



Report of the Independent Evaluation of the HIV/AIDS Programme in Bosnia and Herzegovina

Final Report: January 2014

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¹ The names of people met are listed in Annex A.

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Abbreviations

AAA	Action Against AIDS
AI	Appreciative Inquiry
APMG	AIDS Project Management Group
ART	Antiretroviral treatment
ARV	Antiretroviral (medicines)
BBS	Bio-behavioural survey
BiH	Bosnia and Herzegovina
BSS	Behavioural sentinel surveillance
CBO	Community-based organisation
CCM	Country Coordinating Mechanism
COE	Council of Europe
CSO	Civil society organisation
DIC	Drop-in centre
DOTS	Directly observed treatment, short course: tuberculosis
ECDC	European Centre for Disease Prevention and Control
EU	European Union
FBiH	Federation of Bosnia and Herzegovina
FBO	Faith-based organisation
FP	Family planning
FSW	Female sex worker
GBV	Gender-based violence
GDP	Gross domestic product
GF	Global Fund for AIDS, Tuberculosis and Malaria
GNP	Gross national product
HAART	Highly active anti-retroviral therapy
HBV/HCV	Hepatitis B and C viruses
IDP	Internally displaced persons
ILO	International Labour Organisation
IOM	International Organisation for Migration
IPTCS	Integrated Prevention, Treatment, Care and Support
KAPs	Key affected populations
KAPSB	Knowledge, attitude, practices and behaviour
M&E	Monitoring and Evaluation
MHRR	Ministry for Human Rights and Refugees
MOF	Ministry of Finance
MOH	Ministry of Health
MOHSW RS	Ministry of Health and Social Welfare of the Republic of Srpska
MSM	Men who have sex with men
MTCT	Mother to child transmission
MHC	Municipal Health Council
NEP	Needle and syringe exchange
NGO	Non-governmental organisation
OSDV	On-Site Data Verification
OR	Operational research
OST	Opioid substitution therapy
PHC	Primary health care
PHI	Public Health Institute
PICT	Provider-initiated counselling and testing
PLHIV	Persons living with HIV

PMTCT	Prevention of mother-to-child transmission
PMU	Programme Management Unit
PPF	Programme Performance Framework
PR	Principal Recipient
PSE	Population size estimate
PWID	People who inject drugs
RBA	Rights-based approach
RDS	Respondent-driven survey
RS	Republic of Srpska
RSQA	Rapid service quality assessment
SDA	Service delivery area
SOP	Standard operating procedures
SR	Sub-recipient
SSR	Sub-sub-recipient
SW	Sex worker
TOR	Terms of Reference
TRP	Technical and Review Panel
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
UNOPS	United Nations Office of Project Services
UNTG	United Nations Thematic Group on HIV/AIDS
VCT	Voluntary counselling and testing
WHO	World Health Organisation

EXECUTIVE SUMMARY

Bosnia and Herzegovina (BiH) has a complex political and administrative structure. The Dayton Peace Agreement signed in 1995 retained BiH's international boundaries and created a joint multi-ethnic and democratic government (the Council of Ministers) charged with conducting foreign, diplomatic, and fiscal policy. Also recognised was a second tier of government comprised of two Entities roughly equal in size: the Federation of Bosnia and Herzegovina (FBiH) with cantons, and the Republic of Srpska (RS): each Entity has its own parliament. In 2000, Brčko District became a separate administrative unit under the sovereignty of BiH that remains under international supervision. In total BiH, between the two Entities and Brčko District, has three presidents and 183 ministries.

The country has a low-level HIV epidemic. HIV prevalence has not exceeded 5 % in any defined key affected population (KAPS) and the prevalence in the general population is below 1 %. Since the first registered HIV case in 1986 until the end of 2012 there were 222 HIV registered cases out of which 120 persons developed AIDS. The main mode of transmission for the period 1986 to 2011 is reported as heterosexual (56.1 %), followed by men who have sex with men (MSM) at 21.9 % and people who inject drugs (PWID) at 10.7 %. Recent data show increasing incidence in the MSM population, with 14 out of 17 (82.5 % cases registered for antiretroviral therapy (ART) in the first three quarters of 2012 occurring in the MSM population.

There is a mechanism at the national level that oversees and advises on the HIV/AIDS programme in the country. The National Advisory Board for Combating HIV/AIDS in Bosnia and Herzegovina (NAB) is chaired by the Ministry of Civil Affairs (MOCA) and was established in early 2002 with the task of developing a strategy to prevent and combat HIV/AIDS and further develop the planning and implementation processes in the field. It is comprised of representatives from different Ministries, civil society and international organisations. Each of the two Entities and the District of Brčko has HIV and AIDS National Coordinators to facilitate and coordinate the tasks undertaken by the NAB.

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) has been providing a significant level of funding to the HIV response since awarding the country its first grant in 2005. This grant focused particularly on scaling up HIV prevention among those populations most affected by HIV. This work continued through a second grant awarded under Round 9. Phase I has been completed; Phase II was awarded in 2012 and is currently being implemented.

The United Nations Development Programme (UNDP) was nominated Principal Recipient (PR) by the Country Coordination Mechanism (CCM). While UNDP is the implementing agent and responsible for the management of the HIV Programme, the overall ownership of the implementation of Global Fund grants rests with the Government of BiH and the CCM, where the MOCA is the key counterpart for UNDP at the national level together with the Federal Ministry of Health (FMOH) and the Ministry of Health and Social Welfare of the Republic of Srpska (MOHSW RS), as the two BiH Entity level ministries in charge of health issues.

