2012 Global AIDS Response Progress Reporting
2012 Universal Access in the Health Sector Reporting, and
2012 Dublin Declaration Reporting
Bosnia and Herzegovina

Reporting period: January 2010 - December 2011

Submission Date: 31st March 2012

I. Status at a Glance

Report writing process

For the first time, the 2012 country reporting process includes Global AIDS Response Progress (GARP), Universal Access in the Health Sector (UA) and Dublin Declaration (DD) reports. The reporting process was lead by the Ministry of Civil Affairs (MoCA) jointly with Federal Ministry of Health (FMoH), Ministry of Health and Social Welfare of Republika Srpska (MoHSW RS) and Brčko District Department of Health (BD DoH). The assistance and support in the reporting process was provided by the Office of the UN Resident Coordinator in BiH, through UNAIDS and Joint UN Team on HIV/AIDS in BiH (UNJT).

The first phase of the data collection for the reporting included circulation of National Commitments and Policy Instrument (NCPI) and European Supplement to the NCPI (ESNCPI) questionnaires and requests for information among civil society organisations and international agencies and organisations active in HIV/AIDS response in Bosnia and Herzegovina (BiH).

The questionnaires for Part A of NCPI and ESNCPI were completed and submitted by the HIV/AIDS Coordinator in Federation of BiH (FBiH). The questionnaires for Part B of the NCPI and ESNCPI were received from non-government organisation Action against AIDS (RS). These inputs were crucial in the process of report preparation.

The 2012 GARP, UA and DD reporting process was coordinated by Dr. Šerifa Godinjak, Head of Department for European Integration and International Cooperation within Sector for Health in MoCA BiH. Extensive inputs in terms of data provision and consultation whenever needed were provided by FBiH HIV/AIDS Coordinator- Dr. Zlatko Cardaklija; RS HIV/AIDS Coordinator – Dr. Stela Stojisavljević; Dr. Ljubica Jandrić, Epidemiologist - Institute for Public Health (IPH) RS; Dr. Jelena Ravlija, Epidemiologist - Federal IPH; Dr. Nešad Šeremet, GFATM / UNDP Programme Director; Mr. Haris Hajrulahovic, Head of Office - WHO. Mr. Mirza Musa, HIV/AIDS Advisor to the UNJT / UNAIDS Focal Point in BiH provided inputs, support and assistance in the preparation and submission of the report.

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

- The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) / United Nations Development Programme (UNDP) - Project Management Unit (PMU)
- Federal IPH, IPH RS and Partnerships in Health
- UNICEF BiH

- WHO BiH

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

UNGASS indicator data for BiH in overview table:

Narrative report and Cover sheet

Testing and Counselling		
0.1	Narrative report	Data available and submitted
0.2	Cover sheet	Data available and submitted

Target 1. Reduce sexual transmission of HIV by 50 per cent by 2015

Indicators for the general population		
1.1	Young People: Knowledge about HIV Prevention	Data available and submitted
1.2	Sex Before the Age of 15	Data available and submitted
1.3	Multiple sexual partners	Data not available
1.4	Condom Use During Higher Risk-Sex	Data not available
1.5	HIV Testing in the General Population	Data available and submitted
1.6	Reduction in HIV Prevalence	Data available and submitted

Indicators for sex workers		
1.7	Prevention programmes	Data not available
1.8	Condom Use	Data available and submitted
1.9	HIV Testing	Data available and submitted
1.10	HIV Prevalence	Data available and submitted

Indicators for men who have sex with men		
1.11	Prevention programmes	Data not available
1.12	Condom Use	Data available and submitted
1.13	HIV Testing	Data available and submitted
1.14	HIV Prevalence	Data available and submitted

Testing and Counselling		
1.15	Health facilities that provide HIV testing and counselling	Data available and submitted

Sexually Transmitted Infections (STIs)		
1.17	Sexually Transmitted Infections (STIs)	Data available and submitted

Migrants		
1.18	Condom Use	Data not available
1.19	HIV Testing	Data not available
1.20	HIV Prevalence	Data not available

Prisoners		
1.21	HIV Prevalence	Data available and submitted

Target 2. Reduce transmission of HIV among people who inject drugs by 50% by 2015

Indicators for Injecting Drug Users		
2.1	Prevention Programmes	Data available and submitted
2.2	Condom Use	Data available and submitted
2.3	Safe Injecting Practices	Data available and submitted
2.4	HIV Testing	Data available and submitted
2.5	HIV Prevalence	Data available and submitted
2.6	Opiate users	Data available and submitted
2.7	NSP and OST sites	Data available and submitted

Target 3. Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths

Indicators for mother-to-child transmission		
3.1	Prevention of Mother-to-Child Transmission	Indicator not relevant
3.2	Early Infant Diagnosis	Indicator not relevant
3.3	Mother-to-Child transmission rate (modelled)	Indicator not relevant
3.4	Pregnant women who know their HIV status	Indicator not relevant
3.7	Infants born to HIV-infected women receiving ARV prophylaxis for prevention of MTCT	Indicator not relevant
3.10	Distribution of feeding practices for infants born to HIV-infected women at DTP3 visit	Indicator not relevant
3.13	Pregnant Women Who Inject Drugs	Indicator not relevant

Target 4. Have 15 million people living with HIV on antiretroviral treatment by 2015

Indicators for HIV treatment		
4.1b	Treatment: Antiretroviral Therapy among People Diagnosed with HIV Infection	Data available and submitted
4.2	HIV Treatment: 12 Months retention	Data available and submitted

4.2a	HIV Treatment: Survival After 12 Months on Antiretroviral Therapy, IDUs	Data not available
4.2c	HIV Treatment: 60 month retention	Data available and submitted
4.2d	IDU on treatment: 60 months retention	Data available and submitted
4.4	ART Stockouts	Data available and submitted
4.5	Late HIV Diagnosis	Data available and submitted

