

UNGASS COUNTRY PROGRESS REPORT

BOSNIA AND HERZEGOVINA

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II. Status at a Glance

Inclusiveness of the Stakeholders in the Report Writing Process

In line with Bosnia and Herzegovina administrative structure (two entities - the Federation of Bosnia and Herzegovina (FB&H), and Republika Srpska (RS) as well as the Brcko District), this report has been prepared jointly by the Ministry of Civil Affairs, Federal Ministry of Health and the Ministry of Health and Social Welfare of Republika Srpska. Assistance and support were provided by the UN Joint Team on HIV/AIDS in B&H (UN JT).

The initial phase of the process included distribution and circulation of the specific questionnaires and requests for information among the civil society/NGO as well as international agencies concerned with the HIV and AIDS issues in Bosnia and Herzegovina.

The National Policy Index (NCPI) questionnaire PART A was completed by the HIV/AIDS Coordinator FB&H. The Part B of the NCPI questionnaire was received from 2 NGOs: Action against AIDS (RS) and Partnerships in Health (FB&H). These inputs were necessary for the preparation of the report.

The UNGASS 2010 reporting process was coordinated by Dr. Serifa Godinjak, Head of Department for European Integration and International Cooperation, Sector for Health, Ministry of Civil Affairs. Extensive inputs in terms of data provision and consultation whenever needed were provided by the HIV/AIDS Coordinator FB&H, Dr. Zlatko Cardaklija (FB&H); Dr. Ljubica Jandric, Epidemiologist, IPH 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. Mr. Mirza Musa, HIV/AIDS Advisor to the UN Joint Team on HIV/AIDS in B&H / UNAIDS Focal Point provided support and assistance in preparation and submission of the report.

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

- The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) / UNDP Programme Management Unit (PMU)
- UNICEF
- WHO

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

Status of the Epidemic

B&H is a low HIV prevalence country with an estimated prevalence of <0.1%. Due to the considered low-level of HIV/AIDS epidemic, 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 GFATM programme have singled them out for attention.

The European Centre for Disease Prevention and Control (ECDC) data¹ for B&H to the end of 2008 show a cumulative total of 156 HIV cases, of which 66 have died. For HIV cases where exposure category was known, there are 26 attributed to MSM, 21 to IDU, 88 to heterosexuals, 3 to haemophilia (before 1999), 1 to MCT and 17 unknown. Out of 156 HIV cases, 101 have developed AIDS by the end of 2009.

The policy and programmatic response

As the new National HIV/AIDS strategy 2010-2015 is still in the process of preparation, 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, certain numbers of international agencies have been supporting governmental and non-governmental efforts to enhance HIV prevention activities in the country – namely, UNICEF, UNFPA and Foundation Partnerships in Health. 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.

Given B&H's complex legal framework, fragmented health sector (with no national Ministry of Health), and absorption capacity, Since 2006 UNDP B&H has been the Principle Recipient for the awarded Round 5 GFATM HIV grant, in cooperation with the Federal Ministry of Health and Ministry of Health and Social Welfare RS, to ensure the effective implementation of the GFATM grants. In addition to on-going projects supported by other international organizations, UNDP in the last year provided support to B&H's national institutions, experts and NGO representatives, and through the CCM developed two successful applications to GFATM for implementation of the comprehensive HIV/AIDS and Tuberculosis (TB) prevention and treatment programs.

¹ European Centre for Disease Prevention and Control/WHO Regional Office for Europe. HIV/AIDS surveillance in Europe 2008. Stockholm: European Centre for Disease Prevention and Control; 2009.

As in all Global Fund activities, the GFATM HIV/AIDS programme in B&H 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, Ministry of Health and Social Welfare RS, Federal Ministry of Health, local nongovernment organizations, together with UN partners such as UNICEF, UNFPA and WHO, seek 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.

In the reporting period multi-sectorial cooperation has significantly improved resulting in active involvement of civil society in the policy-making process through civil society representatives' active membership in CCM and National Advisory Board for HIV/AIDS in B&H.