To-date there has never been an evaluation of the national HIV programme in BiH. A Rapid Service Quality Assessment (RSQA) was conducted for the HIV/AIDS Global Fund grant in 2012 and a number of issues related to quality were identified. These issues and suggestions were in the areas of guidelines and protocols, provider practices and recording and reporting; and have been addressed.

Even though the national programme is making progress towards proposal goals, BiH is in need of an independent external evaluation of the national HIV and Global Fund grant programme because it needs to assess progress in order to ensure that the proposed interventions are achieving high impact in the most cost-effective manner. Accordingly, in November and December 2013, a team

from the Aids Project Management Group (APMG) conducted an evaluation of the programme since its inception. This involved reviewing documents, interviewing key informants both individually and through focus groups, and visiting Programme activities in Banja Luka, Bihach, Bjeljina, Brčko, Doboj, Kakanj, Mostar, Sarajevo, Tuzla and Živinice.

In order for a country to respond effectively to its HIV epidemic, it is essential that it understands what drives the epidemic and who and where the key populations at risk are. Under the Round 9 proposal, BiH has defined its target groups as the general population and key populations at increased risk of HIV infection; the key affected populations (KAPs) are MSM, PWID, SW and their clients, asylum seekers, refugees, prisoners, internally displaced persons (IDP), the transient population, young people and persons who live on or below the poverty line. Populations which are vulnerable to HIV also included persons exposed to HIV in a professional capacity; for example, healthcare workers who come into contact with bodily fluids as well as other professionals such as policemen, soldiers, correctional officers, fire fighters, rescue service officers and members of associations and foundations that provide harm reduction services. In addition, there is consensus that significant attention should be paid to the Roma population due to their marginalisation and youth - particularly adolescents and primary school pupils in rural areas.

However, one of the key challenges of developing an HIV programme that is targeted towards KAPS in BiH has been the difficulty in assessing the size of these populations; without a validated population size estimate it is difficult to assess if the coverage of KAPs has been sufficient. In order to calculate this, in 2012 a Population Size Estimate (PSE) survey was organised and implemented by a team of national specialists and international consultants. The monitoring and evaluation (M&E) units of the country's two public health institutes in FBiH and RS, as well as national non-government organisations (NGOs), were involved in the survey implementation process. However, the data obtained did not provide a national level estimate as required by the GF, hence it could not be validated by NAB.

Accordingly the APMG Evaluation Team, concurrently while conducting the evaluation, also undertook a data verification exercise to review the results of the former PSE and present its findings to both CCM and NAB meetings held on 14 November 2013. National stakeholders reviewed the PSE Report and consensus was reached on the size of KAPs.

Successes

Based on the availability of sufficient epidemiological evidence in BiH, it can be seen that the HIV situation in BiH has not moved from one of low prevalence to a concentrated epidemic. Given the risk factors that exist and will continue to exist, it is logical to place the reason for this on the existence of a strong national response to HIV and AIDS. The country has begun to introduce effective HIV prevention measures among key populations at risk, in particular, MSM, PWID, SW, truckers and mobile populations, prison inmates, and the Roma. These include provision of sterile injecting equipment and opioid substitution therapy (OST) through a network of government centres, drop in clinics (DIC) and outreach work; the provision of condoms and other services, including diagnosis of sexually transmitted infections (STI) and Hepatitis B and C and referral for treatment; and the provision of ART through Government ART centres. Services are delivered through a combination of Government services working in tandem with several NGOs.

The HIV Programme has become an unprecedented case of consensus building, bringing together and promoting collaboration among Government and civil society from across all three highly segregated political divisions (the FBiH, the RS and Brčko District) via the platform of NAB and the CCM. HIV is the only state-wide programme with its own Strategy (excluding TB) and one which provides a forum to bring together diverse stakeholders representing different sectors and interests.

If one were to evaluate the Programme from a pure 'value-for-money' perspective, the per capita cost would be expensive. However, it was designed when the country was still recovering from the effects of a war and within a broader framework of health system strengthening; as such, the HIV Programme has had crucial non-health effects, including political, peace-making and socio-economic (income-generating) impacts that cannot be easily measured – if at all.

The HIV Programme has provided a unique opportunity to create a system of anonymous and free-of-charge services bridging most hidden KAPs with the public health system. The engagement of Roma and MSM are seen as special successes since both groups are extremely stigmatised and ignored in society; the HIV Programme is the only intervention so far covering both populations. Stigma and discrimination towards most at risk populations is being addressed and attitudes are very slowly beginning to change.

The past seven to eight years of activities have seen changing attitudes towards, and an increase in, safer behaviour among targeted KAPs, especially PWID and Roma, and in particular as a result of harm reduction interventions. This higher level of awareness is also illustrated by the low number of HIV cases among KAPs.

Success in implementing the country's HIV response is largely attributed to the wise selection, cultivation, and activism of individual agents of change – such as specific Government staff, the UNDP PR and its leadership, and NGO leaders, who have effectively promoted all interventions (including quickly introduced and inclusive activities such as needle syringe exchange programmes (NEP), OST, voluntary and confidential testing (VCT) and antiretroviral (ARV) treatment).

The country has developed a cohort of well-educated, open-minded and experienced practitioners as a result of comprehensive training and education efforts within both Round 5 and Round 9 grants in both state and NGO sectors who will continue using their knowledge and skills after the completion of GFATM project funding; and this is seen as part of the process of sustainability.

Finally, the establishment of a national M&E database and the engagement of all stakeholders, including NGOs, in research and analysis, provide opportunities for increasing the effectiveness of the Programme.

Challenges

In spite of the successes of the Programme, a number of challenges remain. Perhaps one of the biggest obstacles to the future of the Programme is the prevailing and very strong stigma and discrimination against KAPs, particularly MSM and SW, by the general public and health care workers which is also fuelled by religious beliefs and leaders as well as the somewhat conservative and patriarchal nature of society in BiH.

