participation of BIH health professionals in attending international meetings on topics of HIV/AIDS, tuberculosis, blood safety and surveillance of communicable diseases in general. Besides that, WHO organized study tours for BIH health professionals in foreign health

[32] INGO World Vision

institutions in order to strengthen both general communicable diseases surveillance and laboratory management capacities.

- Strengthening evidence based practice at the country level WHO supported health professionals in BIH by providing "HIV AIDS treatment and Care - clinical protocols for WHO European Region".

WHO's overall collaboration with health authorities in BIH is strongly focused on health systems strengthening and above mentioned points are integral elements of this approach.

d. UNFPA has contributed through capacity building at a multidisciplinary level by training health professionals, psychologist, social workers and teachers on youth friendly approaches in SRH including HIV/AIDS. Data obtained from UNFPA initiated evidence based recording with youth friendly SRH services during 2002-2005 was utilized as a baseline in developing Global Fund proposal in BiH. UNFPA also assisted in establishing referrals in 4 locations between youth friendly SRH information services, medical services, VCCT centers, social work centers, schools, parents and youth.

   In 2006 and 2007, UNFPA, FPH, Youth NGOs, Y-Peer Network, Youth Advisory Panel and BiH Parliamentary group for Population and Development completed preparatory work to endorse UNFPA/Y-Peer standards for peer education programmes in SRH, including HIV/AIDS. This process was supported by the BiH Ministry of Civil Affairs and endorsements from various Ministries are expected to take place in 2008.

e. A study among sex workers and MSM is being undertaken by INGO FPH with funding from multiple donors: Joint UN Team on HIV/AIDS / UNAIDS, UNICEF, UNDP/GFATM programme, and FPH. The Institute of Public Health in FBiH assisted FPH with preparation of the survey protocol, questionnaire and similarly will also assist with data analysis. Fieldwork is currently ongoing and the report is due in March 2008.

f. World Vision an INGO working in BiH since 1994 specially caters its programmes towards the Roma population and young school children from 0-13 and 14-15 years in rural areas. Their main focus is training of peer educators on sexually transmitted infections, sexual reproductive health, HIV/AIDS including stigma and discrimination of PLHIV, prevention and protection; training of teachers and pedagogues of elementary schools on HIV/AIDS topics; training of young people of Roma community, community coordinators; and development of information materials. Their aim through the trainings is to separate the risk groups from risk behaviours and the prejudices that only vulnerable groups are endangered when it comes to risk infection and education.

VII. Monitoring and evaluation environment

An integrated system of routine surveillance of communicable disease does not exist at the national level. Each entity has its own data collection system based on physician reports. Information on interventions with populations most-at-risk is kept by individual NGOs working with them and the Entity governments.

Information on HIV amongst military, displaced persons, refugees, trafficked women and prisoners could not be found. Information on HIV risk behaviour on children living and working on streets or in institutions could not be collected either.

Data are collected by age, sex, mode of transmission and place of infection. Information are not collected by geographical areas, or by diversity i.e. displacement, ethnicity, rural/urban migration. With current data it is difficult to identify precise drivers of HIV/AIDS.

At a national level an M&E system does not exist, but funds have been allocated within the 2006 UNAIDS Programme of Accelerated Funds (PAF) to strengthen the national M&E system. This is a necessary requirement, but until now there was very limited support for work in this area. The Global Fund has allocated 6.8 percent of the total funding towards establishing M&E system for HIV/AIDS. The HIV/AIDS M&E is situated in the Programme Management Unit of UNDP with representatives nominated from the Ministry of Health aimed to track UNDP/GFATM programme implementation.

The M&E action plan for UNDP/GFATM HIV/AIDS programme has been developed, staff assigned, and some training as per the plan has already been undertaken. The contracted sub-recipients, NGOs working with the target groups, are periodically required to submit progress reports on their activities. Surveillance surveys are also being carried out in close collaboration with the NGOs.

