Epidemiology, policies and services for most-at-risk adolescents: Current status and options for development in Bosnia and Herzegovina

Country Mission Report

2007

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Authors would like to thank the mission participants and other experts and organization representatives for their valuable input in the report to professionals and organizations that supported them in writing this report:

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June 2008

Table of Contents

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ARV	antiretroviral
ART	antiretroviral therapy
BCC	behavior change communication
BIH	Bosnia and Herzegovina
CCM	Country Coordinating Mechanism
CEO	Council of Europe
CIDA	Canadian International Development Agency
DB	District Brcko
DU	drug use or drug user
EHRN	Eurasian Harm Reduction Network (formerly CEEHRN, Central and Eastern European Harm Reduction Network)
EU	European Union
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
FBIH	Federation of Bosnia and Herzegovina
HAART	highly active antiretroviral treatment
HCV	hepatitis C virus
HIV	human immunodeficiency virus
IEC	information, education and counseling

IDU	injecting drug user or injecting drug use
IPH	Institute for Public Health in Bosnia and Herzegovina
LGBT	lesbian, gay, bisexual and transgender people
LGBTQ	lesbian, gay, bisexual, transgender and queer people
MARA	most at-risk adolescents
MARG	most at-risk groups
M&E	monitoring and evaluation
MCTC	mother-to-child transmission
MMT	methadone maintenance treatment
MSM	men who have sex with men
na	not available
NEP	needle exchange program
NGO	non-governmental organization
OST	opioid substitution therapy
PLHIV	person living with HIV or people living with HIV
PMTCT	prevention of mother-to-child transmission
RAR	Rapid assessment and response
RHRN	Romanian Harm Reduction Network
RS	Republika Srpska
SRH	sexual and reproductive health
STI	sexually transmitted infection
SW	sex worker
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
VCT	voluntary counseling and testing
WHO	World Health Organization
WHO-EURO	WHO Regional Office for Europe
YFS	youth friendly service

Executive summary

Bosnia and Herzegovina (BIH) has low HIV prevalence (<0.1%) and low perceived risk for HIV in society at large and among youth and such highly stigmatized most-at-risk groups (MARGs) like injecting drug users (IDUs), sex workers (SWs), men who have sex with men (MSM), prisoners and Roma. Like in other South Eastern European countries, this complacency contradicts existing behavioral facts, especially among MARGs.

Overall youth is relatively socially vulnerable due to unemployment, insufficient knowledge about drugs, sexual and reproductive health and perceived risks for HIV. In the HIV field, however there are a number of other groups, which even more vulnerable, often are marginalized and live in socially extreme situations. These are IDUs, SWs, MSM, prisoners and Roma, some experts also indicate vulnerable sub-groups of refugees, migrant workers and trafficked people.

A big proportion of IDUs, who account to estimated 8,000-10,000 population of the country, do share needles, have limited knowledge about existing services and limited availability of services, have risky sexual behaviors (including early initiation, multiple social partners and low condom use with both steady and irregular partners). These data are confirmed with the recent comprehensive study on biological and behavioral surveillance among IDUs in 2007. High prevalence of HCV (with exception of relatively low rates in Zenica, especially among young IDUs) indicates risky injecting behaviors. So far, HIV prevalence is low and only few cases were identified in the recent years. In general HIV context of the country, IDUs are important group for HIV transmission, accounting to 14% of all registered HIV and AIDS cases. Due to drug legislation which criminalize possession of drugs as well as a number of other drug-related activities, most of IDUs have experience of arrests and incarceration.

Homosexual and bisexual intercourses account for 20% registered HIV cases with known transmission route in BIH. Existing behavioral data for men who have sex with men are relatively old and will be upgraded with a planned behavioral surveillance study in 2008. However, previous research data and service providers confirm a high number of partners and low condom use among MSM. Besides, due to high stigma a number of MSM have homosexual and heterosexual lives. Key informant indicated that some HIV-positive MSM have IDU practice. According to service providers, HIV-related knowledge is better in the younger MSM population. Estimated number of MSM and estimated number of SWs are similar to the one of IDUs, which is not usual in the practice of the European countries (usually MSM population is higher than IDUs and MSM population is higher than SWs; also numbers of sexual partners of IDUs and SWs are substantial). But these estimates are only indicative and no actual research to evaluate the number has been done in these populations.

Currently, no HIV-positive cases are reported among SWs. Earlier behavioral studies showed greater risky behaviors among most vulnerable street sex workers and willingness not to use condom at additional fee for their service, as well as linkage between SWs and IDU. After implemented more intense policing of SWs, coupled with legislation foreseeing punishment for individual sex work, prostitution is more hidden and is more of in-door nature.
Data on behaviors and knowledge of prisoners and Roma is even more limited. However, on in four IDUs with imprisonment history report that they injected drugs while being in prison.

In 2007-2008 services for vulnerable groups, as well as other HIV services were in a rapid development, as the funding from the Global Fund to fight AIDS, Tuberculosis and Malaria came

in. A network of low threshold services for IDUs, SWs, MSM, prisoners is extended to Sarajevo, Zenica, Banja Luka, Mostar, Brcko. Additionally youth-friendly services are open or are in the process of opening in Sarajevo, Banja Luka, Brcko, Mostar, Bihac Prijedor, Doboj, Bijeljina, Foca, and Trebinje. These services, however, are intended for mainstream youth and not necessarily reaching people from MARGs. Overall the estimated coverage of MARGs with services range from 261 SWs, 198 prisoners to 934 MSM, 2,155 Roma and refugee women, and 915 IDUs (plus additionally 536 in methadone maintenance therapy). Even using indicative estimates of the populations, this coverage (as well as planned coverage at the end of the two-year GFATM project phase) is too low to make impact on behaviors and possible infections and other negative consequences.[1] In case of IDUs, low-threshold services address STI/HIV/HCV prevention and education on safer drug use, dissemination of clean syringes (and other injecting equipment), condoms. Overdose prevention and management is not addressed, as well as sensitization of pharmacists to contribute to HIV prevention. There are other high-threshold services, including drug-free treatment options at charge in eight drug-free communities (three of which are run by NGOs), opioid substitution therapy with methadone at no cost for clients if they have health insurance, as well as withdrawal symptom treatment (detoxification). Currently other substitution therapy substances beyond methadone, like buprenorphine and suboxone are not applied; in order to introduce the latter a legal framework should be upgraded. Drug services in prisons are extremely limited; there are no harm reduction services and opioid substitution therapy available. Cautiousness to some harm reduction services, especially needle exchange, is very much related with legislation, which foresees punishment for possession of drugs (without indicating the minimum quantities, i.e. dirty needles could be accounted as possession) and facilitation of drug use. While there is knowledge about adolescents in MARGs but no information was collected about specific methods to address their needs.

HIV testing and counseling is provided free-of-charge and on voluntarily, confidential basis through 15 voluntarily testing and counseling (VCT) centers. Not all these centers are currently operational. As the national UNGASS report points VCT is primary intended for most-at-risk groups. In 2006, however MARGs comprised one quarter of people tested there and other 44% of people tested were pregnant women. In comparison with the country's plan for the GFATM project, so far testing is not reaching as much MARGs as intended (30% people tested and counseled of those planned in 2007) and this might be related with a need for operationalizing VCT centers that still not operational and intensifying the community outreach among MARGs. As bio-BSS among IDUs showed absolute vast majority of them are not aware about NGO provided services and many do not know about possibilities to get tested for HIV and HCV. HIV treatment and care substantially improved over the last years, which is also reflecting on increasing survival of people living with HIV (including those with AIDS). Today, the country tracks universal 100% treatment coverage. One of the persons receiving treatment is a child. Still there are concerns in the country around treatment sustainability (related to medication procurement and pricing), quality of care and availability of liquid formulations of medications. Sustainability is even at greater concern in terms of NGO low-threshold services for MARGs, as there are no national funds for such services and there is no stated commitment or plan how the current GFATM funding will be replaced in the future and mechanisms how state will buy services from NGOs.

The national state policy on HIV is defined in the National Strategy to Prevent and Combat HIV/ AIDS 2004-2009 addresses prevention among MARGs but does not give substantial attention to them. A number of stakeholders interviewed indicated the need to upgrade it and operationalize it through funded action plan, more active coordination of work and improved monitoring and

[1] E.g. WHO-recommended coverage for IDUs is 60%.

evaluation system (M&E). M&E seems to be one of the weakest points, which needs substantial technical assistance and rethinking of smart ways how to make it functional within complex administrative system of the country. In a way, this will be addressed through the GFATM but only for HIV field and not for, for example, drugs field. The creation of the M&E might need also realized benefit and in the country from the data that can inform decisions and policies. This benefit might lead also to increased appreciation (and maybe even national funding for) of research, services and sensitization programs for MARGs.

M&E systems (including quality monitoring) are being already developed at service levels but needs to be further developed. Services for MARGs are mainly implemented by NGOs. There is a network of at least 8 NGOs active in the field: UG PROI, Viktorija, Poenta, Association Margina, Q, XY, Action Against AIDS and APOHA. With their rapid expansion of services, new staff is being enrolled and therefore capacity building is crucial in order to maintain expertise and skills at similar levels to those experienced people who started their work from the beginning. This could help to address priority for expansion of good quality community outreach. NGO capacity building is being done largely utilizing national (often internal organizational) experiences and to less extend using the experience of neighboring countries. Standard operational procedures and guidelines are not in place and practice of NGOs seems to be diverse in how services are implemented. Also there is no unified training but there is a number of qualified and experienced trainers, specifically in Association Margina, XY, Action Against AIDS, who have their training tools. Better cooperation of NGOs in capacity building and exchanging experience might be highly beneficial for service users (e.g. utilizing unique expertise on sexual and reproductive health for addressing better female IDUs or organizing internal management and M&E systems or integrating drug education and counseling in services which have more 'sexual and reproductive health and rights' approach). Generally, the NGOs have to be praised for their high motivation to work even while there are no currently good perspective of sustainability of their services and experience among some of them closing their services some time ago due to finished funding or hostile policies towards MARGs. Concerns regarding the funding sources are based on the recent facts. International funding coming through UN agencies is reducing at least in case of some NGOs and overall the South Eastern Europe is finding hard to attract international donors attention in the HIV field (as well as in the drugs field). GFATM is major donor in the region but its support for low prevalence countries and countries with improving economies might drastically reduce in near future.

Based on fact-finding and consultations with national stakeholders, the report outlines a set of recommendations to policy makers, decision makers in health, social and prison systems, NGOs and service providers, multilateral agencies and donors, as well as research to highlight priorities for improving policies, services and rights situation of people who are in marginalized situations for the benefit of the BIH society at large.

1. Introduction

In June 2005 a new regional initiative **South Eastern European Human Rights and Treatment Collaborative Networking** (SEE Collaborative Networking) on HIV/AIDS and Drug Use was launched in order to develop and implement a regional strategy to improve the health and rights of most at-risk populations in relation to drug use and HIV/AIDS.

The SEE Collaborative Networking is built upon important work initiated by various networks and key players in the region, linking together related programs and projects. It focuses on filing the existing gaps and enhancing synergies and on maximizing organizational strengths. The network includes stakeholders (organizations, national networks and individuals) from ten countries and territories (Albania, Bosnia and Herzegovina, Bulgaria, Croatia, The Former Yugoslav Republic of Macedonia, Montenegro, Kosovo, Romania, Serbia and Slovenia).

Over 2005-2007 on behalf of the SEE Collaborative Networking several activities were performed. Romanian Harm Reduction Network (RHRN), with financial support from UNICEF, conducted four missions to Albania, Bosnia and Herzegovina, Kosovo and Montenegro, developed 6 reports focusing on most at-risks adolescents (MARA), young people, HIV and substance use in Albania, Bosnia and Herzegovina, Kosovo, Macedonia, Montenegro and Romania, and organized two regional consultations aiming to increase networking and to build advocacy capacities in the region. The outcomes of the first missions in 2006 have already been used as advocacy tools for addressing policies (e.g. initiating drug strategy in Kosovo) and resource for developing grant applications (Albania, Kosovo, Romania). The first NGO expert missions were concluded by the Inter-country Consultation *Counting lives* in Bucharest, on February 15-17, 2006, which was organized by Romanian Harm Reduction Network (RHRN). Macedonian Harm Reduction Network conducted a Regional Drug Policy Snapshot Survey giving civil society perspective and from an NGO Perspective, financial supported by International Harm Reduction Development Program of the Open Society Institute.

In 2007, country missions to Montenegro and Bosnia and Herzegovina were organized as part of UNICEF supported RHRN project ***HIV prevention among most-at-risk adolescents in Romania*.** This report summarizes findings of the country mission to Bosnia and Herzegovina, which was the last one in a series of the country missions in 2006-2007 and took place in October 2007. It was prepared by joint efforts of civil society experts from RHRN, NGO Association Margina and Eurasian Harm Reduction Network (EHRN).

Goal and objectives

The **purpose** of the report is to identify and document the needs related to HIV/AIDS and drug use and to promote evidence based HIV prevention and treatment services and enabling environment for most-at-risk adolescents (MARA) and broader vulnerable groups in Bosnia and Herzegovina (BIH). Additionally, it contributes to sharing knowledge, good practices and lessons learnt at the regional level.