The overall complexity of the administrative system in BiH, including considerable differences among the three political divisions and the impact this has on health service delivery, is a challenge to service delivery in terms of standardising guidelines and protocols and ensuring the sustainability of the Programme. The frequent turnover of Government officials negatively affects the consistency and stability of service provision. Moreover, the variation in the regulatory framework between the two Entities is an example of this. The criminalisation of drug possession and 'politicisation' of OST (OST was legalised as a medicine but there is no political commitment to support it after GFATM funding ends because of lack of funds as well as because different politicians play the OST card as 'legalisation of illegal drugs', 'threatening citizens' well-being', and so on). Both sex between men, and sex work, are illegal, although they clearly exist. This results in these groups feeling even more

isolated and 'hidden', and hence unwilling to access Government services run by staff who they may feel are judgemental and discriminatory.

There appears to be insufficient of coordination and collaboration among different stakeholders, including the sub-recipients (SR) – for example, there is no cohesive SR-wide training strategy or plan; hence there are lost opportunities to combine and maximise training efforts. However, at the same time there have been sudden staff cuts resulting in the number of staff of the PR's Programme Management Unit (PMU) being cut in half. Given the huge amount of work involved in the intensive programme grant management of a large number (12) of SR, the time of the PR staff is spread very thinly with barely enough time for monitoring and supervisory activities. This has resulted in under-resourced programmatic expertise at the PR level along with an under-resourced coordinating role for programmatic activities.

65 % of the HIV Programme is funded by the BiH Government, largely through service delivery (22 VCT centres and three ART clinics) and the purchase of ARV. The remaining 35 % of the Programme is supported by the Global Fund (VCT clinic staff, NGO work with KAPS including the DIC and outreach work that is so critical in reaching these populations with much needed services. However, there have been changes in the GFATM's funding modalities and priorities since Round 9 was approved. In today's economic climate which has also affected the Global Fund, it is hard to see how the Fund can continue to support a high middle income country with a low prevalence rate. It is clearly undesirable and unsustainable for the country to be solely reliant on one external funder. Nonetheless, there does not appear to have been much dialogue on programme sustainability at any level, while Government commitment remains weak to absorbing staff costs or supporting NGOs.

There is low coverage of VCT sites in terms of numbers and vulnerable populations visiting such sites; since HIV testing is only available through medical staff, and lack of rapid testing through NGOs (DIC and outreach workers), means that not enough KAPs are being tested.

Following the closure of the youth-friendly clinics at the commencement of Phase II and the inability of the Government to absorb their activities into either the formal or non-formal education sector, there appears to be an absence of any primary prevention among youth.

There is a lack of gender sensitivity in both service design and provision. All services are tailored to men except for the most recent DIC for female SW (as of June 2013). There are weak linkages with sexual and reproductive health (SRH) services, including family planning (FP). There appear to be no services for pregnant women (some of whom do not even receive prenatal care), children of female clients, violence prevention and protection; all of which lead to women's increased vulnerability. While Phase II clearly states that it is intended to 'feminise' services, integrate SRH and address gender-based violence (GBV) while tailoring services to the needs of female clients and addressing prevention of mother-to-child transmission (PMTCT) through provider-initiated counselling and testing (PICT), so far this has been slow to happen.

Although opinion differs, many interviewees cited the apparently poor availability of health insurance, especially among KAPs, along with the overall complicated nature of the health insurance system and societal ignorance about its requirements, resulting in limited medical coverage, especially when coupled with the poor capacity of people to understand and use the system.

A Hepatitis C epidemic is clearly on the rise with large number of cases detected but limited access to treatment. It is likely that Hepatitis B, closely linked with HIV and Hepatitis C, is also on the rise but there is a lack of Hep B testing kits.

With regard to the CCM, there are no thematic Working Groups to address programmatic concerns, M&E, sustainability and other specific issues in more depth. There is a need for wider representation of some target groups such as PLHIV.

Sustainability

While the location of VCT and OST sites within state public health care facilities could be seen as a weakness that prevents the Programme from reaching out to more KAPs, it is also a strong element of long-term sustainability of services. Procurement of rapid tests systems, however, is the weakness here as it is completely covered by the GFATM. The same relates to procurement of OST medication. A key aspect relating to the sustainability of the HIV Programme will be the willingness of the two entities and district governments to commit to procuring both rapid tests and OST medicines.

Prior to the evaluation, there had been no formal comprehensive discussion of sustainability of the HIV Programme and related services either at the country or local level, neither among Government nor civil society partners. However, some NGOs (e.g. Margina) have been proactive in their sustainability planning and see potential in developing such options as “localisation” of services via social contracting (funding) by the local government and social entrepreneurship. Yet the legal framework and mechanisms to facilitate this and other possible innovations are still to be developed. There is an obvious need to build advocacy skills among NGO stakeholders and support them in collaboration with local and division (FBiH, RS and Brčko District) governments.

The financial power of political divisions (FBiH, RS and Brčko District) varies, hence a variety of approaches to Programme sustainability should be developed, offered to stakeholders and integrated. No single scheme will work.

The CCM should be used as a platform for sustainability dialogues and transition planning.

There is a big risk of losing the positive impact of the Programme on Roma and MSM communities as both groups are highly discriminated and without external (GFATM) funding they will be left behind. The HIV Programme has opened some real opportunities for working with these communities and careful follow-up is needed.

Recommendations

Global Fund support to BiH has resulted in the country keeping its level of HIV infection low, and the elements are in place to continue this. However, the danger of relying solely on an external funding source and the likelihood that Global Fund support may not be forthcoming in the long-term means that the valuable gains of the past seven years may be lost if action is not taken now to ensure programme sustainability.