UNGASS indicator data in an overview table:

The UNGASS Indicator Data table includes 25 indicators of which some have no relevance for B&H context. Below is a summary on each of these indicators.

Indicator 1: AIDS spending

Due to very complex structure of the state, it was not possible to compile comprehensive data for the National Funding Matrix (NFM); NASA system not established.

According to the GFATM programme reports, the overall reported expenditure for HIV/AIDS in 2008 is USD 1,953,094; reported GFATM amount for 2009 is USD 2,739,829. In addition to estimated B&H Government expenditure of USD 600,000 UNICEF's expenditure for 2008 was reported as: USD 226,342, and for 2009: USD 276,303². Foundation Partnerships in Health expenditure for 2008 was reported as USD 161,460³, and for 2009 USD 156,885. UNFPA reported a total contribution of USD 119,012 to HIV/AIDS for 2008 and USD 111,285 for 2009.⁴

The government expenditure is likely to be under-reported as the Solidarity Fond in the FB&H and Health Insurance Fund in the RS covers all treatment costs. As a recommendation, expenditure of these funds needs to be analysed in order to properly assess HIV/AIDS expenditure by public sources.

Indicator 2: The National Composite Policy Index Questionnaire Part A was duly completed by the HIV/AIDS Coordinator FB&H. Part B was completed by one INGO: Foundation Partnerships in Health and local NGO: Action against AIDS (RS).

² UNICEF B&H

³ Foundation Partnerships in Health

⁴ UNFPA B&H

No	Indicator Name	Indicator Relevance
Expenditures:		
Indicator 1 – Domestic and international AIDS spending by categories and financing sources	Actual expenditures classified by eight AIDS Spending Categories and by financing source, including public expenditure from its own sources (i.e. government revenues such as taxes) and from international sources	Relevant – data entered partially
Policy Development and Implementation Status:		
Indicator 2 – National Composite Policy Index	Areas covered: prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation	Relevant – data entered
National Programmes (blood safety, antiretroviral therapy coverage, prevention of mother-to-child transmission, co-management of TB and HIV treatment, HIV testing, prevention programmes, services for orphans and vulnerable children, and education):		
Indicator 3 – Blood Safety - Donated	Percentage of donated blood units screened for HIV in a quality assured manner	Relevant – data entered
Indicator 4 – HIV Treatment: Antiretroviral Therapy (2008 and 2009)	Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy (Percent)	Relevant – data entered
Indicator 5 - Prevention of Mother-to-Child Transmission (2008 and 2009)	Percentage of HIV-infected pregnant women who received antiretroviral treatment to reduce the risk of mother-to-child transmission	Subject matter not relevant
Indicator 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 entered
Indicator 7 - HIV Testing in the General Population	Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	Relevant – data entered
Indicator 8 - HIV Testing in most-at-risk populations	Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results	Relevant – data entered
Indicator 9 - Prevention Programmes: most-at-risk populations	Percentage of most-at-risk populations reached with HIV prevention programmes	Relevant – data entered
Indicator 10 - Support for Children Affected by HIV and AIDS	Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child	Subject matter not relevant
Indicator 11 - Life Skills-based HIV Education in Schools	Percentage of schools that provided life skills-based HIV education in the last academic year	Relevant – No data available
Knowledge and Behaviour:		
Indicator 12 - Orphans: School Attendance	Current school attendance among orphans and among non-orphans aged 10–14	Subject matter not relevant
Indicator 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 – No data available

Indicator 14 - Knowledge about HIV Prevention: most-at-risk populations	Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Relevant – data entered
Indicator 15 - Sex Before the Age of 15	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	Relevant – data entered
Indicator 16 - Higher-risk Sex	Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	Relevant – data entered
Indicator 17 - Condom Use During Higher-risk Sex	Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse	Relevant – data entered
Indicator 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 entered
Indicator 19 - Men Who Have Sex with Men: Condom Use	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Relevant – data entered
Indicator 20 - Injecting Drug Users: Condom Use	Percentage of injecting drug users who reported the use of a condom at last sexual intercourse	Relevant – No data available
Indicator 21 - Injecting Drug Users: Safe Injecting Practices	Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected	Relevant – No data available