The **objectives** of the country mission and the report are to elaborate a general overview of the epidemiological and policy situation, needs of and services for MARA and other vulnerable groups in Bosnia and Herzegovina, as well as to produce recommendations how the response to HIV, sexual and reproductive health needs and drug use could be improved. Additionally, the

mission and the report assess the capacities and needs of the service provides in the country. The latter objective was added after the first mission day in the consultation with UNICEF office in Bosnia and Herzegovina.

Methodology

The report was done in three stages: pre-mission preparation, country mission and writing the report. The process involved the following methods:

1. **desk review** of collected documentation through internet, meetings with stakeholders, follow up with national stakeholders including those who could not be met during the country mission; the list of relevant literature is provided in the reference list of this report;
2. **face-to-face interviews** with and **round table discussion** with policy and decision makers from healthcare sector, police and the UN agencies, service providers and advocacy groups. Stakeholders to be met were identified in preparation for the mission in consultation with NGO UG PROI, NGO Association Margina and UNICEF in BIH. The list of stakeholders met is provided in the agenda of the country mission (Appendix 2); and
3. **data analysis** and **producing recommendations** by engaged experts with involvement of BIH stakeholders in the review of the report.

The country mission took place in October 2007 and it was conducted by Raminta Stuikyte, Eurasian Harm Reduction Network (EHRN), Valentin Simionov, RHRN, and Denis Dedajic, NGO Association Margina.. The report was drafted in early 2008 with a considerable delay caused by engagement of experts in other activities and delayed availability of some relevant information for the report.

The process including the methodology development was led by RHRN and supported by UNICEF Romania and UNICEF BIH.

Limitations and challenges

The country mission in Bosnia and Herzegovina was the most difficult of all four missions organized by RHRN in the SEE region. This was caused by a series of factors and limitations, including:

- country diversity in terms of geographical and complex administrative structure (the country is comprised of the Federation of BIH and the Republika Srpska and its Brcko District has a special status, furthermore the Federation of BIH is comprised of 10 cantons that have a considerable autonomy);
- limited time for the mission and meetings, as 6 cities were visited during the five days of the mission;
- the shortage of time have limited the range of interviewees to rather managers of services and prevented from seeing the services, meeting their staff teams and customers. Moreover, according to NGOs interviewed, injecting drug users (IDUs) and men who have sex with men (MSM) are very reluctant in getting into contact with outsiders (people they do not know already, other than outreach workers);
- only five meetings with governmental representatives (to HIV coordinators from the two

entities, heads of clinics with VCT in Zenica and Banja Luka, representatives of Zenica Police Department on Special Tasks and The Police Department of Crime of the Republika Srpska) due to shortage of time and overlap other major events (national prison staff training and SEE and Adriatic Addiction Treatment Network's conference).

- lack of centralized data, as data collection process throughout governmental and non-governmental structures in the field is not functional at the country level. Additionally, different organizations use different sources to document and design their interventions;

Considerable challenges were also met in the organization of the mission. Initially NGO UG PROI was approached to locally coordinate the visit. Due to overlap with other events, the mission was postponed from September to October and the NGO Association Margina was asked to assist with local coordination of the mission. RHRN was informed about possible sensitivities related to the latter choice of the local partner. The mission timing overlapped with important processes in the country, including the analysis of the major research among SWs, MSM and IDUs, as well as the rapid development of new services with the support of the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM).

2. Young people and most-at-risk groups: epidemiology, vulnerability and behaviors

2.1. Young people in the transition country's context

Bosnia and Herzegovina regained its independence after the collapse of Yugoslavia and experienced major military conflict in the mid-1990s. Bosnia and Herzegovina is a parliamentary democracy that is transforming its economy into a market-oriented system and is a potential candidate for membership in the European Union and NATO and current member of the Council of Europe (COE).

After the war, a central state government, two autonomous entities and a district were established: the state Bosnia and Herzegovina is composed by the Federation of Bosnia and Herzegovina (FBIH), the Republika Srpska (RS), District of Brcko (DB). In 2000, the Brcko district became a separate administrative unit under the sovereignty of the country but remaining under international supervision. Each entity has its own parliament, government, military forces and police, as well as education, health care, and other public services. FBIH is decentralized and is divided into 10 cantons, each with its own government and assembly.

Surface	51,129 sq km
Population	4,590,310 (July 2008 estimation); 3,915,000 (Population Reference Bureau, 2003)
Political status	Emerging federal democratic republic
Languages	Bosnian, Serbian, Croatian
Ethnic composition	Bosniak 48%, Serb 37.1%, Croat 14.3%, other 0.6% (2000)
Religions	Muslim 40%, Orthodox 31%, Roman Catholic 15%, other 14%
Gross domestic Product (GDP) per-capita	7,000 USD (2007 estimate)
Unemployment rate	45.5% official rate; grey economy may reduce actual unemployment to 25-30% (31 December 2004 estimate)
Population below poverty line	25% (2004 estimate)
Neighboring countries	Croatia, Serbia, Montenegro

Source: CIA: https://www.cia.gov/library/publications/the-world-factbook/goes/bk.html (last updated on 19 June 2008)

Youth population

Almost 25% of the overall population of the country is aged between 15 and 30 and, therefore, is considered young.

Although a more conceptual understanding of youth in BIH has not yet been clearly defined, there are a number of definitions used either in the country reports or internationally. 2005 review of the World Programme of Action for Youth in BIH refers to young people in BIH as individuals

aged between 14 and 29 years of age, which represent 20% of the entire electoral body. The UNDP Human Development Report refers to 14-30 year olds as young people. Legally, people under 14 are children and those under 18 are minors.

Poverty and employment

Poverty became a problem after the economic decline of Yugoslavia and the beginning of the military conflict in the SEE region. International agencies estimate the actual unemployment level (considering grey economy at 25-30%). 40% of the overall population in BIH considers it can barely meet its basic daily needs.

The problem of youth unemployment is exacerbated by the fact that the labor market cannot absorb the available labor force. Officially 40% of young people are unemployed. However, the estimates indicate much higher number, between 45% and 60%, with the unemployment rate being the highest in the age group of 21-25 years old and particular groups like women in some regions of the country and people with ethnic minority background, especially Roma. Young people in BIH have additional difficulties in finding employment, poor opportunities for participation in the society, while their dependency on parents and families is increasing. Parents and families represent an important source of income for most of young people.

Specific data on the proportion of young people living below the poverty line are not available.

Education

According to MICS3 2006, 98.3% of children of primary school age attend primary school, while the net enrolment rate for secondary school is 79.3% at country level. Young people are unsatisfied with the contents of their education and feel unprepared in terms of skills and knowledge. The education system is perceived as being old fashioned. The life-skills programs in schools (which include HIV prevention information) are implemented on ad hoc basis. Topics like sexuality and drug use are still seen as a taboo in most schools and high schools in BIH.

Regarding the access to general education, young Roma, young people with disabilities (and other invisible minorities such as the lesbian, gay, bisexual and transgender (LGBT) young people) are especially vulnerable to discrimination and exclusion due to their status and the way they are perceived in the society.

Youth lifestyles, sexuality and HIV

The youth possibilities to organize their extra-curricular activities are limited in the country. The majority of young people in BIH spend their free time in "cafés" and only a third takes part in sports activities. Using of legal psychoactive substances and sexual experience starts early. According to estimates, more than half of young people in BIH smoke and consume alcohol. The age of initiation sexual life in BIH ranges between 16 to 20 years old;[2] this age is considerably younger in the experience of current injecting drug users. According to recent UNICEF BBS survey among IDUs, the average age of first drug use was between 15-17 years of age, with many young people moving to injecting of drugs in three years time.

According to research conducted by UNDP, young people do not have enough information on reproductive health (but have better knowledge on HIV). The major barriers are two-fold. As

[2] For comparison, WHO-EURO 2008 reports that 15-year-olds who have had sexual intercourse in neighboring countries make the following percentage among girls and boys accordingly: 31% and 47% in Bulgaria, 17% and 30% in Slovenia, 17% and 29% in Croatia, 5% and 34% in TFYR Macedonia

mentioned above, the subject is still not covered through the education system. In the context of traditional families with Christian, Muslim and other backgrounds, youngsters discuss sexuality with their friends, not with their parents. Beside friends, other limited source of information is media. Access to sexual and reproductive health to major extend is available through youth-friendly services (YFSs) and through private healthcare providers.

Accurate data on HIV and STI prevalence among young people in BIH are lacking. Generally, due to low prevalence of HIV, young people like society at large perceive to be at low risk for HIV. The UNDP report also revealed that youth does not feel at risk for STIs overall. 48% of the young population in BIH regularly uses contraception methods[3] but 29% of women aged 15-24 years reported not using the condom during sexual intercourse with their last non-regular sex partners in the last 12 months.[4] According to UNFPA, "the paternalist mindset of the society discourages the contraceptive use," especially among young girls.

2.2.Prevalence of HIV and AIDS

National experts agree that BIH is a low prevalence country. UNAIDS estimates the HIV prevalence to be less than 0.1% (UNAIDS 2006).

The country started reporting HIV cases to international sources from 1989. By the end of 2006, the country had reported 133 HIV cases in total,[5] including 92 people who developed AIDS and 51 who later died (EuroHIV, 2007). In 2006, 17 new HIV cases, 4 new AIDS cases and 4 deaths among AIDS cases are reported. At the end of 2007, 43 people who were known to live with HIV were known (including 35 PLHIV in FBIH and 8 PLHIV in RS). During 1986 and 2007 there was only 1 suspected case of MTCT.

Major officially reported HIV transmission route is heterosexual, followed by MSM and IDU. Distribution among reported transmission route among HIV and AIDS cases is similar, which points to that infections took place simultaneously. Three HIV cases reported to be transmitted through blood manipulations (Dancevic 2007).

While distribution of reported HIV cases by age and gender is not reported by EuroHIV, data from the BIH Institute of Public Health point to two major age groups, covering also young people but not adolescents and that HIV mainly affected males. One case recorded as unknown gender, which might indicate HIV case among transgender; but this presumption needs to be confirmed.

There is one HIV case in a child, who, according to the country's UNGASS report 2007, was diagnosed as HIV positive in 2006 when the child was 5 years old; mother of the child was from

[3] There is no good data to compare with other countries; however generally use of pill-based contraceptives is relatively low in South Eastern Europe in comparison with other European countries but using condoms is at European average and upper level: among 15-years-olds the following part was using contraceptive pill at last sexual intercourse: 7% of girls and 4% of boys in TFYR Macedonia, 8% of girls and boys in Croatia, but 25% of girls and 19% of boys in Slovenia; the following part was using condom: 65% of girls and 81% of boys in TFYR Macedonia, 84% of girls and 82% of boys in Croatia, 84% of girls and 70% of girls in Slovenia (WHO-EURO, 2008).

[4] This level is similar to the one in Serbia, Macedonia and Montenegro, according to the recent UNICEF report. (UNICEF 2008a)

[5] The national UNGASS report indicates 134 HIV cases registered (i.e. one case more than in EuroHIV report) by the end of 2006.

Ukraine and there is no information about her HIV status.

In 2006, none of HIV tested pregnant women were found HIV-positive. It is estimated that 3% of all pregnant women voluntarily underwent HIV test in 2006 (WHO, UNAIDS, UNICEF 2008).

Recorded HIV transmission routes	IDU 14% (19) Heterosexual 55% (73) MSM 17% (23) Mother-to-child transmission 1% (1) Unknown/blood 13% (17)
Registered HIV cases by gender	79% males 20% females 1% gender unknown
Age distribution for the registered cases	Major age groups: 25-29 and 40-44 years old; Oldest case: female, 70 years old. Trend: increasing age in-country infection rate
AIDS deaths	51 people who were diagnosed HIV-positive are known to die. 75% died during the first year after being diagnosed. According to the national UNGASS report quoting epidemiologist of Federal IPH Mostar, the proportion of PLHIV living less than 1 year after AIDS diagnosis is estimated 39%, 1-2 years: 12.7%< 3-4 years: 6% and >5 years: 1%. Median survival is approximately 1.4 years. The survival rate is improving.

Sources:
HIV transmission route for registered accumulative cases, number of AIDS deaths by the end of 2006: EuroHIV, 2007;
Distribution of registered HIV cases by gender, age; % of people who died during one year after HIV-positive (or AIDS) diagnosis by the end of 2006: Dancevic, 2007;
Data on proportion of PLHIV survival after diagnosis and median survival rate: The Ministry of civil Affairs 2007.

There are a number of limitations of these data. Key informant from the Ministry of Health of the FBIH informed that there are cases of overlapping transmission routes (e.g. people acquire HIV who have bisexual relations and history of IDU), which lead to difficulties to report transmission route. According to the country UNGASS 2008 report and interviews, due to high stigma, a number of people are seeking for HIV test outside the country. Results of those HIV tests are not recorded in the national system. Testing is introduced in wider scale only recently but now it is at similar levels like in neighboring countries with low HIV prevalence (5.3 diagnostic tests per 1,000 population in 2006: in comparison this number is 5.7 for Croatia, 5.5. for Macedonia F.Y.R, 13.0 for Slovenia); coverage of testing, as it will be described in the report's part dedicated to the national response and services, is improving but still not adequate.

2.3. Prevalence of drug use, injecting drug use and risk behaviors

Historically, the problematic use of drugs was first registered in the territory of BIH in 1973 (UNICEF 2002). Acknowledgement of the drug scene has emerged slowly. The drug use has increased rapidly with the transition after the Yugoslavia collapse, conflict till Dayton Peace Agreement in 1995 and post-conflict period. Currently, BIH is reported to be on heroin transition

route (UNODC 2007).