The Evaluation Team’s overarching recommendation, therefore, is that the country should develop a Transition Strategy with an accompanying costed Operational/Implementation Plan that sees the withdrawal of GF support over a five-year period and the introduction of a sustainable financing effort.

The Evaluation Team’s 12 main recommendations are presented in Box 1 below. While many of the following recommendations can be implemented regardless of whether or not a Transition Strategy is prepared, it is recommended that these proposals are addressed within the context of the Transition Strategy.

Box 1: Main Evaluation Recommendations

1. **Ensure sustainability** through the development of a Transition Strategy with an accompanying Operational/Implementation Plan, with costing, that sees the withdrawal of GF support over a five-year period and the introduction of a sustainable financing effort. Initiate a cross-country (cross-Entity) dialogue on sustainability and ownership of the Programme at the state(s) level through developing and promoting the CCM as an effective platform for such dialogue (including creation of thematic Working Groups as necessary). This means employing a context-sensitive approach and the development of multiple sustainability solutions/models for different political divisions, and identification of different options to work with diverse groups of KAPS.
2. **Strengthen the focus of the Programme's activities on those areas where it can make the most difference, viz. promoting HIV prevention among key populations and in particular scaling up work with MSM and Roma.** This will result in changing some activities, e.g. Partnership in Health to begin to analyse the collected data to feed results back into the system and inform service development and delivery.
3. **Strengthen HIV prevention activities among key populations by expanding services in ways identified by clients and service providers,** such as opening more DICs and mobile services, further strengthening the numbers of gatekeepers and outreach workers, and providing them with the capacity to deliver expanded services (rapid testing, SRH services and so on).
4. **Reduce late HIV diagnosis and encourage more uptake of HIV testing among key populations through introducing rapid testing** through NGOs, DIC, mobile services where possible, gatekeepers and outreach workers.
5. **Strengthen the national M&E database through development of a national strategy,** establishing a working group at sub-CCM/NAB level, reviewing the existing research base and any gaps in knowledge, developing a programme of operational research to create a solid evidence base to be used to inform the development of targeted interventions; including an assessment of existing data collection and how data are analysed and fed back into the system and to service providers.
6. **Conduct another Population Size Estimate (PSE) in 2014/2015,** aided and informed by the 2013 Census results and the PSE Manual provided by APMG.
7. **Implement a Capacity Building Review and Needs Assessment,** as the basis for developing a comprehensive Capacity Development Strategy with accompanying plan and timetable.
8. Assess past research on KAPS, stigma and discrimination, and other related issues to **inform the development of a strategy and implementation plan in Behaviour Change and Communication (BCC).**
9. **Invest in the advocacy and fundraising skills of local NGOs, as well as community mobilisation, to ensure future sustainability.** This Programme has had some real successes and there are several examples of best practice and lessons to be learned that could be applied elsewhere. Best practices should be written up and disseminated through publications, websites or other mechanisms.
10. **Advocate for the introduction of changes in legislation with regard to harm reduction, sex work, standardisation/certification of social services for KAPS and social contracting (state funding),** to encourage use of regular services by KAPS and encourage the development of social entrepreneurship for future sustainability.
11. **Assess how to integrate or ensure HIV service linkages with SRH services, including gender sensitisation of existing services and including capacity to address GBV.**
12. **Review best practices of youth-friendly services from Round 5, and Round 9 Phase I, and develop a strategy and implementation plan for reintroducing these.**

For more detailed discussion of these recommendations, see Section 5.

1. INTRODUCTION

Geopolitical, Governance and Socioeconomic Background

Geography

1.1 Bosnia and Herzegovina (BiH), one of the sovereign republics that constituted the former Yugoslavia, is located in the western part of the Balkan Peninsula and covers an area of 51,129 sq. km. It shares international borders with Croatia to the north, south and west, and with Serbia and Montenegro to the east. BiH has a 24-km stretch of Dalmatian coast, which includes the tourist town of Neum. The eastern and central regions of the country have a sub-continental climate with cold winters followed by hot summers, and the south-west coastal hinterland has a Mediterranean climate. Three quarters of Bosnia and Herzegovina belongs to the Black Sea Basin, a system of rivers feeding the Black Sea, which lies on the eastern side of the peninsula. The rivers of the remaining quarter of the country flow to the Adriatic Sea [Cain, J. et al, 2002]. It is a mountainous country with some hard to reach places.

Political History

1.2 In 1990, the first democratic, multiparty elections were held and in early 1992 BiH became an independent country. At that time, it had a multiparty democratic system and a 240-member parliament located in Sarajevo. In April 1992, Bosnia became a member of the United Nations (UN) and a member of the World Health Organisation (WHO). The planned transition from a socialist system to a market economy was interrupted by the war that commenced in April 1992 and continued until the signing of the *General Framework Agreement for Peace in Bosnia and Herzegovina*, also known as the *Dayton Agreement* in 1995 [*Ibid*].

1.3 It is difficult to appreciate the complex organisation of the health system in BiH without first understanding the impact of the war which shaped the country's socioeconomic situation and which, by extension, affects the present context in which health services – including HIV and AIDS services – are delivered. The war lasted from 1992 to 1995 and its profound consequences are marked by the large number of victims and an increased prevalence of previously uncommon diseases and disorders. The effects of the war on the health status of the entire population was reflected through many negative demographic trends, the increasing prevalence of chronic diseases and the spread of a number of unhealthy behavioural patterns, together with a significant amount of migration.