Impact:

Indicator 22 - Reduction in HIV Prevalence	Percentage of young women and men aged 15–24 who are HIV infected	Relevant – No data available
Indicator 23 - Reduction in HIV Prevalence: most-at-risk populations	Percentage of most-at-risk populations who are HIV infected	Relevant – data entered
Indicator 24 - HIV Treatment: Survival After 12 Months on Antiretroviral Therapy	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Relevant – data entered
Indicator 25 - Reduction in Mother-to-child Transmission	Percentage of infants born to HIV-infected mothers who are infected	Subject matter not relevant

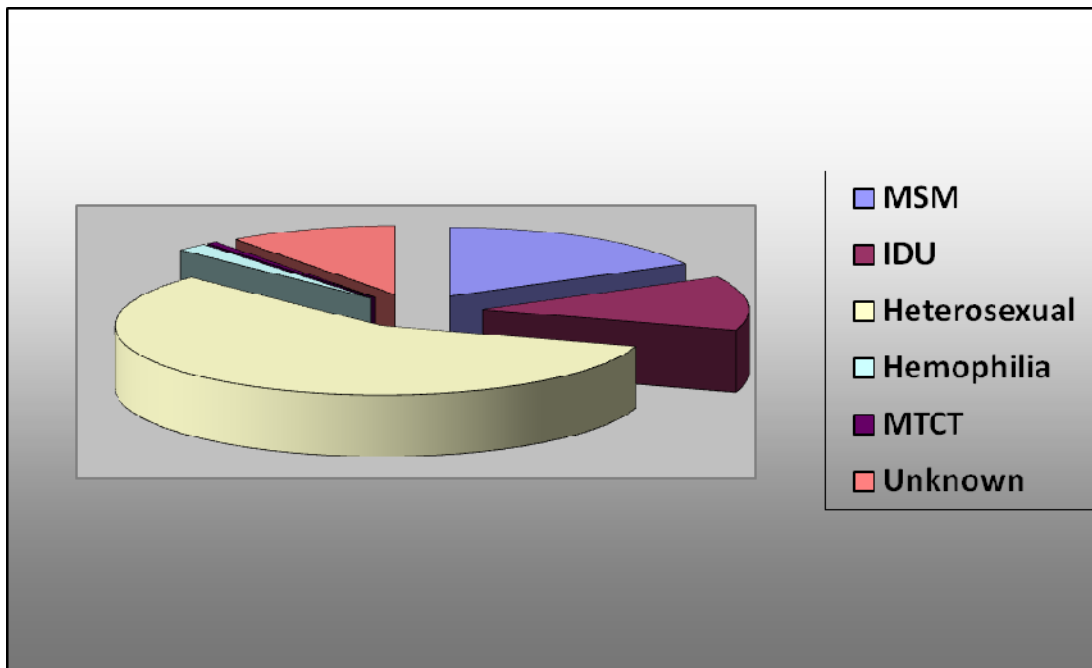
III. Overview of the HIV/AIDS epidemic in Bosnia and Herzegovina:

- a. The first case of HIV was registered in 1986 and until the end 2009 there are 163 registered HIV positive cases. Of these 103 were recorded as males, 34 as females, and 3 recorded cases as unknown⁵. Some of them have died, and some were lost to follow-up. From 2002, with exception of those added to database from older records in 2003 and 2004, up to 2009 there were 73 HIV cases registered. In total, there are 41 PLHIV in B&H.

Percentage of adults and children with HIV known to be on treatment 12 months after initiating ART is: 71,7 %; after 24 months: 93% and 36 months: 75%.

- b. With respect to probable modes of transmission, the majority of reported transmission modalities were heterosexual at 57.4%, MSM at 17.2 %, IDU at 12.7%, unknown at 10.2%, haemophilia at 1.85 % and MTCT at 0.6%.