Major drugs used are reported to be heroin (injecting mode) and marijuana, also some other drugs (like ecstasy in Banja Luka, according to the entity's police). If to judge based on drug seizures and reported local drug production, the following drugs should be the most available in the country: cannabis herb, heroin, ecstasy, also amphetamine, and cocaine.

There is no national estimate of total population using drugs. The NGO UG PROI estimates that only in the capital city Sarajevo there are 3,000 drug users. United Nations Office on Drugs and Crimes estimate 3.0% prevalence of cannabis use in population of 15-64 in 2005 (UNODC 2007).

Number of drug injectors is estimated 6,000-10,000, i.e. around 0.15-0.2% of population. This estimation is, however, only indicative, as it is extrapolated from expert opinion and local stakeholders have various opinions of the number of IDUs. Major injecting drug is heroin. Summary of estimates based on surveys and expert opinions is indicated below highlighting more reliable data:

Estimates of IDU population in different sites by sources of information:

Geographic area	**No of IDU population (estimated or in service)**	**Year**	**Source, comments**
National	6,000-10,000	2006	Dancevic 2007
Sarajevo	3,000 heroin users (mainly IDUs)		Study of Link Coalition (UNICEF 2006)
Sarajevo	1,500 IDUs (in total 3,000 drug users)	2007	NGO UG PROI estimate
Zenica	2,000 IDUs	2007	NGO Association Margina estimate based on 700 IDUs reached in 6-month needle exchange service in 2003
Mostar	Na		But there are 250 clients in methadone maintenance clinic (UNICEF 2006)
Tuzla	2,000 IDUs	2008	NGO Association Margina estimate based on 146 IDUs reached through its service during February-April 2008
Banja Luka	1,500-3,000 IDUs	2006	Academic estimate (based on number of registered IDUs and multiplying it by 7-10) (UNICEF 2006)
Banja Luka	15,000 IDUs	2006	NGO Poenta expert opinion (UNICEF 2006)
Banja Luka	4,500 IDUs	2006	NGO Viktorija estimate based on number of registered 1,500 heroin users National Coordinator for Drug Addictions in RS (UNICEF 2006)
Banja Luka	At least 1,100 drug users	2007	NGO Poenta register of clients reached in 2002-2007
Banja Luka	1,500-2,200	2007	NGO Viktorija

There is no reliable data on the prevalence of injecting drug use in the country or its individual regions.
The only drug user register in the country exists and is regular updated in Canton Sarajevo in FBIH; it includes data from in- and out-of-hospital health institutions serving Sarajevo. For each drug users treated in hospital institutions (KCU Psychiatric Clinic and Institute for Alcoholism and other Dependencies, CS), a standard registration form is filled out and sent to the Public Health Institute of CS where the data are compiled together with those coming from the out-patient treatment sector. The data for the period 2000 to October 2003 indicate the increase in the first-time registered drug users as well as the increase in opiate addictions in general. It is estimated that at least 90% of opiate users are IDUs.

Registered drug users in Canton Sarajevo, FBIH, 2000-2003*

	2000	2001	2002	2003
No. of registered	83	89	158	154
Men	88.0%	88.9%	89.9%	89.0%
Newly detected	54.2%	67.4%	63.3%	81.9%
Opiate addictions	62.7%	64.1%	74.1%	90.2%

*for the period 1 January – 30 September 2003
Source: KCU Psychiatric Clinic and Institute for Alcoholism and other Dependencies, CS, as cited in UNICEF, 2006.

The bio-BSS in three cities, Sarajevo, Banja Luka and Zenica serve as excellent source for understanding drug injecting patterns, risk behaviors and possible options how to best serve IDUs.

It indicates that majority of IDUs are of 25-34 years in Sarajevo, Banja Luka and Zenica (UNICEF 2008). Similar and younger age was reported by service providers. NGO UG PROI found out that IDUs seek medical help between 22 and 30 years of age. In the Sarajevo detoxification program clients are usually 18 to 25 years old (Institute for Alcoholism and other Dependencies, Sarajevo Canton). Clients in the counseling services in the rehabilitation center in Banja Luka are between 23 and 33 years of age (NGO Viktorija, Banja Luka) and in MMT program in Sarajevo, including population with numerous unsuccessful treatment attempts, the clients are from 29 to 36 years of age. NGO Viktorija and the Sarajevo Canton Institute for Alcoholism and other Dependencies, also have contacts with the population below 18.

Bio-BSS study in 2008 and most experts interviewed agree that majority of IDUs are males, who make around 85-90% of the whole IDU population. But interviewed former IDUs from Banja Luka, however, gave significantly higher estimates: 20-30% noting that women rarely approach treatment services. Female IDU clients represent from 5% of the client population (NGO UG PROI) to 10% (Sarajevo Canton Institute for Alcoholism and other Dependences). International and European practice indicate that female IDUs have harder access to services and are more hidden and therefore their population might be underestimated and underserved.

Vast majority of IDUs are unemployed. Unemployment rates varies from 71.7% fo IDUs in Banja Luka to 90.9% in Zenica. This rate is similar among young IDUs (68.9-92.7%).

According to the bio-BSS, a median age of initiating (any kind of) drug use among IDUs was around 15-17. Injecting started at 20 year in average. However, younger generation of IDUs (18-24 years)[6] initiated injecting earlier; many of them before their 18th birthday. Thus the trend is that

[6] Analysis of young IDUs data is based on a non-weighted data set due to sub-samples of insufficient size

the initiation of injecting might become younger.

Injecting of drugs occurs in private houses and apartments, also in shooting galleries, and to less extend in streets, parks, abandoned houses, cars, drug dealers' apartments. The most frequent injectable drug is heroin (more than 90% of interviewed IDUs and all young IDUs injected it in the last month). According to the interviewed service providers, heroin is of good quality and with a price ranging between 15 and 35 euros per gram. Additionally, other drugs injected are: cocktail of heroin and cocaine (14.7% of IDUs in Sarajevo, 4.1% of IDUs in Banja Luka), cocaine (4.8% in Banja Luka, 8% in Zenica), tramadol (11.2% in Sarajevo), ecstasy (7.3% in Zenica).

Approximately one third of surveyed IDUs in Sarajevo, Banja Luka and Zenica indicated they were sharing needles in the last month. Among young IDUs this percentage was substantially higher: 54.7% in Sarajevo, 39% in Zenica and 37% in Banja Luka. Sharing of needles is mainly with a 'close friend.'

The primary source of clean syringes is pharmacies (77-90% of surveyed IDUs through bio-BSS). Most of IDUs were using syringes more than once and tried to clean them during the last injecting drug use. Overall IDUs engaged through the bio-BSS had very little knowledge about and uptake of existing low-threshold services (no one reported NGOs as source of syringes). There is no information how easy IDUs can access clean injecting equipment through pharmacies, but as interviews during the country mission indicated getting syringes in pharmacies might be problematic because of stigma of injecting, pharmacists' unwillingness to sell syringes (and feeling that clean syringes 'facilitate' drug injecting).

Sexual practices of IDUs are raising many concerns and urge for a need to address sexual partners of IDUs. The following significant factors reported: early age of initiation of sexual life (26.4-50% IDUs before 15 years), multiple partners (58.3-63.3% of IDUs within the last month), and unprotected sex (no condom use in the last sexual intercourse with steady partner for 21.7-38.8% and less for casual partner). Getting paid sex and being paid for sex is less common (4.1-13.7% and 1.7-3.7% respectfully).

Other IDU-related risks include overdose, which was reported by service provider in Zenica but is not well documented in surveys and statistics.

IDUs have substantial history of dealing with law enforcement and risky behaviors in correctional settings. Number of IDUs with imprisonment history varies from 27.8% in Zenica, 36.6% in Banja Luka and 54.9% in Sarajevo (42.7% of young IDUs in Sarajevo). Among them, a half was imprisoned more than once and 12-20.5% of IDUs were injecting drugs during their imprisonment. Alarmingly among young IDUs with imprisonment history in Sarajevo, 25% have injected while being in prison. Moreover, 42.3-64.7% of all IDUs in three cities were arrested once or more times within the last year.

The majority of IDUs surveyed through bio-BSS have good knowledge of the ways HIV transmitted through IDU and sexual contact. However, slightly more than a third in Sarajevo and half in Banja Luka and Zenica perceive themselves at no or low risk for HIV.

IDUs account for 14% of registered HIV cases in the country. According to EuroHIV 2007, 0.8% (n=2) of IDUs tested in drug treatment centers were HIV-positive in 2003 in Sarajevo and Mostar

to create population estimates (UNICEF 2008)

(n=255). Bio-BSS found similar low levels of HIV-positive IDUs of around 0.26% prevalence with one case in each Sarajevo and Banja Luka and none in Zenica. Hepatitis C virus (HCV) is of much higher prevalence and represents injecting equipment sharing practices. Rates vary between 18.9% in Zenica to 43.4% and 46.2% in Banja Luka and Sarajevo respectfully. Among young IDUs, HCV rates are lower (36% in Sarajevo, 34.4% in Banja Luka and only 6.1% in Zenica). Only one case of syphilis was found among IDUs.

2.4. Sex workers (SW)

Major information about sex workers is available through UNICEF study on feasibility of behavioral surveillance study (UNICEF 2006) and UNICEF/CIDA rapid assessment among especially vulnerable young people in SEE (Wong 2002), as well as through service providers visited. More data should be collected through the planned behavior-surveillance survey in 2008 and newly established services.

Some earlier estimates indicated 10,000-12,000 sex workers (SWs) to live in BIH. Today police and NGOs note that number of sex workers has decreased and the estimate should be revised.

Before 2003, there were numerous brothels operating in BIH, especially in areas where administrative fragmentation hampered police actions and enabled criminal activities, such as the area between Zenica-Doboj Canton and Srednjebosanski Canton. A number of local and foreign girls and women were forced into sex work through human trafficking; human rights groups harshly criticized the conditions of those trafficked and police 'tolerance' to trafficking in 2002 (Human Right Watch 2002). Following more strict legal measures and police activities in 2003, the brothels moved into private apartments and houses with highly controlled access. Street sex work is changing following to main transportation routes.

Sex work became more hidden. According to experts' opinion, following the closing of brothels in 2003, very little is known about SW population. Existing brothels are now hidden and have a highly controlled access: clients get in contact with brothel owners through taxi drivers, hotel receptionists or other clients. It is not known how well networked are the SWs who work independently. The girls who work in brothels most likely have access to SWs who work in the same brothel only.

Also, some years ago, the majority of sex workers are reported to be foreigners from Eastern Europe (Wong 2002) and there were a number of girls working in sex work coming not necessarily to work in prostitution with their consent, today police and service providers indicate increasing number of local sex workers in the last two years. A recent study carried out among 46 brothel SWs and 11 street SWs indicated to very high mobility of the population, with 71% of all respondents living in Zenica for less that a year (UNICEF 2006).

Like in other countries, there are a number of women (including girls) who are providing sex for benefits who do not associate themselves with prostitution (UNICEF 2006). There are more disadvantaged and vulnerable sex workers, especially street and highway sex workers. Experts indicate that street SWs are usually uneducated, that they come from disadvantaged social groups and often have dependent children. Street SWs have no access to social/medical information and services and they offer sexual services for any amount of money or goods.

Age of sex workers and gender are known largely only through services and anecdotal data but clearly they are young and there might be minors among them. UNICEF/CIDA survey in Banja

Luka targeting especially vulnerable young people reached sex workers of 21.4 years in average (n=24); low-threshold service in Zenica in 2004 reported that their clients were of 23 years in average (CEEHRN 2005). While sex work is dominated and associated with females, there are male sex workers.

So far, no HIV cases are known among local sex workers (CEEHRN 2005; Ministry of Civil Affairs 2008). Around 2000 HIV tests have been carried out in Banja Luka during the period between 1997 and 2001, mainly among SWs who had been working in then tolerated brothels and who were obliged to have HIV tests every six months. Six SWs from Eastern Europe tested positive during those five years. According to some reports, women coming to work in hidden brothels are required to present recent HIV test results (UNICEF 2006). Among 26 sex workers surveyed in Banja Luka in 2002, 96.15% have ever received HIV test. Other limited data indicate that in 2006, 51 SWs throughout the whole country were tested for HIV and in Zenica 64 SWs received test in 2004.

While sex workers in Banja Luka reported good knowledge on HIV (Wong 2002), there is no national and more-up-to-date data on this issue.

Condom use was reported 65.4% in Banja Luka (Wong 2002). In Zenica, 50% of SWs would accept not to use condom if offered more money. At the same time, 78% of them report to use condom always or almost always. STI related examination is not a common practice: 63% of SWs has never been tested on HIV or any other STI (UNICEF, 2006).

There is overlap between sex work and (injecting) drug use. Among 10 to 12 women that come to the Sarajevo Canton Institute for Alcoholism almost half of are SWs, mainly Roma women. For some of them the reason for entering sex work is to support their drug addiction whereas others started using after initiation into sex work (UNICEF 2006). In Banja Luka, 65.4% of 26 young sex workers surveyed used drugs and one injected drugs (Wong 2002). In Zenica, 8% of served clients in 2004 were injecting heroin or methadone (CEEHRN 2005). Sharing of injecting equipment is reported in both Banja Luka and Zenica.