1.4 The current constitution of BiH forms an integral part of the Dayton Agreement. It established two Entities, the Federation of Bosnia and Herzegovina (FBiH) and the Republic of Srpska (RS). Under this constitutional construction BiH is a sovereign state with a decentralised political and administrative structure. In addition, the area of Brčko, in the north-east corner of the country, had already been settled through international arbitration when Brčko District was established in March 2000, with powers largely similar to those of the two Entities. Brčko District was not allocated to either Entity under the Dayton agreement and remains a separate, third authority within BiH. The state of BiH is the central authority but has only limited and specific powers whereas the two Entities and Brčko District are politically, administratively and legally fiscally autonomous to a large degree. The entities have their own respective constitutions and hold all responsibility not expressly assigned to the State by the BiH constitution. As a result, the country has three presidents and 183 ministries spread between the two Entities and Brčko District.

Figure 1: Political and Administrative Map of Bosnia and Herzegovina

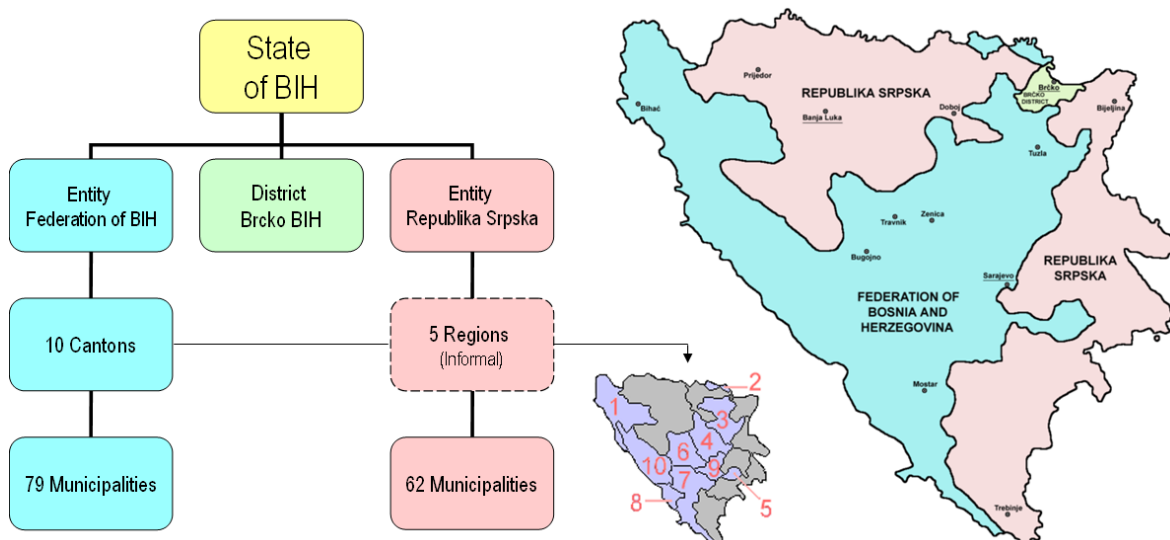


Governance

1.5 Today, BiH is a state with a highly complex and multi-layered political organisation. Constitutionally, four levels of administration, including health system governance, have been recognised (Figure 2 below) as follows:

- (i) State level;
- (ii) Sub-state level, consisting of two Entities, the Federation of BiH (FBiH) and RS, and one independent administrative district, Brčko District;
- (iii) Sub-entity level, consisting of ten formal administrative jurisdictions/cantons in FBiH and five geographical regions in RS; and
- (iv) The community level, represented by over 140 municipalities throughout BiH.

Figure 2: BiH’s Administrative Organisation



Source: Personal Communication with WHO Country Office, Sarajevo, 15 November 2013

1.6 Bosnia and Herzegovina has close to 30 political parties, some with a strong ethnic identity [*ibid*].

Socioeconomic Situation

1.7 Bosnia and Herzegovina is an upper middle-income country which has accomplished a great deal since the mid-1990s. Today BiH is a European Union (EU) potential candidate country moving toward alignment with EU requirements. Between 1998 and 2008 BiH experienced strong growth, with gross national product (GNP) per capita nearly quadrupling and a reduction in the poverty level from nearly 20 % to around 14 %.

1.8 However, despite this strong economic performance, the onset of the global financial crisis in late 2008 had a negative impact on BiH's economy, and is still affecting the country today. Despite the lack of recent data, there are indications that the progress in poverty reduction experienced up to 2007 has been stalled by the recent crisis. Poverty in 2007 was estimated at 11 % (US\$5 per day), with extreme poverty at 1.5 % (US\$2.50 per day). While more recent poverty estimates from the 2011 Extended Household Budget Survey are not yet available, other indicators, such as unemployment, suggest a deterioration in living standards due to the crisis and, as expected, a reversal in poverty reduction. More than 50 % of the population report receiving reduced remittances, and almost 40 % lower wages.

1.9 The main performance indicators of the social assistance system in BiH are poor by the standards of middle-income countries in Europe. Targeting accuracy is low, while the leakage of resources to the richest 20 % of the population is significant. Only a small proportion of the poor receive social benefits, and their poverty reduction impact is negligible. The *2010 World Bank Poverty Report* found that if these transfers were to be eliminated, the poverty headcount would increase by only 1.2 %. In contrast, the poverty impact of pensions is much higher; without these transfers, poverty would increase to 25.8 % of the population².

Population

1.10 According to the preliminary results of the 2013 Census the total number of enumerated persons is 3,791,622 with the majority living in the Federation (2,371,603), followed by the RS (1,326,991) and in Brčko District 93,028 [Agency for Statistics of BiH, 2013]³.

1.11 Ethnically, the composition of BiH society includes Bosnians (48 %), Serbs (37 %), and Croats (17 %). Religions practiced in BiH include Judaism, Islam (40 %), Orthodox (31 %) and Roman Catholic (15 %). The sex ratio in the country is estimated at 1.02 females per male [WHO, 2006].