Probable transmission routes of HIV infections in B&H (1986 – 2009)



There was only one recorded case of mother-to-child transmission in 2006

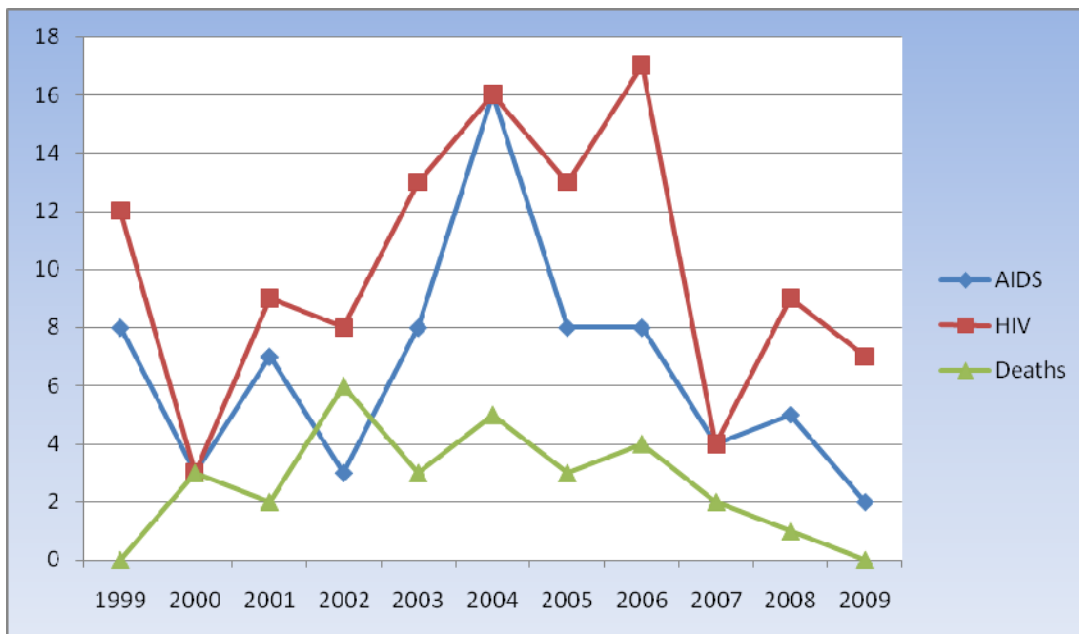
⁵ Source: Source: HIV/AIDS Coordinator FB&H [Due to bad reporting system during former Yugoslavia]

- c. HIV Prevalence: In 2009 the VCCT centres reported 8 HIV positive cases out of total of 7,899 undertaken tests. From the total, 7,327 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 centres, this puts the likely prevalence rate of those tested at VCCT between 0.1 and 0.5%.

Pre-testing and post-testing counselling has existed since the beginning of 2005 through VCCT centres. In 2010 there are 20 VCCT centres established and functioning. VCCT centres 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 B&H reporting to ECDC, the number of AIDS cases in B&H has stabilized since 2002. With the introduction of highly active anti-retroviral therapy (HAART), the number of AIDS cases and deaths from AIDS seems to have slowed down, while the number of HIV positive cases has increased. Please see graph below:

HIV infections, AIDS cases and deaths (1999 – 2009)



IV. National response to the AIDS epidemic:

Enabling environment:

The B&H government is bound by the constitution and other international treaties that guarantee protection of the human rights of all B&H citizens. B&H developed the “Strategy on prevention and fight against HIV/AIDS in B&H 2004-2009”, which included a strategic goal to ensure that a legal framework exists to protect ethical principles and human rights of PLHIV. The new national strategy is being developed for the period 2010 – 2015.

The protocol from VCCT centres clearly states that in B&H 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 checkups 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 B&H.⁶ However approval 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 centres in the RS with some success. In 2008 UNICEF supported drafting of national strategy on supervision over narcotic drugs, prevention and suppression of the abuse of narcotic drugs in B&H aiming to provide legal framework for the implementation of harm reduction activities in B&H. The Strategy has been adopted in March 2009.

In addition to mechanisms for reporting any form of legal violation, mechanisms for recording, documenting or treating cases of discrimination against PLHIV or other vulnerable population groups do not exist. The advancement in policy making is the adoption of the anti-discrimination Law, which was adopted in July, 2009.