In the RS focus has shifted within the IPH to address the national level monitoring and evaluation system. Current legislation on public health protection is not considered up-to-date and is therefore under revision. With inputs also from Entity HIV/AIDS Coordinator, the IPH is in the process of defining the social/psychosocial support for PLHIV and the rights/obligations of the PLHIV. IPH is also addressing by-laws on medical documentation in public health protection including disease revision, defining how cases are reported, and procedures on submitting report to enable centralization of data/information at the IPH.

UNDP/GFATM programme has assisted with the creation of database, and have enabled IPH staff members to participate in trainings. CRIS data processing and analysis has been implemented which began with training of data managers from the region.

Recommendations:

a. National monitoring and evaluation system:
   A national level monitoring and evaluation system is crucial to the entire public health sector not only for HIV/AIDS programme. Any surveillance on public health issues need to be integrated into the national level system. Establishing a national level M&E system including improved infectious disease surveillance is a pre-condition to enable use of data for public health action. An M&E system should have among others: an M&E plan with clearly set indicators, plans for data collection, responsible parties, resources, etc. This should also include capacity building of Public Health staff to analyze and use existing data including HIV/AIDS.

   The implementation of a national M&E system requires political commitment, clear definition of roles and responsibilities and cooperation on the level of entities and State level, and between institutions with relevant data sources. Therefore, it is necessary that key parts of the institutional framework are established.

   Role of the State and Entities: The NAB is an important body that should guide and coordinate HIV/AIDS surveillance at the State level including the production of State-level surveillance reports. The Ministry of Civil Affairs as the Chair of the NAB should be the leading institution for the establishment of the State-level national M&E system. The Memorandum of Understanding signed in 2007 between the Ministry of Civil Affairs and the two Entity Ministries of Health should assist in the clarification of roles and responsibilities in the health sector.

   The FBiH and the RS Ministries of Health and Public Health Institutes as providers of official statistics on public health should collect, compile, and disseminate Entity level surveillance reports disaggregated by sex and age, and diversity. Entity level data should be shared with the NAB periodically to enable compilation and maintenance of State-level data. A bottom-up approach should be used as the M&E system can only be developed and realized in this way.

b. HIV/AIDS surveillance system in the FBiH, the RS, and the Brcko District:
   A formal written protocol for the surveillance system is necessary providing clear guidelines so that all stakeholders are clear on their respective roles. It would be necessary to include the laboratories and IPH as formal part of the reporting system. It is important to provide regular feedbacks in accessible formats to persons who provide the surveillance data and to other stakeholders so that purpose of surveillance and use of data is clear to all.

c. Develop laboratory quality assurance systems internally and externally as reference:
   The main laboratories in BiH need to develop and coordinate quality assurance and training programme for all laboratories receiving blood samples and performing HIV tests. The central laboratories would benefit from participation in international quality assurance schemes to maintain their own

capacity and also build the capacity at the national level to conduct national quality assurances.

d. Continue collecting second generation HIV Surveillance data:
   Routine data collection integrated into the national M&E system is needed to assess the potential for HIV to spread and to monitor the extent of that spread. The ongoing survey on MSM and sex workers should provide information on this most-at-risk population groups. But it is necessary to continue to carry out repeated, standardized studies among marginalized groups to collect behavioural information to guide the development of effective prevention programmes.

e. Standardized information collection:
   National systems and national bodies to collect standardized information on the country to consistently report to international bodies such as UNGASS are necessary.

   Note that 2008 UNGASS indicator questions are different from 2005 and need to be taken into account in future surveys/studies. It is necessary to carefully build in UNGASS indicators questions into surveys otherwise it is unlikely that relevant data can be extracted post facto. See attached Annex 2 for details on questions related to UNGASS Indicator reporting.

Annex 1:

Consultation / preparation process for the country report on monitoring the progress towards the implementation of the Declaration of Commitment on HIV/AIDS.

The Ministry of Civil Affairs, BiH as Chair held a NAB meeting, which also discussed the UNGASS reporting process. NAB accepted the support provided by UNICEF as the Chair of Joint UN Team on HIV/AIDS of technical assistance to assist with the preparation of the country progress report.