1.12 Official unemployment stands at about 10 %. Unofficially, though, the figure could be as much as 40 %.

The Health System

1.13 The complex administrative structure of the country, as described in section 1.4 above, has adverse implications for the efficient organisation of the health system.

² <http://www.worldbank.org/en/country/bosniaandherzegovina/overview>; and World Bank Group Bosnia and Herzegovina Partnership Country Program Snapshot, October 2013.

³ It should be noted that the census results are only preliminary and may be subject to change.

The Pre-War Health Care System

1.14 Prior to the 1992 war, BiH was a member of the former Federal Socialist Republic of Yugoslavia, had a well-developed health care system comprising a large network of hospitals, public health facilities and a network of primary health care (PHC) centres, doctors' offices for ambulatory PHC services, and first aid and emergency service units. The country's population health indicators were comparable to other countries in Europe [Rifat A. *et al.*, 2007].

1.15 Although the health systems in former Yugoslavia shared similarities with those in the former Soviet Union countries (publicly financed and provided by salaried public employees, with free health care at the point of delivery), differences existed. The Soviet Semashko model of health was centrally managed with a large network of secondary care institutions and a fragmented PHC level — comprising a tripartite system of adult, children and women's polyclinics, and specialised dispensaries. In contrast, former Yugoslav states had substantial autonomy in the organisation of their respective health systems — with a strong PHC level and the involvement of local government [*ibid*].

Organisation and Management of Health Care after the 1992-1995 War

1.16 The war caused widespread physical damage and had a devastating effect on the country. Over 10 % of the population was killed or wounded and over two million people — nearly half the pre-war population — were forced from or chose to leave their homes and became refugees, either abroad or displaced internally within BiH. As a result of these population movements, community- and family-based social networks were seriously disrupted. Two-thirds of homes were damaged, with one-fifth totally destroyed. An estimated 30–40 % of hospitals and 70 % of schools were destroyed or severely damaged, and 30 % of health care professionals and a similar share of teachers were lost to death or emigration. The economic situation deteriorated rapidly during the war; the economy collapsed and the per capita gross domestic product (GDP) fell five-fold, from US\$2,429 in 1990 to US\$456 in 1995 [*ibid*].

1.17 The 1995 Dayton Agreement acknowledged the bitter ethnic divides that had led to war by establishing a government structure with a weak central state in which the ethnically based 'entities' retained political, military and economic authority as described in the previous section.

1.18 As a result, health care finance, management, organisation and provision in BiH are the responsibility of each Entity, while Brčko District runs a health care system over which neither Entity has authority. Bosnia and Herzegovina, therefore, has 13 ministries of health and 13 health systems for its 3.7 million people; one for the RS, one for Brčko District, one for the Federation level and ten cantonal ministries in the Federation of Bosnia and Herzegovina (one for each canton). In BiH there is no national or country-level mandate for health care financing and provision. [Cain, J. *et al.*, *op. cit.*].

1.19 There are significant differences in the organisation of health care in the different political areas. In the RS, authority over the health system is centralised, with planning, regulation and management functions held by the MOHSW RS in Banja Luka. However, in the FBiH, health system administration is decentralised, with each of the ten cantonal administrations having responsibility for the provision of primary and secondary health care through its own ministry. The FBiH's central FMOH, located in Sarajevo, coordinates cantonal health administration at the Federation level. This feature has obvious functional repercussions in terms of transaction costs, the coordination of decision-making at the Entity level, and other matters which are not faced by the RS.

1.20 The district of Brčko provides primary and secondary care to its citizens. Because of the small size of its population, the above-mentioned Agreement on Brčko states that each Entity is

obliged to pay health care contributions for pensioners, war veterans, invalids, displaced persons and others not otherwise insured in the Brčko District; and that entities will also cover unemployed citizens of the Brčko District until unemployment bureaus are created by the District itself.

Health Care Reform and Financing

1.21 With the end to the war in 1995, the BiH Government, with support from international organisations and multilateral agencies such as the World Bank, began a health reform programme to restructure its health system and to develop a basic health programme comprising: (i) PHC based on the concept of family medicine; (ii) a shift from the pre-war emphasis on large hospitals and polyclinics towards a more efficient use of outpatient facilities and home-based care; and (iii) a greater emphasis on cost-effective public health, disease prevention and control [Rifat A. *et al.*, *op. cit.*].

1.22 In the FBiH, the Health Care Law (2010) and the Health Insurance Law (1997), along with related by-laws and regulations, divided the responsibilities of the Federation and cantonal levels. The Federation level was given the authority to formulate policy and pass laws, and the cantonal level the authority to prepare local policies, implement laws, and be responsible for the financing and provision of health services. The Strategic Health Care Plan for the Development of the Health Sector in FBiH 2008-2018 (2008) articulated the objectives for health system reform [*Ibid*].

1.23 In the RS, the Strategic Plan for Health System Reform and Reconstruction, 1997–2000 identified key structural problems within the RS health system and articulated the need for health reforms whose objectives were stated in the *Health Policy Targets and Measures in Republic of Srpska by the Year 2020*, with corresponding actions identified in the *Law on Health Care (1999)* [*Ibid*].

1.24 Collectively, these reforms aimed to: (1) develop a sustainable and affordable health system; (2) introduce universal coverage for a ‘basic package’ of services to achieve equity and solidarity; (3) improve efficiency by better use of available resources and allocation of these to priorities through effective management; (4) increase the satisfaction of users and health professionals (higher quality health care with transparency and accountability); and (5) create pluralism and ownership by introducing a public/private mix [*Ibid*].