National Coordination Mechanisms:

At the National level there is a 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 HIV/AIDS Coordinators to facilitate and coordinate the tasks undertaken by the NAB.

⁶ Source: HIV/AIDS Coordinator FB&H

The Country Coordinating Mechanism 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 33 members from the government, NGO sector and Joint UN Team on HIV/AIDS. Various government sectors such as health, legal/justice, and education are represented, as are narcotics, and treatment centres.

The main achievement of the CCM has been the development and subsequent approval of the proposals on HIV/AIDS and TB by the 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.

Diagnostic and HIV/AIDS reporting:⁷

Most infectious diseases are diagnosed at the primary health care level in the Health Centres. 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 Centre and forwarded to the IPH for Entity of residence.

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).

Regular modifiable disease bulletins in B&H are produced monthly. Annual Health Statistics are also produced by the IPH but with a delay of 2 years. Yearly HIV/AIDS statistic data is reported to European Centre for Disease Control (ECDC).

Treatment and care:⁸

Treatment and care in B&H are provided free of charge to PLHIV. Payment of medicines for opportunistic infections depends on whether the medicines are on the list of essential drug. The costs for treatment are covered from the health insurance funds in accordance with agreed list of medicaments (12+1 combination of anti-retroviral medicines) in accordance with WHO Essential Drug List⁹ (revised in 2003).

HIV treatment is available in Sarajevo, Tuzla and Banja Luka.

⁷ Source: HIV/AIDS Coordinator FB&H, Federal IPH Mostar, and IPH Banja Luka

⁸ Source: HIV/AIDS Coordinator FB&H, Federal IPH Mostar, IPH Banja Luka

⁹ ART WHO revision April 2003

In the 2009 there is increased in number of tests in VCT and other health centres, which resulted in decreased number of deaths. In the last two years there is only one death reported.

In 2009, 39 PLHIV received ART. The data is disaggregated as follows: 25 males, 8 females, and 1 under the age of 15. Of the total, 25 PLHIV were registered in the FB&H and 8 in the RS. One PLHIV who had been under treatment in the RS died, and one new PLHIV started ART treatment.

In 2008, 33 PLHIV received ART. Of the total 33 PLHIV in B&H, 32 are older than 15, and 1 is younger than 15. One person died of AIDS in 2009.¹⁰

Opportunistic infections:

Co-infection with HIV and TB has been recorded in B&H 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. Below is the data for the total number of registered TB cases:

Year	New TB cases	Deaths
2005	2.160 (54/100.000)	4/100.000
2006	1.800 (45/100.000)	3/100.000
2007	2.400 (60/100.000)	Data being processed

According to the 2009 Global Tuberculosis Control - WHO Report, in 2007 there were 2,400 new TB cases registered in B&H. The data for 2008 and 2009 is being processed at the time. All HIV patients are tested for TB.

Reduction in HIV prevalence

There is an issue of considerable under-reporting in second-generation surveillance data on HIV prevalence amongst MSM and sex workers. 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.

Throughout the last decade, this region has been used by human traffickers both as destination and as the major transit route to Western Europe. Although the number of women trafficked to and through B&H has reduced significantly, the number of domestic victims of trafficking increased.

¹⁰ Source: HIV/AIDS Coordinator FB&H

Knowledge on prevention

In 2009, UNICEF carried out the Bio-Behavioural Survey (BBS) on IDUs. The aim of the survey was to determine the prevalence of HIV and other blood borne infections and to examine HIV-related risks among injection drug users (IDUs) in Zenica, Banja Luka, and Sarajevo. A further goal was to calculate estimates of the IDU population size in respective cities. Survey used respondent-driven sampling (RDS) to reach a total sample of 781 participants, 260 in Zenica and Banja Luka, and 261 in Sarajevo. Data were collected from October until December 2009 in the premises of the NGO "Margina" in Zenica, while in Banja Luka and Sarajevo separate premises were leased for data collection purposes. The questionnaire was administered face-to-face and it contained 142 questions covering topics from drug injection and sexual risks to knowledge about HIV transmission and harm reduction services coverage. Data were analyzed with RDSAT software for each city separately. The analysis was not disaggregated by gender because there was only small number of female IDUs in the samples. Therefore a parallel qualitative study using in-depth interviews was carried out with 15 females from Banja Luka and Sarajevo.