Target 5. Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015

Indicators for TB and HIV		
5.1	Co-Management of Tuberculosis and HIV Treatment	Data available and submitted
5.3	Percentage of adults and children newly enrolled in HIV care starting isoniazid preventive therapy (IPT)	Data available and submitted
5.4	Percentage of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit	Data not available

Target 6. Reach a significant level of annual global expenditure (US$22-24 billion) in low and middle-income countries

Indicators for AIDS spending		
6.1	AIDS Spending - Domestic and international AIDS spending by categories and financing sources	Data not available

Target 7. Critical enablers and synergies with development sectors

7.1	NCPI Header	Data available and submitted
A-I	Strategic Plan	Data available and submitted
A-II	Political Support And Leadership	Data available and submitted
A-III	Human Rights	Data available and submitted
A-IV	Prevention	Data available and submitted
A-V	Treatment, Care And Support	Data available and submitted
A-VI	Monitoring And Evaluation	Data available and submitted
B-I	Civil Society Involvement	Data available and submitted
B-II	Political Support And Leadership	Data available and submitted
B-III	Human Rights	Data available and submitted
B-IV	Prevention	Data available and submitted
B-V	Treatment, Care And Support	Data available and submitted

7.1c	European Supplement to the NCPI	Data available and submitted
7.2	Prevalence of Recent Intimate Partner Violence (IPV)	Data not available
7.6	Adults and children with HIV enrolled in HIV care	Data available and submitted
7.7	HIV/hepatitis	Data available and submitted

Indicators for Target 3 (MTCT) are not relevant due to only one recorded case of vertical transmission.

Indicator for Target 6 (AIDS spending) is not available. Due to very complex structure of the state, it was not possible to compile comprehensive data for the National Funding Matrix (NFM). The main reason for this obstacle is National AIDS Spending Assessment (NASA) system is not established in the country.

According to the GFATM programme reports, the overall reported expenditure for HIV/AIDS in 2010 is 2,212,926.66 USD; for 2011 the total is USD 6,714,168 USD, while the total planned for the phase I is USD 14,965,778; the estimated BIH Government expenditure for HIV/AIDS is USD 600,000.

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. As a recommendation, expenditure of these funds needs to be analysed in order to properly assess HIV/AIDS expenditure by public sources.

Status of the Epidemic

BiH is a low HIV prevalence country with an estimated prevalence of <0.1%. Due to considered low-level of HIV/AIDS epidemic, the measures in the country are predominantly focused on promotion of protective behaviour in key populations at risk.

The target groups, in accordance with the identified needs, for future activities include the general population, key populations exposed to increased risk of HIV infection (men having sex with men - MSM, sexual workers - SW and their clients, asylum seekers, refugees, prisoners, internally displaced persons - IDP, the transient population, injecting drug users - IDU, young people and persons who live on or below the poverty line and those persons exposed through a professional capacity to HIV: healthcare workers who come into contact with bodily fluids as well as other professionals such as policemen, soldiers, correctional officers, fire fighters, rescue service officers and members of

associations and foundations that provide harm reduction services and similar. In addition, the HIV/AIDS Strategy in BiH 2010-2016 indicates that significant attention should be paid to the Roma population due to their marginalisation and youth - particularly adolescents and primary school pupils in rural areas.

The European Centre for Disease Prevention and Control (ECDC) data for BiH up to December, 2011 indicate cumulative total of 196 HIV cases. HIV cases where exposure category was known are as follows: Heterosexual 56%; MSM/Bisexual 22%; IDU 11%. Out of 196 HIV cases, 116 have developed AIDS by the end of 2011.

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

The first case of HIV was registered in 1986 and until the end of November, 2011 there are 196 registered HIV positive cases. Of these 154 were recorded as males, 42 as females. Some of them have died, and some were lost to follow-up. In total, there are 63 persons living with HIV (PLHIV) on antiretroviral therapy (ART) in BIH.

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

HIV Prevalence: In 2010 the Voluntary Confidential Counselling and Testing (VCCT) centres reported 15 HIV positive cases out of total of 7,196 undertaken tests. From the total, 6,365 were informed of their HIV test results. In 2011 the VCCT centres reported 32 HIV positive cases out of total of 6,011 undertaken tests. From the total 5,497 were informed of their HIV test results. Given the ratio of populations tested in VCCT and HIV positive cases, and given the over-representation of key populations at risk 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 in BiH was established in 2005 through VCCT centres. In 2012 there are 20 VCCT centres established and functional. 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.

According to BiH reporting to ECDC, the number of AIDS cases in BIH 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.

II. National response to HIV epidemic:

Strategy to prevent and combat HIV/AIDS in Bosnia and Herzegovina 2011–2016

In reference to the global HIV/AIDS epidemic, Bosnia and Herzegovina is still considered to be a low prevalence country (less than 0.1%); however, within BiH there are a number of factors that can stimulate the emergence and spread of the epidemic at any time. Since the first registered AIDS case in BiH in 1986, by November 2011, 169 HIV PLHIV have been registered and AIDS has developed in 116 cases. Key population groups identified as being exposed to a higher risk of HIV infection include: IDU, MSM, SW and their clients, the transient population, refugees and prisoners. In addition, significant attention should be paid to the Roma section of the population due to their marginalisation, and youths, particularly adolescents and primary school pupils in rural areas. In the past couple of years HIV infection has been kept under control in BiH. Defined goal of HIV rate less than 1% within the general population and less than 5% in any of the key populations at risk are being successfully maintained largely due to GFATM HIV grants being implemented in BiH.