1.25 Special attention was paid to a new model of PHC centred on family medicine. In 2001, a new type of PHC was piloted in both Entities (FBiH and RS) and simultaneously introduced changes in parts of the health systems, namely: organisational structure and stewardship, financing, provider payment systems, service provision and resource generation. Changes to the stewardship function and organisational structures included the creation of a FMOH with the decentralisation of health services to Entity (in the case of the RS) and canton levels (with a Minister of Health for each of the ten cantons in FBiH). At the operational level, family medicine was established as a medical specialty and introduced into municipality health centres to provide PHC services. Autonomous family medicine teams (comprising a family physician and one or two family medicine nurses) were created. These could contract directly with the municipality health centres or through them with the newly created health insurance organisations (one in RS and one in each of the ten FBiH cantons) to provide health care services: a shift from state funded and fully staffed health care facilities. At PHC level, users were given the right to choose their family physicians [*Ibid*].

1.26 Direct budget funding was replaced with a mixed financing system through the introduction of health insurance to complement budget transfers from the state and local government. Provider payment systems for PHC changed from budgets to simple per capita [*Ibid*].

1.27 Changes in service provision were driven by the introduction of service contracts between health insurance organisations and PHC providers, which defined the scope of services delivered and specified the use of evidence-based guidelines (developed locally with international technical assistance and adopted in law). These set the standards for quality and were used for the accreditation of PHC providers; they also set out the list of essential equipment to be used to deliver services. The family medicine model extended the scope of services delivered in the PHC setting by family physicians and family medicine nurses to include health education, promotion, disease prevention interventions, expanded diagnostic and curative services, enabling the family medicine team to act as a gate keeper while providing more comprehensive and continuous health care services to its registered population [*Ibid*].

1.28 Despite a very challenging post-war context, resource constraints and professional resistance, within four years PHC reforms had some success and as a result were scaled up to cover 25 % of the population in FBiH [*Ibid*]. By law, most citizens should be entitled to health care and have compulsory health insurance coverage. In reality, many are not. A large number of the population in BiH is not covered by health insurance and cannot exercise their right to health care. For example, in 2009 28 % of people in the RS and 15 % of those FBiH did not have an insurance card. The largest number of uninsured people in the RS is company workers whose employers do not pay contributions to the health insurance fund. In FBiH there is an additional problem whereby unemployed persons who miss the deadline of 30 to 90 days for applying to the Unemployment Office lose their right to health insurance through the unemployment bureaus [EU, 2011].

1.29 Health care financing is seriously complicated by the administrative structure of the country, as described below [WHO, 2006]:

(a) In the FBiH:

- The cantonal health insurance funds finance health services, and the Federal Health Insurance and Reinsurance Fund (Solidarity Fund), founded in January 2002, addresses the problems of the highly decentralised system and surmounts the difficulties caused by disparate and unequal inflows of revenues in the form of the health insurance contributions of the cantonal funds (the differences between richer and poorer health insurance funds in the FBiH);
- The collection of funds is low and the movement of funds and patients is obstructed;
- The scope for redistribution of resources to those in need is greatly limited; and
- In 2006, the average contribution rate of 18 % of salary was split between the employee (13 %) and the employer (five %) [*Ibid*; COE, 2010];

(b) In the RS:

- The system is relatively centralised and exists at the Entity-wide level, whereas the Health Insurance Fund is comprised of eight branch offices (Banja Luka, Bijeljina, Dobo, East Sarajevo, Prijedor, Srbinje, Trebinje and Zvornik);
- Around 70 % of the population contributes to the Health Insurance Fund (with rates for different groups) through the compulsory social health insurance system; and
- There is no option for voluntary insurance but supplementary (extended) insurance is allowed for some extra benefits [*Ibid*];

(c) Brčko District has its own Health Insurance Fund which covers the whole district [COE, 2010, *op. cit.*].

1.30 Health insurance fund revenues fall significantly short of covering all legislated entitlements and, as a result, the funds have little control over budget-item spending or its impact on the quality and scope of services. The main shortcomings of the health financing system are:

- The low tax base and high tax burden, particularly in the Federation;
- Low tax collection rates;

- The ineffective inclusion of the self-employed and farmers as contributors to the funds;
- The large number of beneficiaries excluded from making personal contributions, and the widespread failure of intended contributors (extra budgetary funds and government budget) to do so;
- The increasingly large share of people who are not covered, especially among the unemployed whose numbers are growing and who do not officially register as such; and children, young people and Roma who fall out of the system as a result of low awareness/poor knowledge of existing procedures and contradictory regulations;
- Their highly skewed ability to generate revenues across cantons; and
- Small risk pools and their inability to exploit economies of scale [WHO, 2006, *op. cit.*; COE, 2010, *op. cit.*]:

The Status of the HIV Epidemic in BiH

1.31 Bosnia and Herzegovina is a low HIV prevalence country with an estimated HIV prevalence of <0.1 %. By the end of 2012, BiH had reported a cumulative total of 223 HIV cases to the WHO Regional Office for Europe and the European Centre for Disease Prevention and Control (ECDC), including 120 people who had developed AIDS. 81 % of the newly reported HIV infections in 2012 were among men. At the end of 2012 a cumulative total of two mother-to-child-transmission (MTCT) case had been reported (and this was in 2006) [UNAIDS, 2012; WHO, 2013]. Changes in the number of registered HIV cases, especially the last two years, show an upward trend. According to data from routine statistics and surveys, the most common cause of infection is risky sexual behaviour (78% of all registered). The highest number of infections is among people between 20 and 49 years of age, with the average age at infection being 31. The predominant mode of transmission in 2012 is heterosexual at 52 % (2011 56 %; 2010 56.5 %); homosexual/ bisexual 28.5 % (2011 22 %; 2010 18.9 %), and people who inject drugs 9.5% (2011 11 %; 2010 12.4 %) [UNAIDS, 2012; WHO, 2013].