Recommendations for prevention activities are focused on increasing the awareness and utilization of the local HIV prevention services; reducing sexual risk behaviours, especially because of the potential for IDU population serving as a bridge towards the general population for HIV and other blood borne pathogens; enhancing outreach in group injection sites such as shooting galleries; targeting youth early on with drug abuse prevention materials and information about sexual risks; making local policing practices more sensitive and less antagonistic when dealing with IDUs; focusing prevention on the Roma IDU population in Sarajevo; and aiming to reduce the frequency of overdose. In addition, a set of recommendations for future surveillance surveys is also provided.

Knowledge on HIV prevention

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. GFATM programmes which support 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.

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 Association XY, implemented by in 2009 has provided a number of peer presentations for youth in 186 locations – 98 primary schools, 86 secondary school and 2 universities other locations.

City	Organisation	Activities
Sarajevo	Asocijacija XY	13 High schools 5 Preliminary schools
Banja Luka	Asocijacija XY	10 High schools 11 Preliminary schools
Bihać	NGO Novi put	6 High schools 2 Preliminary schools
Bijeljina	NGO Lara	4 High schools 9 Preliminary schools
Brčko	NGO Vermont	5 High schools 16 Preliminary schools
Doboj	Tolerancijom protiv različitosti (ToPeer)	5 High schools 11 Preliminary schools 1 University
Foča	Savjet mladih	1 High school centre 6 Preliminary schools 4 High schools from other cities (3 cities)
Livno	Centar za građansku inicijativu	3 High schools 2 Preliminary schools
Mostar	NGO Altruist	16 High schools 7 Preliminary schools 2 High schools from other cities (2 cities)
Prijedor	Omladinski savjet opštine Prijedor	7 High schools
Travnik	NGO Otvorena Asocijacija mladih	3 High schools
Tuzla	NGO Zemlja djece	8 High schools 5 Preliminary schools
Zenica	NGO Mladi za mlade PLUS	6 High schools 8 Preliminary schools 1 University
Derventa	NGO Derbent	2 High schools 2 Preliminary schools
Mrkonjić Grad	Omladinski centar	2 High schools 1 Preliminary schools
Orašje	NGO Puls	1 High schools 1 Preliminary schools

UNFPA Youth Sexual and Reproductive Health Programme (SRH), includes peer education programme which enables 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.

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.

- a. Sex workers and MSM: A biological-behavioural survey initiated in 2007 on sex workers and MSM provided results for 2010 UNGASS reporting. These are hidden populations that due to stigma and discrimination are to a large extent inaccessible.

The NGOs XY, PROI, Margina, Action against AIDS (AAA) had only limited access to sex workers and MSM population for their programmes.

- b. IDU: The majority of the respondents to the 2009 BB survey among IDU had good knowledge of the ways HIV can be transmitted through sexual contact and injecting drugs use. Around 95% are aware that HIV risk can be reduced by always using condoms, having sex with one faithful partner, and that a healthy-looking person can be infected. Forty five percent are estimated to know that HIV cannot be transmitted by using the toilet previously used by an HIV-positive person and 52% think that one cannot get infected by sharing a meal with a positive person. HIV risk awareness ranges from 20% of those who believe they are exposed to no risk of infection to an estimated 20% who believe the risk is high or extremely high. Thirty six percent correctly identified all the ways HIV can be transmitted and acquired as measured with the composite HIV knowledge indicator.

Efforts need to be taken to scale up prevention programmes and prevention services for MSM and SW populations as there is still lack of adequate services available.

Risk behaviour and behavioural practices:

- a. IDU: According to the 2009 BBS survey among IDU, average age at first vaginal and/or anal sexual intercourse was 16 with an estimated 42% of those who have had sex at age 15 or younger. Eighty nine have had sex during the last year and 76% during the past month. Sixty one percent have had more than one sexual partner in the last year. Less than one third have used a condom during the last time they had sex, no matter with what kind of a partner.