As a response to the global HIV/AIDS epidemic and pursuant to the UN Declaration of Commitment on HIV/AIDS, as well as other international documents, in 2002 the Council of Ministers BiH (CM) established the National Advisory Board for Combating HIV/AIDS in Bosnia and Herzegovina (NAB) with the task to develop a strategy to prevent and combat HIV/AIDS and further develop the strategic planning process in this field.

The Strategy to Prevent and Combat HIV/AIDS in Bosnia and Herzegovina for the period 2004-2009 was adopted during the session of the CM BiH held in February 2004. The strategy has ensured that government institutions and civil society organisations (CSO) plan and implement programmes arising from the specific goal set forth in strategic documents at all levels. BiH has been awarded with funds by the GFATM since 2006 and this has been reflected to a great extent in the country comprehensive HIV response.

More intensive activities on implementing the new strategy for the period 2011-2016 were initiated in mid 2010, when the NAB in BiH was appointed with the task force to develop the strategy. Strategy development was coordinated by the MoCA BIH, together with the entity HIV coordinators and the representative of the UNJT in BiH. Significant contribution was made by the appointed representatives of the FMoH, MoHSW RS, BD DoH , the FBiH PHI, RS PHI, the Infectious Diseases Clinics of the clinical centres in Sarajevo, Tuzla and Banja Luka and representatives of civil society and international

organisations working with PLHIV. The UNJT on HIV/AIDS provided logistical support for the facilitation of the meetings.

A key vision of the Strategy is for BiH to become a state experiencing a gradual decrease in the number of newly infected persons with the HIV virus and to create an environment that will ensure a long quality and healthy life for all persons living with HIV.

The HIV/AIDS Strategy in BiH for the period 2011-2016 was adopted by the CM BiH in September, 2011. The strategy sets the overall aim as: to maintain the HIV rate in BiH below the level of 0.01%. With this aim in mind, the 6 strategic goals identified in the strategy for 2011-2016 are:

1) Universal approach towards prevention, treatment, care and social support;
2) Strengthening surveillance of HIV/AIDS;
3) Strengthening of inter-sectoral and multi-sectoral cooperation;
4) Strengthening and capacity building of all stakeholders to combat HIV/AIDS;
5) Strengthening the legal framework for the promotion, respect and protection of human rights and;
6) Decrease stigmatisation and discrimination.

Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) R5 HIV Programme

Given BiH complex administration, legal framework, decentralised health sector (with no state Ministry of Health) and low absorption capacity, in 2006 the United Nations Development Programme (UNDP) BiH has been selected by the Country Coordinating Mechanism (CCM) as the Primary Recipient (PR) for the awarded Round 5 of GFATM HIV grants. The project was implemented in cooperation with the FMoH, MoHSW RS and CSO sector. The title of the grant is “Coordinated National Response to HIV/AIDS and Tuberculosis in a War-torn and Highly Stigmatized Setting” and it was successfully implemented in two phases: phase I, November 2006 – October 2008 and phase II, November 2008 – 31 October 2011. The overall goal of the programme was to maintain the low level of HIV prevalence in BiH through increased access to high quality services and reduced stigma and discrimination connected with HIV/AIDS. Implementation of this programme has contributed to achieving this goal by ensuring earlier HIV diagnosis and enrolment in treatment programmes. The overall ownership of the project remained with the Government of BiH and the CCM, while UNDP BiH as the nominated PR has been responsible for the overall successful management of the programme. The total budget of the grant was USD 9,775,439.

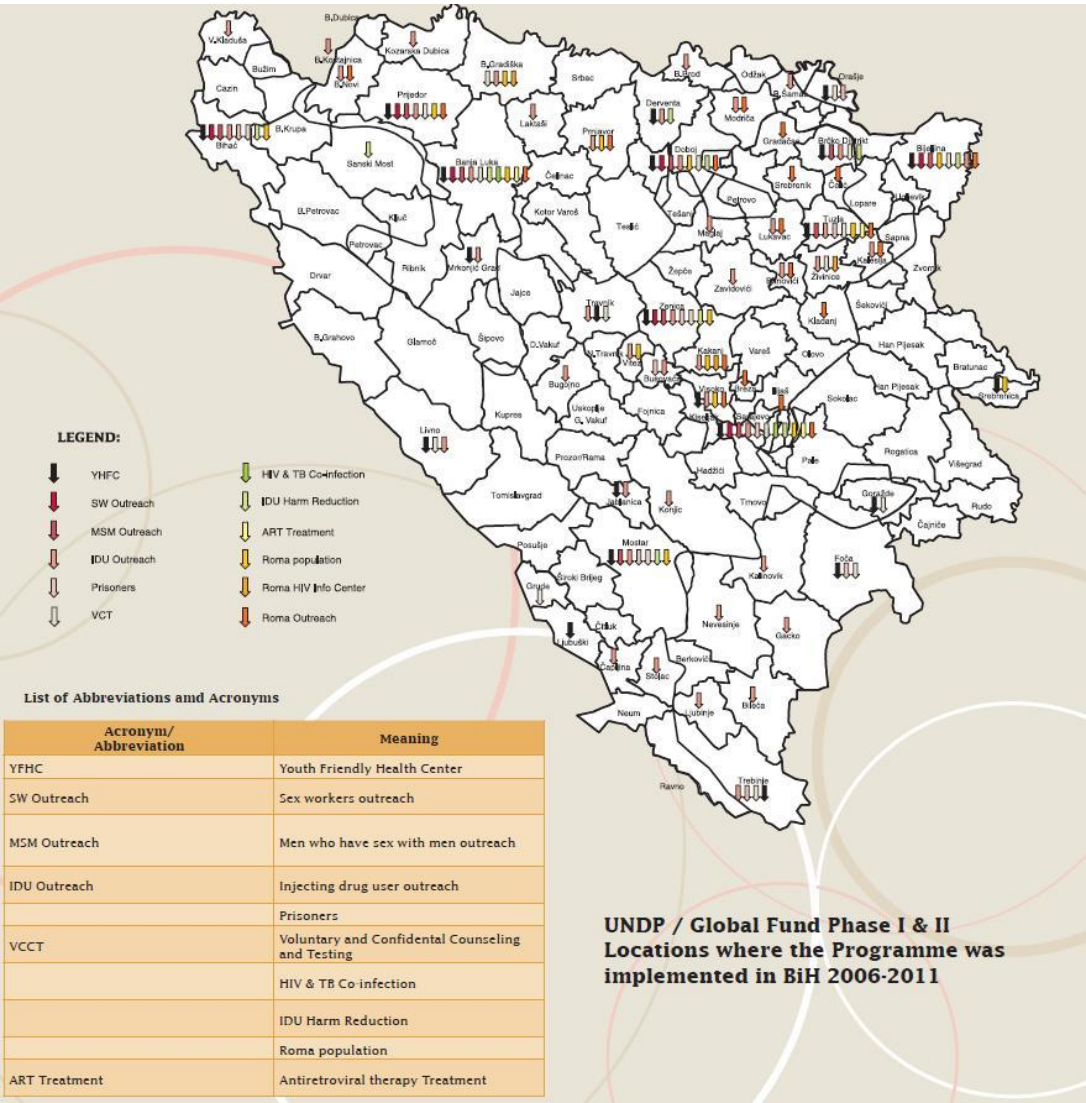
The programme objectives of successfully implemented GFATM R5 HIV grant in BiH were:

1) Scale-up Information, Education, Communication / Behavioural Change, Communications (IEC/BCC) and Prevention Education among the Youth
2) Objective 2: Scale-up Information, Education, Communication / Behavioural Change, Communication (IEC/BCC) in Population groups with Increased Risk of HIV/AIDS Infection
3) Improved Access and Quality of Voluntary Counselling and Testing
4) Co-infection HIV/AIDS and Tuberculosis
5) Improvement of harm reduction services
6) Objective 6: Introduce HIV Prevention into Roma communities and for Former Displaced Persons
7) Universal Free Access Provided for PLHIV for ART, Treatment of Opportunistic Infections, Hospitalisation, Psychosocial Counselling and Palliative Care

The main partners in the project implementation were:

- Ministry of Civil Affairs of Bosnia and Herzegovina
- Federal Ministry of Health
- Ministry of Health and Social Welfare of Republika Srpska
- Institute for Public Health of the Federation of Bosnia and Herzegovina
- Institute for Health Protection of Republika Srpska NGO Association for Sexual and Reproductive Health “XY”
- Association “UG PROI”
- Association “Q”
- NGO Action Against AIDS
- Association Viktorija
- Partnerships in Health Bosnia and Herzegovina
- NGO Margina
- NGO Poenta
- World Vision Bosnia and Herzegovina

GFATM R5 HIV grant – geographic locations 2006 - 2011



List of Abbreviations and Acronyms

Acronym/ Abbreviation	Meaning
YFHC	Youth Friendly Health Center
SW Outreach	Sex workers outreach
MSM Outreach	Men who have sex with men outreach
IDU Outreach	Injecting drug user outreach
	Prisoners
VCCT	Voluntary and Confidental Counseling and Testing
	HIV & TB Co-infection
	IDU Harm Reduction
	Roma population
ART Treatment	Antiretroviral therapy Treatment

Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) R9 HIV Programme

In addition to on-going projects supported by other international organizations, UNDP in 2009 and 2010 provided support to BiH's national institutions, experts and NGO representatives, and through the CCM developed two successful GFATM applications for R9 HIV and Tuberculosis (TB) prevention and treatment programs.

As in previous GFATM grant (HIV R5), the approved R9 HIV/AIDS GFATM programme in BiH is 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, MoHSW RS, FMoH, local civil society organisations, together with UN partners such as UNFPA, UNDP, UNAIDS,

UNICEF 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 NAB. The approved amount for GFATM R9 HIV grant – first phase is 14,965,778 USD.

Research among key populations at risk

Injecting drug users (IDU)

The study, using respondent driven sampling, was conducted in 2009 with the support of UNICEF. The results estimated the prevalence of HIV and HVC among IDU as well as the frequency and patterns of behavioural risk. RDS was conducted in three towns: Sarajevo (pattern 261), Zenica (pattern 260) and Banja Luka (pattern 260). The average age was between 29 and 30. Around a quarter of the IDU in Zenica and Banja Luka and one third in Sarajevo were estimated to have injected with previously used needles and or syringes for their own injection during the last month. In most cases in all the cities during the last 12 months this injection equipment had been borrowed from close friends or sexual partners. Twenty six percent in Zenica, 22% in Banja Luka and 30% in Sarajevo were estimated to have given their own used needles and or syringes to one or more person during the previous month. Eighty six percent of the population in Sarajevo, 74% in Banja Luka and 78% in Zenica were estimated to have used sterile injection equipment the last time they injected. In the month preceding the survey needles and or syringes had most often been purchased in pharmacies, which were also the main source of supply for injection equipment in each city.