2.5. Men who have sex with men (MSM)

Officials estimate there are 8,950 MSM in BIH. Real numbers are hard to assess due to high stigma of gay and bisexual people. Action Against AIDS has reached 150 MSM in Banja Luka. NGO Q reached almost 300 MSM in the first 4 mounts of the implementation of the GFATM project. In Sarajevo, contact has been established with 200-300 of MSM through local NGOs XY and Q. In Tuzla, it is assumed there are around 300 MSM, whereas in Banja Luka, Action Against AIDS have contacts with around 150 MSM.

Experts from the NGO sector agree that the members of the MSM population in Sarajevo and Tuzla are between 16 to 35 years of age and that many have families that are not aware of their bisexuality (or hidden homosexuality). In Banja Luka, the MSM population is somewhat younger: majority is university students 17 to 24 years old and only a minority is 25 to 30 years old.

Surveys and interviews report existence of a number of risk factors for HIV and STIs which are present in larger or smaller scale, including unsafe sex (not using condoms, bisexual relations, low precaution of safer practices while affected by drugs), drug use (including some injecting), high stigma and discrimination and limited while increasing services. According to UNICEF

(2002) and World Bank (2003), 77% of them use drugs and 10% tested for HIV. Data on this topic needs to be renewed. The Global Fund proposal includes specifications on the links between MSM and drug using. When linked, unprotected homosexual sex and drug consumption are especially risky behaviors. Surveys and studies conducted by international agencies and local NGOs confirm drug consumption among MSM. MSM community in BIH is characterized by a high promiscuity level, low awareness of risks of getting HIV or STI through unprotected sex. Condom use is very low. 9 MSM from 10 had sex under the influence of drugs.

MSM are very mobile. MSM from Banja Luka and Sarajevo in parties organized in Belgrade, where general opinion regarding sexual orientation seems to be more comprehensive compared to their home cities. MSM community is very closed and hidden. Apart from NGOs which provide free counseling, condoms and lubricants, information materials and organize focus groups, MSM are reluctant to get into contact with other services in order to avoid moral issues and stigmatization.

NGO Q points to a high number of partners and low condom use within MSM population. Young MSM, who are generally well informed about HIV risks and prevention, do not pay attention to eventual consequences of risky behavior while older MSM, especially the ones hiding behind marriage and conventions, are uninformed about prevention and do not use condoms.

Low condom use has been confirmed among MSM population in all big cities in BIH. According to UNICEF RAR in 2002, only 6.7% of 30 young MSM surveyed in Tuzla were always using condoms.

Research carried out among MSM through Q in Sarajevo, Banja Luka and Mostar in 2005 showed similar numbers and risk behaviors: 20% out of 66 respondents stated that they had over 10 partners in the previous year. 30 % reported consistent condom use (higher than in RAR) and 5% reported never using them. 38% respondents reported knowing somebody who exchanged sex for money or other goods. Less than half of the respondents had been tested on HIV or STI (48%).

Of 58 MSM tested through VCT in 2006, 6 (10%) were found to be HIV positive (Ministry of Civil Affairs 2008). Share of homosexual and bisexual transmission of HIV is 20% among registered cases with known transmission route.

2.6. Prisoners

In 2007, prison population in FBIH and RS is 2,649, which is relatively low number in comparison with other European countries (International Centre for Prison Studies, 2008). International groups indicate that prisoners live in relatively bad conditions and prisons are overcrowded, specifically in FBIH. At least by March 2007, juveniles, who constitute 0.6% of prison population in both entities, did not have a separate penitentiary institution (DFID 2006, COE 2007).

A number of studies throughout the world and Europe indicate that due to drug policies and lack of health and social assistance to drug users outside and inside prisons, there is a number of increased risk factors for prisoners. IDUs are often highly present among prisoner populations and forced into risky behavior due to the lack of sterile injecting equipment in prison environment. Generally, prisoners are also exposed to higher risks because of the possible sexual encounters with other prisoners and unavailability condoms. Moreover, experience of Western

and Central European countries indicated that HIV, tuberculosis, hepatitis are 8-30 times more likely among prisoners than outside prisons (Stover 2007). In spite of this, existence of drug using behavior and sex is often denied.

According to NGO Association Margina, in BIH, prisoners are not included in the general health protection system. In the largest prison in BIH located in Zenica, there are usually 120 IDUs at any time. At some point, there were VCT services in the Zenica prison when among 56 tested IDUs 66% tested positive to HCV, HBV or both but none was HIV positive. Prisoners in the whole prison system of the country have never been vaccinated against HBV.

Bio-BSS among IDUs confirm that a number of IDUs are imprisoned and than around one quarter of them do inject drugs while imprisonment (UNICEF 2008). There is also a documented case of fatal overdose of one prisoner, which confirms drug use in BIH prisons (CEO 2007). Currently there are no data available about inmates risk behaviors.

2.7. Roma community

Roma population represents the largest ethnic minority and very highly marginalized group in BIH, which experiences major problems in accessing health care, education and employment. Although Roma have integrated into communities, many are still mobile. They have been subject to constant displacement during the war and constant discrimination. A low illiteracy rate of 23 percent and low attendance rates at primary schools have resulted in an almost total absence of high school, vocational, and university education. Many have no identification papers, so consequently they cannot qualify for general social security programs and specially adapted programs.

Current estimates are between 17,000 and 80,000 (76,000 is an estimate of the World Vision 2008, which works with Roma on HIV prevention in BIH).

NGOs working in the HIV field report very low HIV/STI awareness among Roma. Furthermore, previous and current services report about challenges in accessing Roma, enabling them to uptake existing services.

No data on risk behaviors or HIV prevalence among the Roma community is available.

2.8. Other groups at higher risk for HIV

Experts from country's Institutes of Public Health indicate other groups that are of increased vulnerability in the context of HIV, like victims of trafficking (population of 2,000), displaced persons (>1 million). The national UNGASS report indicates cross-border migrants, migrant workers, also refugees as part of groups at higher risk. Migration rate is estimated 2.1-6.38 migrants per 1,000 (IOM 2007; CIA 2008); intension to migrate is estimated at 65.7%. Data suggest high rates of emigration for work but estimates are not available and health issues of labor migrants are in the process of documentation by the International organization for Migration (IOM).

3. Policy: legal framework, strategies, monitoring system and human rights

The Constitution of BIH, as well as Constitutions of the FBIH and the RS put human rights and liberties, the principles of non-discrimination and equality highly. The national Constitution sets that the European Convention for the Protection of Human Rights and Fundamental Freedoms and its Protocols shall be applied directly in the territory of the country. However, as the Commissioner for Human Rights of the Council of Europe states in 2008, in spite of comprehensive framework, "the implementation of anti-discrimination laws and provisions is far from satisfactory."

In the HIV and drugs field, the country has a number of relevant strategies (including on AIDS, drugs, Roma, displayed people), relevant laws (on gender equality), also is in the process of preparing youth strategy. However, there are challenged in the implementation of those strategies. These challenges are related with diversity of challenges that country meets with, funding, lack of actions plans, also complex distribution of competences and lack of monitoring mechanisms.

The major problems with implementation of strategies and enabling HIV prevention among young people at risk are: semi-illegal status of needle exchange, high stigma and discrimination of vulnerable groups, absence of youth policy and sustainable funding mechanisms of strategies (including funding for NGOs).

3.1. HIV and AIDS policy and coordination

In 1987, AIDS was classified as an infectious disease in the Republic of Bosnia and Herzegovina, as part of the former Socialist Federal Republic of Yugoslavia, and was subject to the Law on Protection from Infectious Diseases Threatening the Entire Country, which implied mandatory reporting, epidemiological monitoring and compulsory treatment. Given that legislation closely linked to this specific disease has not been passed in Bosnia and Herzegovina to date, the mentioned law is in force, as well as the Decision on the Measures for Protection of the Population from the Acquired Immune Deficiency Syndrome.

A National Strategy to Prevent and Combat HIV/AIDS 2004-2009 is built on the 2001 Declaration of Commitment and 2002 SEE Declaration on HIV/AIDS Prevention, as well as national resolution on the Policy "Health for All Citizens of Bosnia and Herzegovina." The HIV Strategy includes 5 strategic aims, including prevention; treatment, care, and support; legal protection of ethic principles and human rights for PLHIV; cooperation and development of sustainable capacities to combat HIV/AIDS; and strengthening links with international organizations in the HIV field. The prevention goal is the most substantial of what it includes and the scope of activities proposed. In terms of adolescents and young people, the strategy indicates the special emphasis on young people (as well as groups-at-risk) in prevention efforts, including such "age-appropriate" measures like school based programs on HIV prevention and STIs, prevention programs on drug abuse and HIV prevention, promotion of safe sexual behavior aim young people at schools and at large. Groups at risk indicated in the document include only injecting drug users, sex workers, men who have sex with men and prisoners. There is no special emphasis on Roma and migrant workers/cross-border migrants, which identified as vulnerable groups through UNGASS report in 2008. During the study visit, experts heard criticism of the

strategy and proposals that it should be renewed and updates. In spite of substantial criticism to the document's content, a number of positive issues are outlined there, like need to assess the scope of IDU, SW and MSM populations and their risk behaviors, focus on PLHIV rights (while not on rights of people from groups-at-risk), proposal of improvement of monitoring and evaluation systems, ensuring blood and its product safety. However, many of these proposals are delayed with its practical implementation.

The biggest challenge for BIH in present is to develop a national monitoring and evaluation system for HIV. UN qualified BIH health system as "slow performer". In 2003, a new HIV/AIDS reporting system backed by legislation was introduced in the FBIH guaranteeing thorough confidentiality and collecting behavioral data. According to National Public Health Institute, this system is not operational. Disfunctionalities in data collection and monitoring can be overlapped only through a national data system, included as a priority in the GFATM project.

A National Committee for Prevention and Monitoring of HIV/AIDS within the Ministry of Health of FBIH was established in 1997. In 2001 the Committee has drafted a Program of second generation of HIV/AIDS monitoring in FBIH, which targeted subpopulation at risk.

In order to coordinate comprehensive policies on HIV/AIDS prevention and services for PLHIV, a National Advisory AIDS Board (NAB) was established. In December 2003, NAB developed BIH HIV/AIDS. The Council of Ministers of Bosnia and Herzegovina endorsed this strategy. NAB is responsible for monitoring the implementation of the strategy. Country Coordinating Mechanism (CCM) is another body operating in the HIV field; its competence is related with the implementation of the GFATM projects. The body includes PLHIV, former IDUs, and LGBT activists, as well as service providers. The CCM membership was due to revision in 2008, but during the study visit it was still very numerous and a number of interviewees mentioned challenges of making this 44-member body operational.

Low HIV prevalence is confirmed by no HIV cases identified through blood and organ donor testing, which is now regular practice in all parts of the country (42,483 first time and candidate blood donors tested in 2004, 64,987 in 2005 and 101,729 in 2006) (EuroHIV, 2007a).
The Ministry of Civil Affairs is responsible in developing public health policies at country level. For the moment, each Ministry of Health in both entities and in each canton from FBIH has its own regulation with regards to HIV prevention and services for PLHIV.

3.2. Drug legislation, policy and coordination

Drug legislation in BIH is incomplete and differs on a wide range inside entities and among cantons in FBIH.

Criminal codes in FBIH consider drug possession as a crime punishable by imprisonment for a term not exceeding one year. It foresees punishment for sharing drugs (with special provision of this offence against a child or juvenile as aggravating condition). Also imprisonment is foreseen for enabling another to enjoy narcotic drug, which might be broadly interpreted.

Differences between RS and FBIH criminal codes determine the number of arrests and each entity. Unofficial data mention 200-300 drug related crimes in RS and 1,300 drug related crimes in FBIH in 2006.

BIH has recently developed a drug strategy after a long process, which included of discussions, establishing different working groups, consultations and legislation analysis. Previous initiatives

at country level had failed in accomplishing this task. Ministry of Security (country level) had developed a working group in order to establish priorities and objectives for a strategy. The working group met for several times and stopped due to unknown reasons. Ministry of Civil Affairs established a Commission for Drugs, which was assigned to elaborate the drug strategy. The strategy is not available in English translation for the moment.

At the moment of writing this report, the strategy needs to be endorsed by the State institutions responsible with its implementation by all administrative levels. Harm reduction services seem to be a delicate issue in this document.

RS has drafted its own strategy on drugs before the national strategy was ready. Brcko District supports the idea of a single national strategy on country level. One of the key points for a future strategy is harm reduction as an effective way to prevent HIV among drug users.

Punishments for drug possession and 'enabling another to enjoy narcotic drug' is identified by services providers, as well as other national stakeholders as a major barrier for developing and implementing needle exchange programs without putting staff at risk to be arrested under the charge of drug possession and/or encouraging drug using. Besides the newly developed strategy on drugs, no other official regulation mentions harm reduction services.

Outreach workers are informed about the risks involved by this job with regards to current legislation. The negative implication of the legislation lead to limitations of some existing low-threshold services in the country: some of them are not collecting used syringes (which is desirable for protection environment and prevention of infections during injuries). NGOs are just distributing clean injecting equipment, without retrieving used syringes. NGOs Association Margina, Poenta and UG PROI (in the Brcko District) are collecting the used syringes, which are destroyed in clinical centers. To ensure confidentiality of drug users and ensure that service data could not be used against them for drug possession charges, IDUs are served using anonymous codes.