Seventy eight percent had sex with a steady (regular) partner during the last year and 15% have used condoms consistently with such a partner during the last month. Around one fifth have used a condom during the last intercourse with their regular partner. Seventy eight percent are estimated to currently have a steady partner or whose last steady partner is not an IDU. Slightly less than half have had sex with a casual partner during the last year and 30% have had more than one such partner in that period out of which 29% of these partners are also injecting drugs. Fifty eight percent

have always used condoms when having sex with casual partners during the last 12 months. Forty two percent are estimated to have used a condom during last sex with a casual partner and that partner was also an injection drug user for 62% of the population.

The main sources of condom supply are tobacco shops and gas stations (35%) and pharmacies (18%). During the last year, 51% received a condom from an outreach service, a prevention program, or in a counselling centre related to an NGO or a medical institution.

- b. MSM: In 2007 BBS survey among MSM, although there is a relatively high level of awareness of the ways of acquiring HIV infection more than 80% of respondents believe that a certain personal risk in their case exists and more than 50% of respondents stated that they hadn't change a thing in their behaviour within the past six months in order to reduce the risk of acquiring HIV.

The largest part of 102 respondents who have stated that they have changed something in their behaviour in order to reduce the risk of getting HIV/STI – 48% stated they are using condoms more often.

- c. SW: The 2007 BBS survey among SW indicates that majority of respondents (92.5%) are aware that the adequate use of condoms reduces the risk of transmission of HIV. About more than one third (70.5%) of respondents know that a healthy looking person may be infected by HIV, while 76.2% answered that HIV infected woman can transmit the virus to her child.

HIV testing:¹¹

HIV testing is available in B&H as VCCT and the provider initiated testing (protocol). HIV testing is only provided for pregnant women when requested (“opt-in”). In B&H 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.

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, except for BB surveys. 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

¹¹ Source: HIV/AIDS Coordinator FB&H, Federal IPH Mostar, IPH Banja Luka

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 FB&H but these are not reported to the IPH.

All donated blood units are mandatory tested for HIV, HCV, HBV, and syphilis by the laboratories at the transfusiology institutes. Each year approx. 70,000 received blood units are tested by ELISA method.

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.¹² But, there is no reference laboratory service in B&H, which means no formal quality assurance programmes for laboratory testing exists – either in general or for HIV, internally or with laboratories outside the country.

In the period of 01.01 2009 - 31.12.2009, there were 70,287 blood donations tested for HIV.

HIV testing amongst most-at-risk groups in B&H:

- a. MSM: Out of 224 participants in the 2007 BBS survey among MSM, 152 were tested to HIV, with 0.7% of HIV positive results.
- b. IDU: Through VCCT centres, 1.162 IDU were tested in addition to 162 non IDU drug users. Majority of IDU population knows where an HIV test can be done if they want to take one (78%) and almost all were able to name at least one place where the test is available. Seventy seven percent have taken an HIV test once or more times during their lifetime. An estimated 44% have been tested during the last 12 months and for 29% this testing was required. Most (49%) took the test the last time they tested at a clinic for infectious diseases or a hospital. Almost all (91%) know the result of their last HIV test. An estimated 30.5% have been tested on HIV in the last year and knows the result of their test. An estimated 79% have ever been tested on HCV and 57% tested last time in 2009 or 2008. Ninety one percent know the result of their last HCV test and 37% have reportedly been diagnosed with an HCV infection.
- c. SW: 42 (28,8%) out of total number of respondents in the 2007 BBS survey among SW got tested to HIV and 81% know the results, with 20 (13.6%) respondents getting tested within the last 12 months; there were no HIV positive cases revealed in the survey.

¹² Source: HIV/AIDS Coordinator FB&H

V. Best practices:

GFATM HIV/AIDS programme:

In 2006 B&H was awarded the Global Fund grant of USD 11,042,257 for duration of five years. The comprehensive Global Fund HIV/AIDS programme is based on the B&H 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 centres; 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. Currently the phase 2 of the project is being implemented.