The National Policy Index questionnaire PART A was completed by the two Entity AIDS Coordinators. The Part B of the NCPI questionnaire was received from four NGOs (one from RS, and three from FBiH): INFO FPH, NGO Margina, NGO APOHA, and NGO AAA (RS). These inputs were necessary for the preparation of the report.

Extensive inputs in terms of data and consultation whenever needed were provided by the two Entity AIDS Coordinators, Dr. Zlatko Cardaklija (FBiH) and Dr. Natasa Loncarevic (RS); Dr. Jelena Ravlija, Epidemiologist, Federal IPH, Mostar; Dr. Nesad Seremet, Programme Director and Ms. Mirela Kadribasic, Coordination Assistant of HIV/AIDS & TB, UNDP; Mr. Haris Hajrulahovic, Head of Office, WHO; and Ms. Deborah McWhinney, Deputy Resident Representative of UNICEF.

Ms. Vesna Besirevic, HIV/AIDS Project Officer of UNICEF provided assistance in contacting the Treatment Centers in BiH, the State Hospital in FBiH to clarify data on ART. Ms. Elizabeta Hopic, Programme Assistant, UNICEF assisted with the translations of NCPI submitted in local language.

Past reports and survey data on HIV/AIDS situation in the country were shared by:

- UNDP/GFATM programme
- UNICEF
- WHO
- INGO World Vision

All the above-mentioned partners have collaborated and assisted with the preparation of this report.

Annex 2:

Questions for UNGASS Indicator Reporting:

Although the most recent survey of UNICEF amongst IDU in 2007 collected information on traditional questions, it had also catered its research planning and implementation as defined for the 2005 round of UNGASS indicator reporting. But as the change in questions to be asked to survey respondents was only notified in August 2007 via the Guidelines, it had no impact on the already completed survey. Therefore, parts of the data on injecting drug users are incomplete.

Care must be taken in the future to integrate questions into survey questionnaire directly addressing UNGASS Indicator to provide data for 2010 UNGASS Indicator reporting.

On HIV testing:
1. I don't want to know the results, but have you been tested for HIV in the last 12 months?
2. I don't want to know the results, but did you receive the results of that test?

Prevention programme:
1. Do you know where you can go if you wish to receive an HIV test?
2. In the last 12 months have you been given condoms
IDU should be asked in addition:
3. In the last 12 months have you been given sterile needles and syringes?
Data has to be aggregated to collect information on all respondents who answered "yes" to both (all three for IDU) questions.

Knowledge about HIV prevention:
1. Can having sex with one faithful, uninfected partner reduce the risk of HIV transmission?
2. Can using condoms reduce the risk of HIV transmission?
3. Can a healthy-looking person have HIV?
4. Can a person get HIV from mosquito bites?
Or change as in the case of IDU survey to:
Can HIV be transmitted using already used needle/syringe?
Q.5. Can a person get HIV by sharing a meal with someone who is infected?
Data must be generated of all respondents who answered correctly to all 5 questions.

Condom use:
1. In the last 12 months how many different people have you had sexual intercourse with?
If answered more than one, then ask:
2. Did you or your partner use a condom the last time you had sexual intercourse?

IDU – condom use:
The traditional questioning was used in IDU survey i.e. condom use with steady partners, condom use with casual partner, and condom use with client. A query to establish respondents who answered yes to condom use regardless of the

distinction on the data sets was not possible. Theoretically those who had sex with steady partner could have also had sex with a casual partner and vice versa.

The questions needed to be asked were:
1. Have you injected drugs at anytime in the last month?
2. If yes, have you had sexual intercourse in the last month?
If answer is yes to both 1 and 2, then ask
3. Did you use a condom when you last had sexual intercourse?

On safe injection practices for drug users:
1. Have you injected drugs at anytime in the last month? If yes,
2. The last time you injected drugs did you use a sterile needle and syringe?

See UNGASS on HIV/AIDS, Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on Construction of Core Indicators, 2008 Reporting for further explanations.