Although official legislation criminalizes drug possession, police in several cantons and in RS is aware of the importance of harm reduction services. Different trainings and meetings, memorandums of understanding signed by more stakeholders responsible in HIV prevention field among drug users have changed the police perception in the last 2 years. Police is recognizing the impact of harm reduction measures (substitution treatment and needle exchange) on increasing security in the streets, especially when NGOs emphasize their role in cleaning the public space of dirty syringes. The initiative for changing the legislation belongs to the Ministry of Security at the country level.

No data on implementation of human rights of IDUs were obtained through the literature review and the study.

3.3. Sex workers legal status

Sex worker is not recognized as profession, thus people engaged in sex work are not paying taxes and are often not socially insured.

Sex work is an illegal activity in BIH. In FBIH, SWs can be imprisoned up to three moths, while in RS they are fined for this activity. In both entities pimping is incriminated. Police is very active in fighting human trafficking and prostitution. Numerous raids in fun houses and bars turned

prostitution almost invisible. Street prostitution became rare as SWs moved into apartments.

Moreover, there are reports of violations of rights of sex workers: rape by police, violence by clients, especially violent male clients of 18 and younger age (CEEHRN 2005, UNICEF 2006). Sex workers feel stigmatized and perceived as sources of STIs (Wong 2002).

3.4. Legal and actual situation of LGBT (lesbian, gay, bisexual and transgender people)

In BIH, same sex conduct between consenting adults is no longer a crime in BIH. LGBT organizations can constitute as legal entities, similar to any other civil society organization. The Law on Gender Quality adopted in 2003 specifically prohibits discrimination based on gender and sexual orientation. Moreover, the national Criminal Code foresees imprisonment for an official or responsible person in the institutions of BIH who denies or restricts the civil rights based on sexual orientation (or national, ethnic background, sex, language, social status or social origins) (Criminal Code of BIH, Article 145).

However, some legal guarantees, like provisions of right to legal, social or health care to transsexual individuals is lacking. Implementation of the laws and negative social perceptions remains the major problems in the situation of LGBT persons. They are especially effecting in workplace related environment and in media. Due to social exclusion, many LGBT persons "are forced to hide their orientation and identity in fear of abuse and even physical attacks, sometimes by their own family members." Also a number of people with LGBT or queer identity migrate from country for a life without fear. (COE 2008)

3.5. Monitoring and evaluation system

BIH has no M&E system at the country level. Ministries of health in each entity are expected to work together to establish it. Data collection system on HIV is working through national HIV coordinators, which report to European Centre for Disease Prevention and Control (ECDC) and WHO-EURO. In the process of preparation of the monitoring systems public institutions face numerous challenges. The interviews with national stakeholders did not show signs of recognition of benefits of well-functioning monitoring and evaluation system and research to inform relevant policies and decisions.

Due to the political and administrative system in BIH, the present data collection system on HIV and other sexually transmissible or blood-borne infections is separated per each autonomous entity. RS has a centralized data collection system, while in FBIH it seems to be difficult to set up a centralized system: epidemiological data is collected at cantonal level. Due to the absence of clear regulations, cantonal public health institutes refuse to send this information to the Federal Public Health Institute, which is based in Sarajevo. However, epidemiological data on HIV seems to be available at the Mostar Medical Faculty. The GFATM support foresees assistance in developing M&E system for HIV. In the drugs field, the progress with M&E system might be more complicated to develop, as there is no available funding for this purpose. However, there is a possibility to address the EU agency on drugs (European Centre for Drugs and Drug Addiction, EMCDDA) for their support and the authors have preliminary informed EMCDDA about such need.

At service level, quality of intervention is not reinforced so far in the major national HIV program - GFATM project. All indicators focus on quantity and UNDP and national coordinators do not

have criteria and clear procedures of assessing quality. But attempts from the national coordinators to visit services and make on-site assessments are welcomed.

NGOs in BIH are used to work with these quantity indicators. Information about impact of services on behaviors was not received during the visit but would be partly addressed through bio-BSS studies. Also so far there is no single national client database for low-threshold services, which proved to help the M&E systems for such services.

On the other hand, visited NGOs and other services file data on clients and services on daily basis. NGO XY uses also electronic means for M&E in daily practice and also has system for M&E throughout their various projects (not only those funded by the GFATM).

The limitations in M&E, especially of quality of services are numerous in the country. Lacking expertise in estimating the impact of the intervention, limited data collection possibilities, unclear baseline information are only few of them. Moreover, the starting of the GFATM was very rapid and required high dedication of services providers and other stakeholders in order address the initial delay in the start-up of the GFATM and reach the indicators.

4. Services, capacities and funding

4.1. Overview of services

Before the war, BIH had a good health service infrastructure. Youth and women were targeted through special services. Drug detoxification (management of withdrawal syndrome) and opioid substitution treatment were available. As it was designed, the system could include medical and social service for vulnerable populations. During the war this system crashed. The administrative structure became a barrier in developing and scaling up prevention and harm reduction services. Moreover, a private system developed in parallel to national healthcare. Based on division of competences, the healthcare system is in competence of the state entities and therefore might differ among them.

In FBIH, young people's access to healthcare might be problematic, since they are not automatically insured by state; this problem is being addressed by youth advocacy groups in ongoing development of youth policy. Moreover, throughout the country people from most-at-risk groups, such as injecting drug users, sex workers, Roma from poorer communities, often do not have health insurance and can access only low-threshold services where they exist, drug treatment after compiling documentation and waiting in waiting lists or access them in private sector at fee. Youth at large is served through free-of-charge so called youth-friendly clinics/services, which are largely focusing on sexual reproductive health and psychological counseling. Like in the society at large, in healthcare and social systems, stigma and discrimination persists for IDUs, sex workers, Roma, LGBT (including MSM), which additionally constrains accessibility to health, which is guaranteed for all people in BIH in the Constitution.

The current HIV services (as well as some drug services) largely rely on international support, specifically the grant from the Global Fund to fight AIDS, TB and Malaria (GFATM).

Sexual and reproductive health (SRH) and youth friendly services

Youth friendly services (YFSs) exist in Brcko, Banja Luka, Sarajevo, Mostar, Bihac, Prijedor, Doboj, Bijeljina, Foca, and Trebinije. They are provided free of charge, anonymous and using an approach suitable for youth.

YFSs operate in two different models in the country. One model is based on youth centers and integrating friendly health and counseling services into NGO work. The other model is attached to existing health settings and focusing on youth-friendly health clinics. Stakeholders interviewed had different opinions of which model is more efficient and more sustainable in the long-term. Clearly, youth centers can attract more youth, as they have other extra-curricular activities (e.g. are situated near youth cafes) and they integrate social and health services for youth but they are more expensive. This model is supported by NGO XY, who one of the major GFATM implementers and is responsible for YFS development. NGO XY developed this model, while earlier was supported by UNFPA to develop so called 'UNFPA model' or model of youth-friendly clinics model. The latter model is promoted by UNFPA, which invested its technical and financial support into them for a number of years and now has limited sources for continuing this work. The advantages of youth-friendly clinic model are: working with state ensures co-funding,

reduces costs, ensures good quality human resources, and links the clients to other services.

Sexual reproductive health services focus on general youth, considered to be e vulnerable group in BIH. YFS provide information on HIV and STIs, contraceptives, sexual rights through peer education and specialized staff (medical doctors and school teachers). Drug information can be added to existing curricula in trainings and information packages are needed. Compared to illegal drugs, YFS consider alcohol and tobacco use as being the biggest problem for youth health.

Based on interviews, no good evidence exist about benefits of YFS for most-at-risk groups, such as young IDUs, SWs. However, HIV prevention messages, especially on safer sex and sexuality, seem to be well integrated in YFS. Drug education is not so well emphasized in the work of YFS, but there are good practice examples of how this could be addressed. In Sarajevo, NGO XY has close relations with NGO UG PROI working in the drugs field and can refer their clients for drug counseling, treatment and other assistance. In Brcko, youth center by NGO Vermont holds lectures on drugs issues and has hours when drug treatment specialists are making counseling on alcohol, tobacco and narcotic drugs. Also they maintain contacts with three drug communes where they refer people for drug-free treatment.

YFS have substantial experience in BIH. They were first established in 2003-2007 with support of UNFPA. Current funding from the GFATM helped to expand the YFS network to more cities. Local ownership of YFS (including in-country funding for their development) is lacking. However, there is a good practice in the Brcko District, where NGO Vermont, earlier supported by UNFPA, now fully maintains its services using funding from the local authorities budgets. UNFPA and Canadian International Development Agency (CIDA) supported also developing of standards and documentation of good practices of YFS and overall addressing SRH.

Sexual and reproductive health is not well covered in schools and SRH education is provided only on ad hoc basis. School curricular still lacks SRH information and should be reviewed to include sexual and reproductive health education, which could benefit from relevant youth work experiences, as well as peer education practices, as they are based on the work of grass roots organizations and international agencies.

The reach-out of SRH education through peer education and YFSs is relatively high in BIH. According to the CCM report to the GFATM in April 2008, within the first year of the GFATM support, peer-based SRH education in schools settings and in out-of-schools reached 14,407 young people of 15-19 years old and 15,597 people of 15-24 years old respectfully. After the second GFATM project year, this number is expected to increase substantially: more than two-fold (to 40,000 young people) in school settings and almost 6-fold (to 80,000 young people) in out-of-school settings.

Pharmacological drug treatment and management of withdrawal syndrome

Drug users receive treatment for addiction at mental health clinics and psychiatric wards. The main two types of drug assistance in state institutions are pharmacological drug treatment, namely opioid substitution therapy, and detoxification (management of withdrawal syndrome).

Opioid substitution treatment (OST) is provided in 8 locations (Banja Luka, Brcko, Sarajevo, Bihac, Sanski Most, Doboj, Mostar, Zenica). The medication used is methadone, which is the cheapest and the most practiced drug for substitution therapy. Buprenorphine is available but not applied.

EuroMethwork guidelines are used for application of methadone maintenance therapy (MMT).

These European guidelines, which are also used in some other countries, including Slovenia, are translated. Main criteria for admission in treatment are the minimum age of 18 years old, medical insurance and at least 1 year of opiate using; these criteria may vary, even from canton to canton within FBIH. MMT include provision of medication, as well counseling and social reinsertion schemes. HIV and hepatitis tests are available in the evaluation phase. Methadone treatment is covered by health insurance and through the GFATM.

Some NGOs indicated that the quality of MMT is not necessarily satisfactory. This was illustrated by two arguments. First, some individuals go abroad for treatment, which is very expensive and an available solution for only a few. Additionally, some MMT clients are coming for clean needles, i.e. continue injecting drug use. There was no possibility to meet drug treatment experts during the country mission to address those concerns. However, based on international practice, MMT is not putting stoppage of illicit drug use and injecting as an ultimate objective and rather is invented for reducing illicit drug use (and injecting), as well as reducing health-related harms associated with injecting drug use and improving social well-being of clients.

With the GFATM support, in 2007 536 MMT clients were enrolled and preliminary 710 should be reached by the end of November 2008. In Sarajevo, the Kosevo Hospital provides methadone substitution for 250 patients alone. Data also indicates increasing number of IDUs in substitution therapy in Sarajevo, Zenica and Mostar. However, the MMT scale is reported insufficient. Treatment demand is much bigger than the current possibilities of the system. The scale is limited by the institutional capacities and also in some places MMT is not introduced due to negative attitudes of medical doctors. In Tuzla, medical doctors of Islamic background refuse to introduce MMT and, therefore, IDUs from Tuzla have to travel to Sarajevo in order to receive MMT. Also Tuzla was not identified as the MMT site in the GFATM project and funding drug treatment services there would be a challenge. In other places with limited capacities to serve IDUs, a lot of IDUs are put on waiting lists.

There is illegal methadone in the black market (even in Tuzla, where there is no MMT) and is in concern of police and NGOs. Some NGOs indicated that this is direct consequence of MMT scale limitations and willingness of IDUs to ‘self-medication’ of their addiction.

In terms of choice of medication for OST, beside methadone, buprenorphine (which is opioid agonist and antagonist) is also available in the country but so far is not applied for ST. Suboxone (which is mix of buprenorphine and naloxone, with very strong features on blocking of possible euphoria if other drugs are used) is not introduced as well, while medical doctors in Tuzla who refuse to introduce MMT have expressed their interest in introducing it for OST. In order to introduce suboxone therapy, the legal framework needs to be addressed.

As a consequence, Tuzla is not a part in the GFATM application as a location for OST. In absence of substitution treatment, other harm reduction services such as needle and syringe exchange weren't developed.

Medical treatment for drug withdrawal for IDUs is currently available in Sarajevo (University Clinic), Banja Luka and Zenica (opened in May 2008).

Outreach and low threshold services for IDUs, SWs, MSM, prisoners, Roma and refugee returnee women

Classic outreach among vulnerable groups is developed in BIH. It includes face-to-face information and education sessions, counseling, condom and syringe distribution, as well as

referral for testing and counseling, other information, skills and tools (depending on clients needs). Some outreach is done via 'feet outreach' or street outreach or outreach in parties (specifically to reach LGBT), however in order to cover bigger geographical area mobile services are being developed as well. There are fixed (stationary) low threshold services (e.g. in Zenica). Most of outreach schemes involve peer educators (so called gate keepers).