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 GFATM supported programme. NGOs dealing with these issues are making significant efforts in the area of HIV prevention, work with PLHIV, and vulnerable populations. Counselling centres 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 GFATM HIV/AIDS programme are:

<u>RS</u>	Action Against AIDS (AAA)	MSM, sex workers, psychosocial support to PLHIV
	UG Viktorija	IDU, sex partners of IDU, prisoners
	Poenta	IDU (drop in centre, needle/syringes exchange programme)
<u>FB&H</u>	INGO Foundation PH Suisse – Partnerships in Health	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, sex 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, currently in the second implementing phase.¹³

Public Sector:

Further progress in the reporting period has been made. Among the adopted legislation are: anti discrimination law, Law on medicine and medical products, Strategy on supervision over narcotic drugs, prevention and suppression of the abuse of narcotic drugs in B&H, Youth and health Strategy and basic package of health rights FB&H.

New legislation which is in the development stage: Law on blood safety, in FB&H Law on health protection, new Law about health insurance, Law on protection of patients rights etc.

Since 2007, Partnerships in Health organised VCT trainings for primary health care professionals working on HIV/AIDS as a step towards mitigating discriminatory practices. The complete list of medical staff trainings in primary and secondary health protection can be found in the graph below.

Year	Total participants	Participants
2007	48	24 doctors 24 nurses
2008	55	27 doctors 28 nurses
2009	152	27 doctors 125 nurses

VCCT centres:

In total there are 20 VCCT centres established and functional.

Second-generation surveillance:

An important step forward for evidence based policy making are the BBS surveys conducted on MSM and SW in 2007 and IDU in 2009.

The three BBS surveys provided 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. Fragmentation in administrative organization in health sector in B&H is the reason why not all civil categories are not covered by the health protection system.

¹³ UNDP/GFATM HIV/AIDS Programme

- b. Although development and monitoring of National HIV&AIDS Strategy has been functioning at the state level, planning and coordination has been done at the entity level
- c. 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.
- d. HIV Testing: In order to avoid stigma and discrimination, the coding system enables PLHIV to remain anonymous, until the beginning of ART treatment.
- e. 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 will be strengthened with the requirements of the UNGASS Guidelines in mind, which is covered by the new Law on blood safety.

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 B&H 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”.

In addition, the Strategy on Roma has been adopted along with the relevant action plan. This successfully addressed the obstacles reported in the UNGASS 2008 report.

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

- a. The UN Theme Group / Joint UN Team on HIV/AIDS in B&H, with UNICEF as the Chair, provided technical assistance in compiling existing information / data sets within the country and preparation for the 2010 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 B&H'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 2009, which provided data sets for 2010 UNGASS indicator reporting.

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

- Capacity building: WHO supported participation of B&H health professionals in attending international meetings on topics of HIV/AIDS, tuberculosis, blood safety and surveillance of communicable diseases in general.
- Strengthening evidence based practice at the country level, WHO supported health professionals in B&H by providing "HIV AIDS treatment and Care - clinical protocols for WHO European Region".

WHO's overall collaboration with health authorities in B&H 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.

e. In 2007, a BBS survey among sex workers and MSM has been undertaken by Foundation Partnerships in Health with funding from multiple donors: Joint UN Team on HIV/AIDS / UNAIDS, UNICEF, GFATM programme, and Partnerships in Health. The Institute of Public Health in FB&H assisted Partnerships in health with preparation of the survey protocol, questionnaire and data analysis.

VII. Monitoring and evaluation environment

An integrated system of routine surveillance of communicable disease still 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.

Data is being collected in accordance to WHO and ECDC HIV reporting system standards.

At a national level an M&E system is being developed. GFATM and WB support the development of the M&E system in B&H. The GFATM 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. Through established system within

the M&E unit, data is collected on 120 indicators at the national level for HIV and TB.

The M&E action plan for UNDP/GFATM HIV/AIDS programme has been developed, staff assigned, and 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.

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.