The average age for first vaginal or anal sexual intercourse in each city was 16. In Banja Luka 41% were estimated to have had two or more sexual partners in the last year, as did 61% in Sarajevo and 54% in Zenica. Around half of the IDU had had a casual sexual partner in the previous 12 months. Condoms had always been used with casual partners during the last year by 21% in Zenica, 29% in Banja Luka and 58% in Sarajevo. The main sources of condoms in all three cities were tobacco shops and petrol stations, while slightly less than half had received condoms from an outreach service or an organisation in the previous year. An estimated 69% of IDU in Banja Luka, 73% in Zenica and 78% in Sarajevo knew where they could get an HIV test and the majority reported a clinic for infectious diseases and or a hospital as the place where HIV testing was available. In Zenica 39% were estimated to have never had an HIV test, 45% in Banja Luka and 77% in Sarajevo. Clinics for infectious diseases and or hospitals were the most frequently

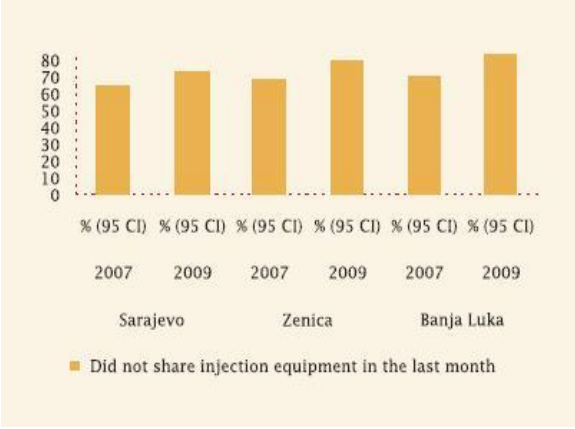
reported places where the last HIV test was made. More than 80% in Banja Luka and more than 90% in Zenica and Sarajevo knew the result of their last HIV test. Thirty nine percent in Zenica, 35% in Banja Luka and 79% in Sarajevo had never been tested for HCV, out of whom 26% in Zenica, and around a third in Sarajevo and Banja Luka had been diagnosed with a HCV infection.

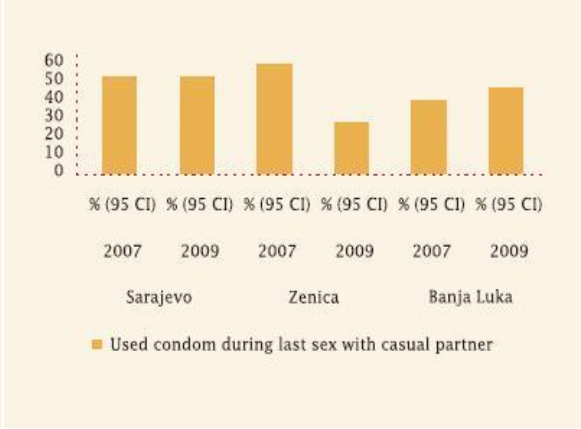
An estimated 70% of the IDU population in Sarajevo had undergone treatment against drug addiction in their lifetime, as had 50% in Banja Luka and 48% in Zenica. Around 28% of IDU in Banja Luka and 63% in Zenica were currently under treatment. In Sarajevo and Zenica a large majority (97% and 79%, respectively) of those who were currently under treatment were undergoing methadone substitution therapy, while in Banja Luka the majority (47%) was trying to treat their addiction on their own.

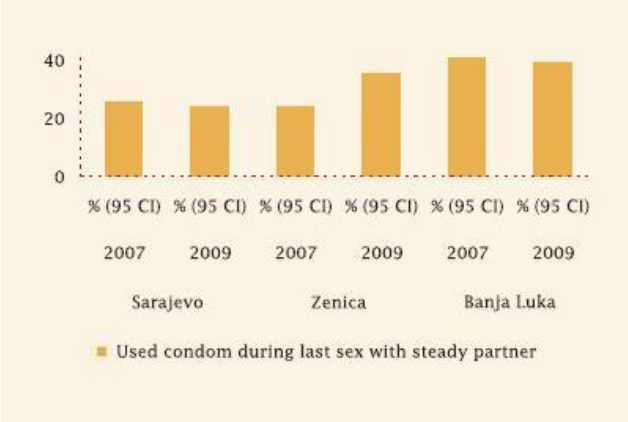
Comparison of outcome indicators through RDS among IDU in 2007 and 2009

Indicator	Sarajevo		Zenica		Banja Luka	
	2007.	2009.	2007.	2009.	2007.	2009.
	% (95 CI)	% (95 CI)	% (95 CI)	% (95 CI)	% (95 CI)	% (95 CI)
Did not share injection equipment during the last month	60.6	68.4	63.2	76.4	66.5	79
Used a condom during their last sex with a steady partner	23.2	21.4	21.7	33	38.8	37
Used a condom during their last sex with a casual partner	48	46.9	54.6	22.7	34.2	40.9

In comparison to 2007, in 2009 clients (IDU) slightly changed their behaviour regarding the use of sterile needles and syringes. As far as condom use is concerned, in 2009 a decrease in practicing safe sexual intercourse was recorded for clients.







Men who have sex with men (MSM) and sex workers (SW)

Two studies were conducted for MSM and SW populations. The first, conducted in 2008 and the second, conducted in 2010/2011. The authors of both studies were Jelena Ravlija M.D., Ljubica Jandric M.D., Marija Zeljko M.D. and Aida Kurtovic M.D. The survey into Behavioural risk in Relation to the Prevalence of HIV amongst Population Groups with Higher Risk of HIV Exposure was conducted during the period from January to February 2008. The sample consisted of 224 MSM respondents and 164 SW respondents in seven urban centres in Bosnia and Herzegovina. Surveys were conducted in Sarajevo, Banja Luka, Mostar, Tuzla, Prijedor, Bijeljina and Prnjavor with the aim to monitor the magnitude and collect data on the prevalence of HIV, Hepatitis B, Hepatitis C and Syphilis infections within the targeted population groups.