Funding for outreach services are provided by the GFATM. As stated in the GFATM project, the objective of outreach is to scale up IEC/BCC in populations with increased risk for HIV/AIDS infection. Targeted populations through outreach are IDUs, MSM, SWs and Roma. Outreach is developed in the biggest cities of both entities and in the Brcko District. The outreach and low-threshold services are implemented exclusively by NGOs.

In April 2008 CCM reports that 934 MSM, 261 SWs, 915 IDUs, 198 prisoners, 2,155 Roma and refugee women were reached through outreach and HIV prevention within the first year of the GFATM support. Most of services are being implemented at the levels earlier planned while writing the GFATM application. However, in case of the Roma communities and refugee returnee women and IDUs much more people are reached than initially planned. On the other hand, reaching prisoners is backslashing as NGOs who are to start those activities receive permissions to enter prisons with a considerable delay. Until there are estimates of vulnerable populations, it is not possible to calculate the coverage of vulnerable groups through those services.

In terms of the outreach and other services for vulnerable groups reached there are three major concerns by the mission experts. The number of IDUs and Roma people foreseen to be served through the GFATM support are too low in order to make impact on HIV (only 985 IDUs through outreach and 710 IDUs in ST, 3000 Roma and refugee women at the end of 2008, i.e. at the end of phase one of the GFATM project). Secondly, the outreach and low-threshold services are completely depending on international funding and might be not sustainable. Experience of services for IDUs and SWs, which were supported for a number of years by UNICEF or other international donors,[7] was not sustained in some cases and their work was interrupted. The interviews with authorities and NGOs did not resolve those concerns. As one official said in the interview, "it is unrealistic to expect that country will manage to fund HIV services at the same level as the current GFATM funding, after the international support is finished." Third, vast majority of IDUs surveyed through bio-BSS were not aware about low-threshold services; thus visibility of services and better outreach is urgent.

Among other concerns raised during the visit, there is no 'united front' of NGOs who are active in the field. NGO Association Margina is not among sub-recipients of NGO consortium which manages services for young people and groups-at-risk, and in spite of its previous experience of work with IDUs, SWs, prisoners got smaller piece of services to be implemented than it expected; moreover, it did not get funding to continue its work for prisoners and other NGO without previous experience in penitentiary settings got contract to start the work. But increasing understanding and cooperation of NGOs, including NGO consortium and Association Margina is reported, which should help to overcome tensions. Overall, with the rapid expansion of services, there are more people coming into the field which are not necessarily have knowledge and skills in HIV prevention and work with vulnerable groups and substantial training and technical assistance needs for NGOs should be addressed.

[7] With UNICEF support, NGO Association Margina was the first NGO in BIH to develop a needle exchange program and soon acquired sufficient experience to provide technical assistance for other NGOs. NGO UG PROI initiated outreach in Sarajevo in 2005 but it has difficulties in sustaining this service due to police raids.

Drug-free treatment: therapeutic communities

According to UG PROI, 3 therapeutic communities and 5 religious centers are available in BIH.

Different religion communes exist in this multi-ethnic and multi-religion country. Non-religious communes are run by NGOs such as UG PROI and Viktorija. Most clients accessing this service are opiate users. Depending on the approach, the intervention can last up to three years. Ex-drug users can become peer educators or professionals working in a commune after graduating the treatment.

The NGO-run therapeutic communes are positively seen by a number of stakeholders, including police and local authorities, as well as local communities.

Both females and males are accepted in communes

Voluntary counseling and testing (VCT) for HIV

VCTs are intended to target most-at-risk populations with the provision of free-of-charge voluntary and confidential counseling and testing for HIV. Low threshold services are referring their clients to VCT centers. Another source of information about VCT are testing campaign, also medical doctors and posters in the health and youth-friendly settings.

5 VCT centers are operational in RS: Baja Luka (2 VCTs), Doboj, Bijeljina, Foca. 10 VCT centers are established in FBIH, but only few were functioning in 2007. The support for VCT is provided from in-country sources and from the GFATM. So far the GFATM supported reconstruction, upgrading and staff training of 8 centers. It support will be extended to four more centers in the following year. VCT is officially free of charge only since 2004.

Officials indicate that 5000-6000 people tested on HIV during 1986-2006, representing approximately 0.15% of the total population in BIH.

In 2006, alone 3,464 people were tested and counseled (3,435 people were informed of test results). Most-at-risk population comprised 24% (n=834) of all people tested at VCT and among them 50% were identified as IDUs. 44% of all people tested were pregnant women. HIV positive cases are identified in 15 people tested, including 6 MSM, 4 IDUs and 2 family members of PLHIV, as well as 3 people infected through heterosexual contact. WHO-EURO indicated 20,904 people getting HIV tests (including VCT) in 2006 with 17% of them getting pre- and post-test counseling (WHO-EURO 2008).

From May 1, 2007 to October 31, 2007, 1,809 people were reached through VCT services. There is no data which part of them was from most-at-risk populations. Due to initial delays in starting the GFATM project, the VCT services did not reach such large number of people, as it planned (during the first year, implementation level was estimated of 30%, according to country's report to GFATM). Additionally, the bio-BSS survey indicated low awareness of HIV testing possibilities among IDUs (20% in Sarajevo and more than 50% in Zenica and Banja Luka did not know where to get tested). Moreover, before bio-BSS almost 40% of IDUs in Sarajevo, 60.9% in Banja Luka and 75.6% in Zenica never had HIV test. For some people, motivation to participate in the bio-BSS was related to possibilities to get HIV and HCV tests.

The testing promotion campaign, which was launched by UNDP in 2007 with the GFATM

support, is criticized by NGOs and field experts. It said to have low visibility and lack of infrastructure sustainability. NGOs contacts were not included in Campaign billboards and promotion. Critics say the campaign promoted stigmatizing ideas over vulnerable groups, strengthening the stereotypes with regards to drug users and sexual minorities. Moreover, in October 2007, when the campaign was launched no VCT was functioning in Sarajevo, the capital city of FBIH and the country.

Antiretroviral therapy and care for PLHIV

According to UNAIDS/WHO/UNICEF 2008 report, all people in need for antiretroviral therapy (ART) were receiving it at the end of 2007. There was rapid increase of ART in the last years: from 1 patient at the end of 2002, 10% of assessed need in mid-2003 to 19 people in 2006 to 30 at the end of 2007.

In total, 33 HIV patients were seen for medical care during 2006 (WHO-EURO, 2008a) and 30 people were in HIV care at the end of 2007 (CCM 2008).

Since 2007, the only HIV-positive child is receiving therapy, however, as the national UNGASS report indicates, there was lack of liquid ARV drugs in the country.

There is no information about application of PMTCT, however at least for women from the Roma communities it should be covered through the GFATM grant.

HIV treatment and care is provided at infectious disease clinics. ARV treatment is available in the biggest cities. People living with HIV are referred to clinics in Sarajevo, Tuzla, Mostar and Banja Luka. All these clinics report to offer both in- and out-patient services. Some stakeholders interviewed said the quality of these services to be poor. Treatment is based on three-medication ART therapy (highly-active antiretroviral therapy). Cost for medications is relatively high. 14 different ARV drugs are available in the country. Problems in drug importations still persist. In Banja Luka ARV provision is continuous in the last two years.

Protocols on HIV treatment and care are being developed, but have not yet been officially adopted by Ministries of Health in the two entities. So far, doctors report to use the international guidelines (either EACS or WHO-EURO protocols).

Facilities for determining CD4 cell counts and measuring viral load are available in Sarajevo and Baja Luka. In 2008, 14 people were receiving diagnosis and treatment for opportunities infections (in comparison: 5 PLHIV at the end of 2007). According to national UNGASS report, there are cases HIV co-infection with TB recorded (1 in 2005 in RS, 1 in 2006 in FBIH and 1 in 2007 in FBIH). PLHIV are proposed testing for HCV but there are no data about proportion of them with co-infection and accessibility of hepatitis C treatment, while overall hepatitis C treatment exists and is provided in the country.

Support for PLHIV

An organization for people living with HIV and AIDS is organized in FBIH and is named APOHA. It provides psychosocial support and self-support for PLHIV. In RS, NGO Action Against AIDS is providing comprehensive counseling and support for PLHIV.

At the beginning of 2008, 27 people were benefiting from those activities.

4.2. Current capacities and needs of NGO service providers

NGOs are the main implementers of the GFATM funded services. The monitoring of the project at large is mandated to the UNDP and HIV coordinators, delegated on behalf of the Ministries of Health in each entity. During the assessment phase of the GFATM, 20 NGOs have been evaluated in order to establish their capacity to implement HIV prevention activities. The 2007 country mission organized by RHRN reach only some NGOs, which work and capacities are analyzed.

UG PROI (Sarajevo, Brcko)

NGO UG PROI was established by former drug user, members of drug users families and health workers. It started work back in 2001. The aim of the organization is to educate BIH citizens about drug abuse, problems caused by drugs and to provide help to the active drug users.

Already in 2005, UG PROI provided direct services to 150 injecting drug users and it continues this work today in Sarajevo and more recently in the Brcko District. Around 90% of the NGOs clients are from Sarajevo.

Activities of the organization include: referral to treatment, psycho/sociological counseling for IDUs and their families, re-socialization assistance after the treatment, telephone line for questions related to usage of drug as well as to HIV&HCV, 12-step self-help for IDUs and education carried out by former IDUs in schools, referral of IDUs to detoxification and MMT programs at the Sarajevo Canton Institute for Alcoholism and other toxicological addictions, assistance in obtaining health insurance (30 cases) and assistance in HCV treatment provision (10 cases).

While the major focus of the organization is provision of drug-free and low-threshold services for drug users, since July 2007, UG PROI works through a network of outreach workers and gatekeepers with population of SWs in Sarajevo. Earlier the organization implemented a survey among SWs in Sarajevo and Mostar.

UG PROI is a good example of involvement of drug users in developing of drug services and reaching the non-discriminative balance of drug-free and low-threshold drug services.

UG PROI is the active member of CCM and has close cooperation the Center for Social Work of Sarajevo Canton, Ministry of Health, Detoxification Ward, Kosevo Hospital and other state institutions.

Viktorija (Banja Luka)

Since 2002, Viktorija has been implementing a program of comprehensive approach to treatment "Projekat Covjek". The project includes counseling service for prevention and treatment of IDUs and their family members, two-year rehabilitation program within the therapeutic community, day center for drug dependent people, SOS telephone line and occasional training of medical staff and public policy actors.

In 2004 only, Viktorija managed to establish 147 new contacts through the counseling services. Among the clients, 92% were heroin users, 30% had HCV and 4 had HBV, whereas none of them

was HIV positive. 10% of clients were adolescents below 18 (none of them was positive on hepatitis) and 8% were over 33. So far, 35 clients successfully passed through the therapy community program and re-socialization program.

With the GFATM support, Viktorija is expanding its services in RS geographically and in terms of scope. The strengths of the organization is counseling and drug-free approaches. Involvement in low threshold services is low but the organization seems to progress on that and could implement even wider scope of services if legal framework of harm reduction is established.

Poenta (Banja Luka)

NGO Poenta has counseling service for prevention and treatment of addictions, provides referrals to testing and counseling for HIV, HCV and HBV tests as well as refers to therapeutic communities in BIH and Croatia. With a financial support, the members produced and broadcast a short program about the life of SWs and IDUs. The organization estimates that over the past four years they have had contacts with 10,000 IDUs. Poenta is currently documenting its experience in activity report.

Poenta carries out needle exchange program independently. The data on clients and activities are not being kept and their loose estimates indicate that 7-8 IDUs take 4-5 injection kits daily. The program is functioning according to the following principle: number of new sterile needles = the number of used ones.

The organization is led by a person from drug user community. The organization actively participates in various policy development initiatives, including in development of youth policy.

Association Margina (Zenica, Tulza, Mostar and Sarajevo)

Association Margina started its HIV prevention among most-at-risk groups back in 2003, when it started six-month outreach needle exchange program (NEP) in Zenica. The program recruited 700 clients. Out of that number 270 were new clients. 2 USD remuneration fee helped to reach such high coverage in short time. Following the success of the program and with certain verbal agreements by the local authorities, a drop-in center was opened. The needle exchange soon stopped functioning because of the arrival of a new Interior Minister who exerted pressure on the program staff to stop the activity referring to the existing legislation.

In 2007, the drop-in center and outreach workers provide such services: distribute condoms, exchange needles, provide information on HIV prevention and send IDUs to other services such as VCT, drug-free communities (80-90 IDUs and 150 people coming from other at risk groups annually), social welfare (especially assistance in applying for health insurance). The geographical area of the Association Margina is expanding beyond Zenica and Tuzla.

Other activities aimed at IDUs and carried out among relevant organizations include training on harm reduction approach intended for law enforcement (Interior Ministry staff specifically), lobbying with judges to apply more frequently alternatives to imprisonment (mandatory treatment measures could be ordered by court according to the Criminal Code) and to reduce the sentence duration for ex-IDUs who leaving therapeutic community programs.

The Association Margina has a partial access to sex workers, limited mainly to the industry in Zenica. At the same time, there is a large number of organizations dealing with sub-population of

women forced into sex work – trafficking in women.

In spite of and even after their withdrawal into private houses and apartments, the Association Margina has managed to keep the confidence of brothel owners in the area of Zenica. The outreach brothel program has been organized for two weeks as well as on call visits during which 300 to 500 condoms are distributed and some counseling sessions provided on a monthly basis. In the course of 2004 and 2005, they organized HIV/HCV/HBV tests among risk populations, including brothel SWs.

The Association Margina has experience of working in prison settings and this work is more or less discontinued due to lack of funds. Still it has good cooperation with the staff and doctors in the largest penitentiary facility, which is located in Zenica. In the past, they have been included in VCCT activities carried out among prisoners. Out of 56 tested IDUs, 66% were positive on HCV, HBV or on both while none of them HIV positive. VCCT has been terminated due to withdrawal of funding that used to cover the medical staff expenditures.

A survey carried out among the prison staff, including medical staff, other specialists and guards, has indicated that there is generally low level knowledge about human rights policy and harm reduction mechanisms among the surveyed.

According to Margina, the current director is interested in introducing a well designed and controlled harm reduction program among prisoners and is less interested in MMT.

The association is very active at the international level. It is member of Eurasian Harm Reduction Network (EHRN, formerly Central and Eastern European Harm Reduction Network, CEEHRN), SEE and Adriatic Drug Treatment Network as well as SEE Collaborative Networking. Currently they are trying to establish the network of NGOs dealing with IDUs.

The organization has substantial experience in developing low threshold services for IDUs, SWs and prisoners, as well as advocacy and networking. Its strength also lies in provision of trainings. The unique knowledge and skills of organization is concentrated in very few people.

Q (Sarajevo)

Q is the first LGBTQ organization in BIH that promotes culture, identity and rights of people of non-heterosexual orientation. The organization emphasizes queer identity and therefore extends their identity beyond ‘traditional’ LGBT definition.

Daily activities are carried out by 10 active members who are familiar with additional 5 to 7 other MSM. They have contacts with more than one thousand MSM, mainly via Internet. Currently there is also an outreach program with distribution of HIV educational materials.

A network of Q activists from Sarajevo, Tuzla, Bihac, Mostar and Trebinje worked for 10 months on a joint project which involved initiation of contacts with local MSM population through distribution of HIV prevention materials. After 10 months, the project was concluded with local meetings of MSM in which experienced activists from Sarajevo led the discussion on local LGBTQ needs and self-organization.

Although MSM show a great interest for the development of the direct legal assistance and lobbying for the rights of LGBTQ, Q reports that there are strong limiting factors for this: many

potential clients still insist on anonymity and that the sensitization of the legal system has not been carried out.

Several studies have been conducted through the Q network, including the study on HIV prevention among MSM carried out through questionnaires described above.

Q is in unique position to serve LGBT, as well as has unique experience in advocacy (including documentation and analysis of rights, interests and policies and representation of rights and interests of their constituencies, networking with groups internationally).

XY (Sarajevo)

XY was established in 2001 and is member of the International Planned Parenthood Federation since July 2002. They are focused on the young peoples' rights (10-24 years old) and on sexual and reproductive health.

For the first two years of their functioning as the members of regional Risk.net Group (Romania, Bulgaria, Croatia and BIH) they have been working with IDUs, MSM and Roma and from 2005 they started to work only with MSM and Roma population due to lack of financial resources.

Currently they have contacts with 200 to 300 MSM in Sarajevo through the outreach program and drop-in centre where they organize meetings every two months.

Their future plans include development of "Popular Opinion Leader" Program (POL) for MSM that would initially include 50-100 POL and in the later phases they intend to include 2 additional POLs as well as to work on prevention of trafficking in human beings, mainly in rural areas and among young girls from higher secondary school grades.

They have opened an office in Banja Luka. However the office lacks financial support.

NGO XY started its work with prisoners in 2007. It carries out IEC campaigns in the Zenica Prison. This work is supported through the GFATM project. The main activities were counseling sessions and condom distribution. Working in prisons is appreciated to be particularly difficult because of detention and security requirements.

XY has unique expertise in sexual and reproductive health, both as service provider and as host of trainers. Additionally, its management (including service and activity monitoring system, which is supported by IPPF) seems to be a good practice which could be shared with other NGOs. The NGO supports and closely works with PLHIV group APOHA.

Action Against AIDS/Q (Banja Luka)

NGO Action Against AIDS (AAA) from Banja Luka was founded in 1997 and in that time was the first organization dealing with HIV prevention and discrimination of people who live with HIV and AIDS (PLHIV).

Members of the organization are young professionals from different fields such as: medical doctors, social workers, psychologists, pharmacists, educators, managers, HIV counselors, and journalists.

AAA activities are: education of general population, medical staff, police and military, media, support for PLHIV, lobbing and advocacy, support for vulnerable populations such as: MSM, SW, Roma's, IDUs and prisoners, outreach work, counseling on HIV and AIDS and other STIs, distribution of written materials, condoms an lubricants, info line, etc. In the past, they have taken part in RAR implementation in Banja Luka and have conducted HIV-related campaigns.

At the moment, AAA participates in the implementation of two objectives of the GFATM project. AAA provides support for PLHIV at Clinical Center Banja Luka, Clinic for Infectious Diseases as part of objective 7 in GFATM project as well as individual and group work with PLHIV and their families about all the problems and questions they have.

Outreach work with highly stigmatized populations such as: MSM, SW, Roma, IDUs and prisoners is developed as part of objective 2 in GFATM project.

PLHIV, at risk groups and general population can access AAA info line in order to get information about HIV/STIs, risk behaviors, services, legislation, and patient rights.

AAA also fights discrimination of PLHIV and at risk groups through public campaigns.

AAA members belong to Q network within which they conducted a few studies and ten-month activity related to HIV prevention. At the end of the activity they organized a meeting to discuss the Banja Luka MSM needs. Present in the meeting were 20 MSM and the activity was facilitated by Q members from Sarajevo. One of the conclusions was that they would either establish a "grass-root" NGO for MSM or become part of the existing NGO and start advocating for LGBTQ population needs.

Over the past two years, the organization has conducted 5 studies independently or as part of Q network, including EC study on coverage of MSM by health protection system (results are not available yet) and HIV prevention among MSM (UNICEF, 2005c).

AAA is the NGO with probably the most comprehensive activities in the HIV field and addressing needs of vulnerable groups and PLHIV through services and advocacy. They have very good connections with RS authorities, healthcare settings and other stakeholders, including media.

4.3. Funding

Several international organizations have provided financial and technical assistance in advocacy, research, prevention and other-related interventions in the HIV field and for most-at-risk groups. Among them are UN agencies and some bilateral ones such as USAID, CIDA (Canada). Starting from 2006, the major donor of HIV services and monitoring and evaluation system in BIH is the GFATM (round 5).

In-country funding

According to the UNDP/GFATM project report, BIH expenditure for HIV was 400,000 USD in 2007 (18.5% of all estimated expenses for HIV in the same year).

Small grants are also available at cantonal and municipality level. State authorities in several cantons from FBIH organize public tenders. NGOs can apply projects and receive money from public budgets. NGOs note the funds are insufficient to insure good quality and sustainable interventions. Most of the projects supported are either youth oriented or AIDS one-time event oriented. Cantons also fund drug treatment (including in specialized centers and in therapeutic communities). Therapeutic communities are funded through private funds and from a fee paid by clients.

No national funding is available for vulnerable groups specifically. BIH does not have funds overall at national level to sustain health services for vulnerable populations. On long term, this might affect general HIV/STI prevention in BIH, especially after international funding will stop.

UNDP and the Global Fund to fight against HIV/AIDS, Tuberculosis and Malaria (GFATM)

Starting from 2006, BIH is implementing the GFATM supported project. Its first phase should conclude at the end of November 2008. The project could be further extended based on implementation indicators.

The country application was written by experts in HIV/TB prevention and services. NGOs were actively involved in this process, although there are complains about selectivity in choosing the main implementers and distributing funds per organizations. UNDP became the principal recipient of the grant. As main sub-recipients, NGOs are entitled with service development for youth and vulnerable groups.

Planned budget by objectives and two years of phase one:

OBJECTIVE	YEAR 1	YEAR 2
1. IEC/BCC, YOUTHS & YFS	$726,640	$716,422
2. IEC/BCC, VULNERABLE	$376,747	$300,659
3 SCALE UP FREE VCT	$193,390	$195,522
4. REDUCE HIV/TB COINF	$45,110	$62,710
5 REDUCE # OF STIs, VULN	$385,337	$498,507
6. Roma & DP PMTCT	$73,515	$55,547
7. FREE TREATMENT PLWHA	$476,590	$191,522
GF PROJECT MANAGEMENT	$207,000	$126,000
MONITORING & EVALUATION	$122,472	$78,697
TOTALS	**$2,606,801**	**$2,225,586**

Source: www.theglobalfund.org

UNICEF

UNICEF is the major UN agency helping country to address most-at-risk people's health, while from recently UNDP, being the GFATM principal recipient, is in a similar position. In 2007 alone, UNICEF spent 424,480 USD (The Ministry of Civil Affairs 2008).

UNICEF initiated and provided support for HIV/AIDS studies among young people, such as

Rapid Assessment and Response to HIV among highly vulnerable youth that included IDUs, SWs, MSM (UNICEF, 2002) as well as a study into sexual behavior of young MSM, SWs and members of general youth population (UNICEF 2005a, 2005b, 2006c). Although the studies carried out among IDUs, SWs, and MSM were based on small samples, they provided important initial information on young peoples' risk behavior. It funded and provided technical support for bio-BSS study among IDUs in 2007-2008.

From 2002 to 2004, UNICEF provided support to outreach program for especially vulnerable young people at high HIV risk, including IDUs, SWs and victims of trafficking in human beings, as well as to VCCT programs. Implementing partners were NGOs: IFS, Genesis and Youth Action against AIDS. As part of global communication initiative "Right to Know", UNICEF implemented a regional training project including 3,000 young people, including BIH youth.

At present, UNICEF provides support to HIV M&E improvement programs, including the support for participation of local experts in regional trainings on second generation surveillance over HIV and STIs, carrying out rapid evaluation of M&E system as well as lobbying for systemic introduction and monitoring of MARA indicators and supporting developing of coordinated drug policy framework.

Canadian International Development Agency (CIDA)

From 2001 to 2005, Canadian CIDA has conducted a four-year, youth-friendly health care system project. During the first two years of the project implementation both RAR and HIV/AIDS prevention in SEE have been funded.

CIDA has recently started implementing a three-year project aimed at improvement of health conditions of young people in the Balkans. The aim is to build capacity within the framework of primary health care system for implementation of youth-friendly models of health related counseling, diagnostics and treatment, and 2) education and outreach initiatives with a view of promoting healthy way of living in order to decrease psychoactive substance use prevalence and incidence, STIs and mental disorders among young people. Three components of the project are as follows: (1) assistance in preparation of National Youth Action Plan; (2) support to planning and implementing of pilot programs directed toward the youth within the primary health care system (that will be included in the Action Plan); and (3) advisory role in the reform of youth/centered serviced within the primary health care system. The entire project in BIH and Serbia is worth 7-10 million Canadian dollars.

The project includes and develops capacities in planning, implementation, monitoring and evaluation and not only in public health care system but also in relevant NGOs and organizations representing the youth. The project is implemented by the Canadian Society for International Health and the World University Service, Canada.

Project HOPE

With the support of Swedish Agency for International Cooperation and Development (SIDA), project HOPE initiated in January 2004 a three-year program to combat HIV/AIDS in Western Balkans. The aim of the entire program was to halt spreading of HIV/AIDS in the Balkans and to build capacities of the countries in the field. The program consisted of two prevention

components with the focus placed on the NGO work with local populations including risk populations, on care and support with the focus on clinic sector capacity building and the corresponding support by NGOs. Renamed as "Foundation Partnerships in Health", the program supports the work of XY (Sarajevo and Banja Luka), APOHA (support program for PLWHA, Sarajevo) and UG PROI (Sarajevo) and Viktorija (Banja Luka).

UNFPA

UNFPA works on promotion and improvement of sexual and reproductive health especially among adolescents, focusing on the development of adequate health care models in the field of sexual and reproductive health, including capacity building among health workers and reproductive health services, raising awareness on reproductive health and HIV/AIDS protection, provision of modern and safe contraceptives and other materials for reproductive health and systematization of monitoring and evaluation of health and development indicators.

UNFPA provides support to NGOs representing women's rights as well as NGOs working with young people. Earlier it provided substantial funding for YFSs; currently available funds for such support have finished.

World Health Organization (WHO)

WHO works in the area of capacity building and improvement of the contagious disease surveillance system as well as improvement of treatment protocols.

5. Conclusions and recommendations

Being low HIV prevalence country, Bosnia and Herzegovina is making a substantial process to address risks for HIV among youth, IDUs, SWs, MSM, Roma and refugee women, prisoners. However, this progress is not meeting the scale of existing demand and still a number of the conclusions and recommendations made back in 2002 or 2005 remain similar.

The existing limited data on most-at-risk groups, like IDUs, SWs, MSM, prisoners, (for their subgroups of adolescent age) from previous research and recent bio-BSS among IDUs indicate existing risky drug injecting and sexual behaviors. In national policies and some expert opinions youth aged 15-30, which constitute almost 25% of the country's population, is indicated at high risk for HIV and as underserved group. However other experts interviewed argue that there are their sub-groups which are particular vulnerable and that addressing HIV among youth at large should be done through general framework of sexual and reproductive health and rights and limited HIV resources should be focused at those at most risk for HIV.