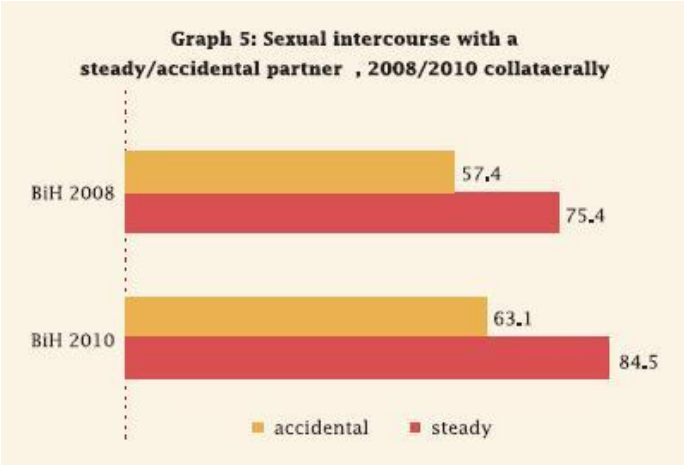
Research of Behavioural Risk with Regard to the Prevalence of HIV in Groups at Increased Risk was conducted in November 2010 and February 2011 and was based on a similar sample to the one conducted in 2008. It included a comparative analysis of the key behavioural and biological indicators of the population groups targeted by these two studies, namely MSM and SW. These indicators produced key information on socio-demographic features, behavioural risk and the level of HIV, Hepatitis and Syphilis for each of the two target population groups.

Men who have sex with men (MSM)

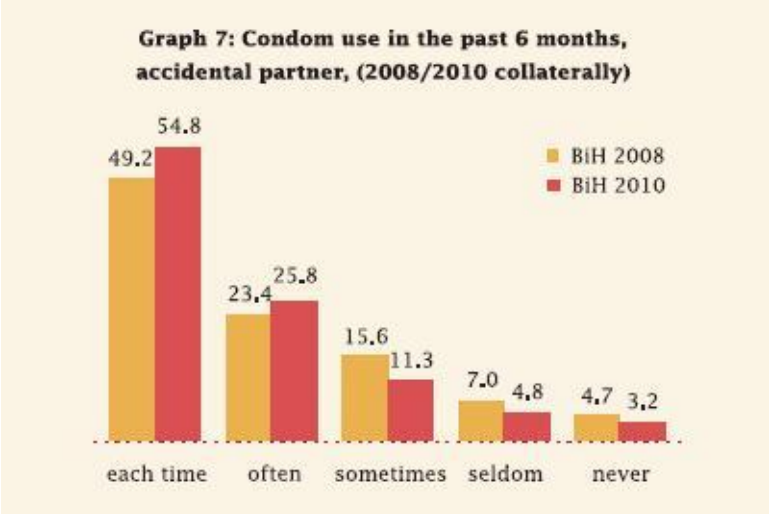
The total sample of the MSM population group comprised of 248 examinees whose average age was 26.7, most of them (94.3%) were from an urban area (slightly less than in the 2008 research: 96.4%), 98.8% were BiH nationals, the majority of them were secondary school graduates (72.2%), 39.1% of them were unemployed (considerably more than in 2008: 22.4%) with a statistical significance of $p<0.001$. 10.6% of examinees

had their first anal sex with a man when they were less than 16; the average age at which they had had their first anal sex with a man was 19.33 years.

84.5% of examinees report having sex with a steady partner in the past 6 months, which represents an increase in comparison to 2008 (75.4%), with a statistical significance of p=0.024.



Even though a high percentage of examinees knew that the consistent and proper use of condoms may prevent HIV infection (over 99% of examinees knew that the risk of HIV may be reduced by the proper use of condoms) and 89.9% of examines knew that a person who may appear to be healthy can be infected with HIV, the majority of examinees were not familiar with the HIV status of their sexual partner either because their partner had never been tested for HIV (23.3.%) or they never discussed the matter (37.9%). The results of the research show that the frequency of regular use of a condom with a steady partner in the past 6 months did not exceed 23%, while 16.9% of examinees never used a condom. Over 63% of examinees reported having anal sex with an accidental male partner in the past 6 months, which represents an increase when compared to 2008 (57.4%). 54.8% of examinees reported using a condom each time they had sex with an accidental partner in the previous 6 months, which represents an increase in comparison to 2008 (49.2%), without any statistical significance (p>0.05). 63.7% of examinees reported using a condom during their last anal sex with a male partner, while only 8.6% of examinees used it during their last oral sex.



21.5% of examinees believed that there is no risk of HIV infection (16.5% in the 2008 research), while the percentage of those who estimated the risk to be great (5.7%) had reduced in comparison to 2008 (9.8%). This research established that there is relatively good general knowledge about HIV and sexually transmitted infections (STI), the need to use condoms and testing, but it was observed that, in general, this knowledge is rarely transferred to the reported behaviour. The research indicates that a significant proportion of the examinees practiced unprotected sex and had multiple non-commercial sexual partners.