Most-at-risk groups are mentioned in the policy documents but are not necessarily adequately addressed with national funding. Data on their sub-group of adolescent, so called most- at-risk adolescents (MARA), are even more limited. They are not given a special attention neither at policy level nor at service delivery levels.

Public health policy is coordinated at country level by the Ministry of Civil Affairs and two ministries of health at entity level. FBIH counts another ten cantonal ministries of health. This context is relevant enough to explain the difficulties faced by policy makers in implementing a data collection system and an effective epidemiological surveillance at country level. Bosnia and Herzegovina elaborated national strategies to respond to HIV and drugs but these strategies must be translated in action plans and need to be budgeted in order to be effective. Legislation on HIV and drugs is old – harm reduction services are still illegal at country level and different criminal codes at entity level determine huge differences in drug related crime statistics.

Harm reduction services expended in the last two years, but capacity building is still required for the NGOs operating in this field in order to increase the quality of intervention. VCTs and HIV treatment need to be developed as well (ART is available only in three cities).

GFATM gives a unique opportunity to develop HIV prevention services for most-at-risk groups (including low threshold prevention services for IDUs, SWs, MSM, Roma, prisoners). NGOs are responsible for more than 60% of the GFATM grant. GFATM targeted interventions for vulnerable groups are actually reaching mainstream youth. The national stakeholders have different opinions whether young people are underserved and those services are reaching those underserved young people. GFATM need to reassess the intervention and to make its focus on vulnerable populations and increasing their reach out through the interventions (beyond so far planned targets for MARP reached). Bosnia and Herzegovina plans to apply for a new round to further develop HIV services and infrastructures in the country, however the further international support should come also with BIH demonstrated policy changes (e.g. introduction of SRH in school curricular, making harm reduction completely legal, introducing mechanisms of buying services from NGOs and not only funding short-term projects).

In order to improve responses to HIV among most-at-risk adolescents and overall vulnerable

groups in Bosnia and Herzegovina, a set of actions around policy, research and services should be implemented.

Recommendations to policy makers

- Ensure a proper legislation at country level regarding drug use, addiction and the provision of effective interventions, such as harm reduction services and decriminalize drug users in order to allow access to health and social care for drug users
- Develop an action plan for the drug strategy with responsible stakeholders and adequate budget; specifically giving attention to injecting drug users, including adolescent, young, female and Roma IDUs , as well as IDUs in prisons
- Assess the effectiveness of the National Strategy to Prevent and Combat HIV/AIDS 2004-2009 in order to measure the progress and to eventually re-orientate it according to changes that appeared meanwhile and facilitate faster its implementation through action plan with long term budget planning
- Develop quality standards for HIV prevention services and promote good practice models at country level
- Build a legal framework to ensure prisoners access to health care based on the principle of equivalence: prisoners have the right to similar medical and/or social care as the general population
- Include most at risk adolescents as priorities in the present strategies on drugs and HIV/AIDS as a priority for HIV prevention and social reinsertion programs
- Introduce evidence based sexual and reproductive health education in public education system
- Enact buying services of NGOs and foresee increase funding in various services and sensitization programs for marginalized groups, including SWs, MSM, IDUs, Roma, prisoners
- Ensure that sexual and reproductive health and rights are high in the agenda and well integrated into health and youth programming
- Ensure implementation of Constitutional right to health in practice, in particular for underage people, prisoners, IDUs, SWs and Roma through legislation and funding mechanisms
- Together with other stakeholders (and using GFATM and other funds) improve the national decision-making and coordination in the HIV and drug fields in order to make them truly inclusive and operational

Recommendations to decision makers of health, social and prison systems

- Design guidelines on public purchase of services from NGOs, including HIV prevention, care and support services
- Gradually increase funding for services and sensitization programs for marginalized groups, including SWs, MSM, IDUs and experimenting/occasional IDUs, Roma, prisoners, as well as for sexual and reproductive health and rights in order to replace upcoming gaps of funding as international funding, including GFATM, phases out
- Organize a communication system in order to insure proper data collection and analysis on HIV and other sexual or blood borne infections
- Develop data collection system on drugs using EMCDDA guidelines (with special attention to drug related deaths)
- Develop quality monitoring models using international models adopted to national context

- Develop community services for ethnic minorities, especially for Roma, using good practice models in the region
- Ensure sustainable procurement of antiretroviral medications, including liquid pediatric formulation drugs and consider price negotiations with pharmaceutical industries
- Together with NGOs, introduce harm reduction services in prisons and together with services assess the drug use and sexual behaviors in prisons, as well as feasibility of linking prison and community services
- Ensure legal framework to allow wider medication options for opioid substitution therapy and sponsor drug treatment options for adolescents
- Increase knowledge on issues related to HIV, harm reduction, human rights, and at-risk populations among law enforcement and medical staff
- Increase capacity of professionals from health care and social sectors to provide services for at risk populations with a special focus on most-at-risk adolescents

Recommendations to NGOs and service providers

- Increase NGO and service providers' capacity in developing community outreach, low threshold and other harm reduction services for at-risk populations, especially IDUs, sex workers, Roma and prisoners, utilizing various aspects of NGO knowledge and skills in place (e.g. on M&E, service delivery) and paying special attention to promotion of those services in the relevant communities
- Strengthen cooperation of services providers and NGOs for advocacy as well as for increasing capacities
- Develop peer education programs for IDUs, SWs and prisoners
- Where possible, involve clients in service development (including planning, implementation, monitoring and evaluation) to ensure the best approach for their beneficiaries
- Advocate for an integrated legal framework in HIV prevention and care, as well as for financial involvement of state before the GFATM grant phases out in BIH
- Cooperate with expert fund raisers, public relations specialists and elaborate advertising strategies in order to actively involve private funders in HIV prevention using corporate social responsibility
- Promoting dignity and human rights of male and female at-risk populations in constant threat of discrimination, social exclusion, stigmatization
- Strengthen elements of existing services, such as: drug counseling through the YFS, gender sensitization and SRH in drug services, special attention to young and underage people from most-at-risk groups

Recommendations to multilateral agencies and donors

- Finance advocacy programs targeted on increasing cooperation among governmental structures and NGOs
- Provide technical support to NGOs in elaborating organizational development strategies and increasing management capacity
- Provide grants for study visits and internships for professionals working in harm reduction and overall HIV prevention and care field in the neighboring countries
- Build capacities of local partners (including governmental institution, civil society groups and service providers) to advocate and introduce effective HIV/AIDS and drug legislation, policies and strategies

- Support anti-discrimination campaigns focused on reducing negative perception of at-risk groups in general population
- Advocate and support national stakeholders in planning increasing in-country funds for addressing drug use, HIV and related issues
- Provide technical support to national stakeholders for building M&E systems, especially in drugs field, as well as HIV/STIs, health of marginalized groups and mobile populations

Recommendations to researchers

- Conduct national estimation on the size and characteristics of at-risk groups using the EU assistance in developing drugs information systems (data collection) – EMCDDA and similar positive experiences in the region
- Conduct a General Population Survey focusing on drug use at country level or, if not possible, at entity level
- Develop a comprehensive epidemiological system
- Estimate the number of SWs in BIH
- Help service providers to establish the impact and quality monitoring systems
- File effectiveness and cost-effectiveness of services for most-at-risk groups which could be used for advocacy for in-country funds for these services

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7. Appendices

7.1. Terms of Reference of Country Mission in Bosnia and Herzegovina

Background:
In June 2005, a new regional initiative **The Human Rights and Treatment Collaborative Networking on Drug Use and HIV/AIDS in South-Eastern Europe** (SEE Collaborative Network) was launched in order to develop and implement a regional strategy to improve the health and rights of at risk and vulnerable populations in relation to drug use and HIV/AIDS in this region. The SEE Collaborative Networking is built upon important work initiated by various networks and key players in the region, linking together related programs and projects. It focuses on filling the existing gaps and synergies and on maximizing organizational strengths. The network includes stakeholders (organizations, national networks, and individuals) from nine countries (Albania, Bosnia and Herzegovina, Bulgaria, Croatia, FRY of Macedonia, Kosovo, Montenegro, Romania, Serbia, Slovenia) who share common interests and values related to building relationships, sharing knowledge and learning. The SEE Collaborative Network will contribute to solving specific problems related to the health and rights of at risk and vulnerable population in SEE and will achieve individual and collective results at the regional level through sharing information and best practices, establishing different task forces and committees and developing cross-country projects.
One of the objectives of the project **"HIV prevention among most-at-risk adolescents in Romania"** developed with financial and technical support from UNICEF Romania is to increase the capacity building of Romanian Harm Reduction Network to offer support for other national harm reduction coalitions in order to strengthen the regional response for maintaining a long term, viable HIV/AIDS prevention, treatment and care services. This objective will be achieved through sharing experiences, lessons learned and best practices at the regional level, through identifying and documenting the needs related with HIV/AIDS and drug use and through promoting the HIV/AIDS prevention and specific treatment services for most at risk adolescents (MARA) priorities in the Balkans.
As part of this project, in October 15-19, 2007, one country mission will be performed in Bosnia and Herzegovina.

Objectives:
The main objectives of the country mission are:
• to collect data about most at-risk adolescents (MARA)
• to map the existent services for MARA
• to assess the availability of international and national funds for HIV/AIDS services
• to elaborate a general overview of the situation and the needs of at risk and vulnerable populations from Bosnia and Herzegovina.

Key tasks:
• Prepare and facilitate a plenary meeting with main local counterparts is planned to happen during the first day of each country mission. At the meeting will participate representatives of governmental institutions, nongovernmental organizations and international agencies from Bosnia and Herzegovina. The meeting will be organized with local support from NGO Margina, (partner in SEE Collaborative Networking) with UNICEF Country Office in Bosnia and Herzegovina.
• Prepare and conduct meetings on the field with stakeholders, representatives of NGOs and

beneficiaries (IDUs) in order to collect accurate and relevant data about HIV/AIDS and harm reduction services in Bosnia and Herzegovina.
The information collected will consist of demographic and behavioral data about MARA (IDUs), number and type of YFS in place at the community level, the coverage of MARA, the response of YFS to MARA specific needs (according to their age and gender), number and types of HIV prevention interventions for MARA etc. All this data will create the baseline for the development of the national evidence-based interventions (including advocacy).
• Prepare and deliver the report of country mission in Bosnia and Herzegovina. The report will include the results of the mission, as well as recommendations for national/local advocacy strategies (see the template for the report).

Deliverables:
• Agenda for the country mission;
• Materials to be used during the country mission;
• Resource materials collected during the country missions (e.g. national reports, national statistics etc – list of resource materials and copies, if possible)
• Final report of the country mission

7.2. Agenda of BIH Country Mission

Date	Time	Name	Institution	Cofirmed
October 15, 2007 - Sarajevo	**10.00**	Dr. Milka Dancevic	Federal Public Health Institute	√
	13,00	Jasmina Islambegovic	UNDP	√
		Dr. Ranko Petrovic	UNICEF	√
		Svetlana Durkovic	NGO Q	√
		Jasmina Islambegovic	UNDP	√
	14,00 LUNCH	Dr.Milka Dancevic	Federal Public Health Institute	√
	16,00	**Darko Paranos**	Youth and Health in Balcan	√
	17,30	Samir Ibisevic	NGO UG PROI Executive director CCM member	√
October 16, 2007 - Sarajevo	**09.00**	Dr.Ranko Petrović (CCM Member) Deborah Mc Winie	UNICEF	√

	10,00	Dr. Zlatko Čardaklija,	F BIH Ministry of Health, National coordinator for HIV/AIDS in Federation BiH, CCM member	√
	14,00 – LUNCH			√
	15.30	Željka Mudrovčić	UNFPA Assistant representative CCM Member	√
	17,30	Tijana Medvedec (CCM member) Irina Puvača	XY ; APOHA (NGOs)	√
October 17, 2007 - Zenica				
	08.30	Mirela Kadribašić Svetlana Mijuk	NGO Coordinator in PM Unit GFATM BiH Procurment officier in PM Unit GFATM BiH	√ √
	10.00	Svetlana Durkovic	NGO Q	√
	13,30	Dr. Lejla Čalkić	Head of Infectuos Disease Clinic Zenica Counselor HIV/AIDS	√
	14,30	Zeljko Karac	Head of the Police department for special tasks	√
	15.30	Nermin Golub	Association Margina	√
October 18, 2007 – Banja Luka				
	10.00	Dr. Zdravka Kezić	ARV Treatment Provider & Counselor HIV/AIDS	√

	11.00	Srdan Kukolj	NGO Action against AIDS, Head of office	√
		Dr. Natasa Loncarevic	National Coordinator HIV/AIDS Republika Srpska (UNAIDS focal point, CCM member)	√
		Jelena Medar	Ministry of Health and Social welfare of RS	√
	14.30	Gojko Vasić	Director of criminal police in RS	√
	16.00	Tatjana Preradovic	NGO Viktorija	√
	17.30	Željko Marjanac	NGO Poenta	√
October 19, 2007 – Brčko, Tuzla	**09.00**	Damir Radenković	NGO Vermont Brčko	√
	14,00 Lunch	Nataša Dedajić Executive director	Association Margina	√
	21,00	BACK IN SARAJEVO		