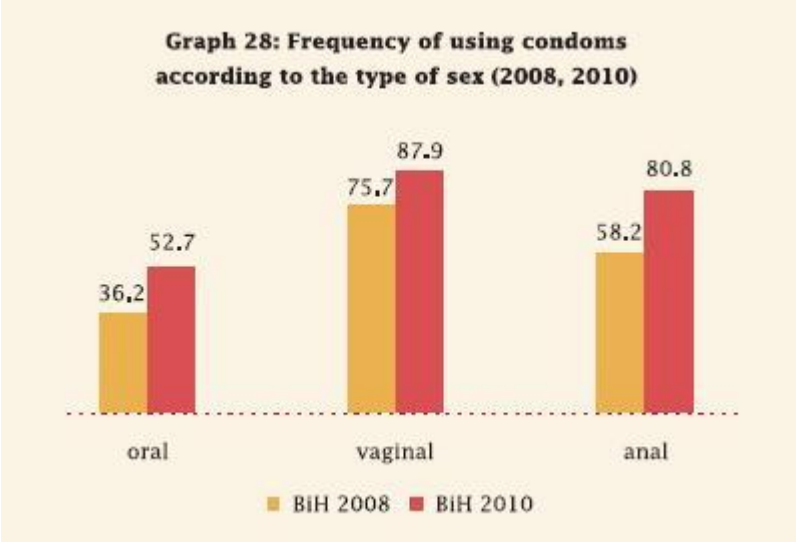
Sexual workers (SW)

The research was conducted using a sample of 154 female examinees. Around half of the examinees were between 18 and 27 years of age and over 90% of them were BiH nationals. Somewhat more than two-thirds of the examinees had secondary school qualifications (74.7%) and around 15% had college or university degrees. 83.1% of the examinees were not permanently employed, which is significantly statistically higher than the rate in the 2008 research (69.8%), ($p<0.02$). The majority of examinees were single, 18.6% were divorced and 9% were married or in a common-law relationship. 29.9 % of examinees had had their first sexual intercourse before the age of 16, which statistically is significantly higher than the rate in the 2008 research (16.4%), ($p<0.001$). On average the examinees had around 5 different sexual partners per week. The research has shown that a large number of the examinees demonstrated reduced behavioural risk in terms of condom use during their last sexual intercourse, when compared to the 2008 research.

Concerning their reported use of condoms, during their last sexual intercourse with a client the percentages for condom use were 52.7% oral, 87.9% vaginal and 80.8% anal,

which is more than the 2008 research percentages: 36.2% oral, 75.7% vaginal and 58.2% anal.

The most common manner in which the examinees found customers was through arranged channels (43.8%), while the most common locations for meeting customers were bars (50%) followed by clubs (45.2%), which statistically is more significant than in the previous research (20.5%), ($p<0.001$). The most common locations for providing sexual services were rented hotel rooms.



The most common types of violence that the examinees reported were mental abuse (41.2%) followed by physical violence (39.2%) and every fifth examinee (19.6%) had been subjected to sexual violence. 88.7% of the examinees had had sex under the influence of alcohol and 53.3% of them under the influence of narcotics, which statistically is more significant in comparison to the 2008 research (35.6%), ($p<0.01$). When asked if they had STI, 26.6% of examinees answered affirmatively. The most common self-registered STI were genital herpes (56.4%), gonorrhoea (33.3%) and the human papilloma virus (12.8%),

which is significantly less than in the 2008 research (33.3%). The majority of examinees (over 80%) answered most of the questions related to their knowledge of HIV/STI correctly, while other questions were answered correctly by around 50% of examinees. A comparison of the data shows that the examinees' knowledge was to some degree better than in the 2008 research; however, the self-assessment of risk showed that 42.2% of examinees believed that the risk was low, which was significantly more than in the last research in 2008 (28.8%).

Although SW are in a population group that is hard to access this research obtained significant information about their sexual behaviour, level of knowledge, awareness and risk perception as well as the biological parameters of HIV and other sexually transmissible infections. In comparison to the last research conducted in 2008 some segments showed a certain improvement in their knowledge, attitude and behaviour, but still demonstrated a significant level of vulnerability and risk.

III. 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. The country 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 centres 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 labour law 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 BiH. However approval has been given on a case-by-case basis for harm reduction programmes in different cities since 2006. Several 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 BiH aiming to provide legal framework for the implementation of harm reduction activities in BiH. 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 key populations at higher risk 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:

The NAB, which oversees and advises the HIV/AIDS programmes in the country, with MoCA 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 Brčko District nominated Entity HIV/AIDS Coordinators to facilitate and coordinate the tasks undertaken by the NAB.

The 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 33 members from the government, NGO sector and UNJT 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 HIV and TB proposals by the GFATM. Some of the specific tasks carried out by CCM during the reporting period beside the proposals for GFATM were: strengthening of CSOs 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.

Gender equality mechanisms, international and national legislation in Bosnia and Herzegovina

In recent years, BiH has taken important steps towards more clearly defining gender discrimination and developing a gender equality institutional framework at all levels of government. In March 2003 the State Parliament of BiH adopted the Law on Gender Equality. The passage of the Law – the first comprehensive gender equality law in the Region – has been a result of Bosnia and Herzegovina Government's political will for gender mainstreaming procedures, as well as strong encouragement by the UN Gender Group (UNGG), along with consistent NGO coalition lobbying.

The state Agency for Gender Equality, special body within the BiH Ministry for Human Rights and Refugees, was established in January 2005. Along with the implementation of Gender Equality Law in BiH, this period has been marked with the number of processes that brought about significant improvement of the gender mainstreaming in Bosnia and Herzegovina, but also increased capacities of its primary actors, the BiH Agency for Gender Equality and the both entity Gender Centres. BiH Gender Coordination Board (GCB), composed of the directors of the BiH gender equality institutions, developed the BiH Gender Action Plan (GAP), which is thematically enclosing all existing gender related documents, set the guidelines for BiH gender mainstreaming and gender equality in all working areas being a part of the European integrations. GAP was adopted by the CM BiH in September, 2006, and thus has become an official document of Government of Bosnia and Herzegovina. GCB has completed the initial CEDAW Report (Committee on the Elimination of Discrimination against Women), which was presented to the respective UN Committee in May 2006. Recommendations received from the Committee have been incorporated in the GAP.

Throughout all HIV programme activities, gender is thoroughly incorporated and measured since 2008. The new Monitoring and Evaluation software also incorporates gender both in systems (nongovernmental institutions) and sub-systems (governmental institutions).

Diagnostic and HIV/AIDS reporting:

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 BiH 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 ECDC.

Treatment and care:

Treatment and care in BiH are provided free of charge to PLHIV. Coverage of medicines for opportunistic infections depends on whether the medicines are on the list of essential drugs. The costs for ART 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 List (revised in 2003).

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

In 2010 there is increased in number of tests in VCCT and other health centres, which resulted in decreased number of deaths. In the last two years there is only one AIDS related death reported.

In 2010, 48 PLHIV received ART. Of the total, 32 PLHIV were registered in FBiH (26 male, 6 female) and 16 in RS (13 male, 3 female).
In 2011, 64 PLHIV received ART. Of the total 43 PLHIV were registered in FBiH (34 male, 9 female) and 21 in RS (17 male, 4 female). One PLHIV is younger than 15 and there is one AIDS related death in 2011.

Reduction in HIV prevalence

There is an issue of considerable under-reporting in second-generation surveillance data on HIV prevalence amongst MSM and SW. In the opinion of many, sexual orientation and modes of transmission may be falsely reported due to stigma and discrimination associated with bisexual or homosexual status.

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 BiH has reduced significantly, the number of domestic victims of trafficking increased.

Knowledge on prevention

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.

Education regarding sexual and reproductive health (SRH) 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.

In the last two years, Association XY has been implementing peer education programs in 23 cities in BiH: Banja Luka, Bihać, Bijeljina, Brčko, Derventa, Doboj, Foča, Livna, Mostar, Mrkonjić Grad, Orašje, Prijedor, Sarajevo, Travnik, Tuzla, Zenica, Ljubuški, Goražde, Srebrenica, Jablanica, Trebinje, Visoko i Istočno Sarajevo. Peer education is a methodology allowing peers to transmit information to peers using a set of tools that develop life-based skills. Although HIV prevention is the key programme focus, peer education results go far beyond improving HIV/AIDS response. Through this programme, Association XY with support from partner organizations in the period 2010-2011 organized a large number of:

- ✓ peer education in elementary and secondary schools;
- ✓ educational activities in faculties;
- ✓ educational activities with parents and school personnel;
- ✓ various events for young people (concerts, street activities, etc..)
- ✓ continuous distribution of condoms and educational materials.

Accomplished results for 2010 and 2011 include:

- Young people (14 - 19) from peer education on HIV prevention in the school environment – 8,522
- Young people (15 - 24) from peer education on HIV prevention in extra curriculum activities – 19,759
- Educated peer educators – 217
- Distributed condoms – 382,286
- Distributed educational materials – 188,491
- Young people (14 - 19) from peer education on HIV prevention in the school environment – 5,809
- Young people (15 - 24) from peer education on HIV prevention in extra curriculum activities – 18,396
- Educated peer educators – 261
- Distributed condoms – 350,140
- Distributed educational materials – 150 312



Planned improvements of the programme include:

- ✓ Expand and strengthen the network of peer educators through continuing education
- ✓ Continue implementation of peer education in secondary schools and elementary schools
- ✓ Educate young people from rural areas
- ✓ To introduce new topics of presentations at schools
- ✓ Strengthen the engagement of an informal network of friendly centres for youth in BiH
- ✓ Promote all friendly youth centres in BiH through media
- ✓ To strengthen cooperation with relevant institutions in the field of education

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

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.

HIV testing:

HIV testing is available in BiH as VCCT and the provider initiated testing (regulated by protocol). HIV testing is only provided for pregnant women when requested (opt-in). 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.

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 bio-behavioural surveys (BBS). The initial HIV test performed is the ELISA screening 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 relevant 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 require mandatory testing 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. 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.

VCCT centres:

As of 2012, in total there are 20 VCCT centres established and functional throughout BiH.

Second-generation surveillance:

An important step forward for evidence based policy making are the BBS conducted on MSM and SW in 2008/2010 and IDU in 2009.

The three BBS surveys provided useful for the purposes of second generation surveillance data on the key populations at risk in the country.

IV. Major challenges and remedial actions:

Fragmentation in administrative organization in health sector in BiH is the reason why not all civil categories are not covered by the health protection system.

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

a. Surveys/studies are usually undertaken by international agencies as the government at national and entity level lacks capacities in this area. 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.

HIV Testing: In order to avoid stigma and discrimination, the coding system enables PLHIV to remain anonymous, until the beginning of ART treatment.

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 surrounding countries, stigma and discrimination against PLHIV and key populations at risk is identified as one of the main obstacles in country HIV response. According to MICS3 2006, 64.2 percent of women and girls in BiH unfortunately support at least one of the discriminatory attitudes towards PLHIV. 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”. The data from the new MICS study will be available in the second half of 2012.

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

The UN Resident Coordinator and Joint UN Team on HIV/AIDS in BiH, with UNFPA as the Chair, provided technical assistance in compiling existing information / data sets within the country and preparation for the 2012 GARP, UA and DD country progress reports.

The UN Joint Team on HIV/AIDS in BiH provided support in the development of HIV/AIDS Strategy in BiH for 2011-2016 as well.

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

- Capacity building: WHO supported participation of BiH health professionals in attending international meetings on 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 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.

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.

VI. 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 key populations at higher risk is kept by individual CSOs 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 with support from GFATM and World Bank. The GFATM/UNDP PMU has allocated 8 percent (USD 1,215,965) 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 Ministries of Health aimed to oversee UNDP/GFATM programme implementation. Through established system within the M&E unit, data is collected on 151 indicators at the national level for HIV and TB.

The M&E action plan for UNDP/GFATM HIV programme has been developed, staff assigned, and training as per the plan has already been undertaken. The contracted sub-recipients, CSOs 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 CSOs.

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