1.32 During 2013, BiH reported a cumulative total of 245 HIV positive cases of which 126 have developed into AIDS. A total of 22 new HIV cases have been registered (16 men and six women), from which six developed AIDS. As of November 2013, 91 people are on ART in BiH and two more are being treated in neighbouring countries⁴.

HIV Prevalence

1.33 In 2010 the VCT centres reported 15 HIV positive cases out of total of 7,196 tests undertaken. However, only 6,365 of this total were informed of their HIV test results. In 2011, the VCT centres reported 32 HIV positive cases out of total of 6,011 tests. From this total, 5,497 were informed of their HIV test results. Given the ratio of populations tested in VCT and HIV positive cases, and given the over-representation of key populations at risk undergoing testing in VCT centres, this puts the likely prevalence rate of those tested at VCT centres between 0.1 and 0.5% [UNAIDS, 2012, *op. cit.*].

1.34 As of 2010, 41 facilities in BiH were offering HIV testing; in 2010, 19,897 people over the age of 15 were tested for HIV. Systematic HIV testing was carried out on blood donors and HIV testing was promoted on a voluntary basis for pregnant women. HIV testing is free and non-mandatory (except for patients requiring transfusion or organ transplantation). Pre-testing and post-testing counselling in BiH was established in 2005 through the VCT centres. In 2013 there are 23 VCT centres of which 22 are established and functional. VCT centres have increased the number of people coming in for tests; this is important since the increased availability and use of HIV testing is a

⁴ Personal communication with UNDP team, November 2013.

necessary pre-requisite for diagnosing and providing appropriate treatment and care to people living with HIV (PLHIV).

1.35 In BiH, treatment and care are provided free of charge to PLHIV. It is interesting to note that of the 48 people on ART in 2010, 39 (81 %) were male. Three health facilities based in Banja Luka, Sarajevo and Tuzla provide ART [WHO, 2013, *op. cit.*].

1.36 According to BiH reporting to ECDC, the number of AIDS cases in BiH has stabilised since 2002. With the introduction of highly active anti-retroviral therapy (HAART), the number of AIDS cases and deaths from AIDS seems to have slowed down, while the number of HIV positive cases has increased.

1.37 In the past few years, therefore, HIV infection has been kept under control in BiH. The goal of the *Strategy to Respond to HIV and AIDS in Bosnia and Herzegovina 2011–2016* is to keep the HIV rate at less than one % within the general population and less than five % in any of the KAPS; and these rates are being successfully maintained largely due to the GFATM HIV-supported programme being implemented in BiH. However, there are a number of factors that can stimulate the emergence and spread of the epidemic at any time – the disruption of the war; post-traumatic stress syndrome among those who fought in the War and their relatives, leading to greater violence to women and increased drug use; a conservative and largely religious society whose traditional views give rise to prejudice against KAPS; vulnerable populations who remain ‘hidden’ and are frightened to use services due to fear of being stigmatised or discriminated against; a large number of migrants and refugees from other countries in conflict, as well as many people travelling through BiH to get to other countries in the region; and so on.

1.38 Given the country’s low HIV prevalence, interventions are predominantly focused on the promotion of preventive behaviour in key populations at risk. The Round 9 Global Fund proposal described these as including the general population, key populations at increased risk of HIV infection (MSM, PWID, SW and their clients, asylum seekers, refugees, prisoners, IDP, the transient population, young people and persons who live on or below the poverty line). HIV vulnerable populations also included persons exposed to HIV in a professional capacity; for example, healthcare workers who come into contact with bodily fluids as well as other professionals such as policemen, soldiers, correctional officers, fire fighters, rescue service officers and members of associations and foundations that provide harm reduction services. In addition, there is consensus that significant attention should be paid to the Roma population due to their marginalisation and youth - particularly adolescents and primary school pupils in rural areas [UNAIDS, 2012].

Population Size Estimation (PSE)

1.39 One of the key challenges of developing an HIV programme that is targeted towards KAPS in BiH has been the difficulty in assessing the size of these populations. In order to calculate this, in 2012 a PSE survey was organised and implemented by a team of national specialists and international consultants. The M&E units of the country’s two public health institutes in FBiH and the RS, as well as national NGOs, were involved in the survey implementation process. The national experts’ working group agreed on a definition of KAPS subgroups as MSM being men who had sex with a male partner, both donor and recipient, in the past six months; PWID being people who have injected drugs at least once in the past month; and female sex workers (FSW) - women who were paid money in exchange for sex in the past year.

1.40 The survey was implemented in January 2012 in the cities of Banja Luka, Bihać, Bijelina, Brčko, Mostar, Sarajevo, Tuzla and Zenica. The NGOs covered the following KAPS: MSM [NGOs

Action Against Aids (AAA) in the RS, and Association XY (FBiH)]; PWID: NGOs UG PROI and Margina (FBiH), and Viktorija and Poenta (RS); and SW: NGOs AAA (RS) and UG PROI (FBiH).

1.41 At the same time as the APMG team evaluated the HIV/AIDS Programme, a PSE Report was also prepared and disseminated for discussion at a CCM meeting held on 14 November 2013, involving the National Experts Team, together with NAB members and other key stakeholders.

1.42 The Report made the following recommendations:⁵

1. The CCM should develop and recommend a unified approach to estimation (called a KAPS size estimation protocol) in order to: (i) define the frequency of the process (for example, biennially); (ii) facilitate close collaboration between Government, NGOs and international organisations; (iii) strengthen partnerships through establishing a National Consensus Team; and (iv) facilitate the support of local administration (the local health coordinating bodies) in the estimation process.
2. Coordinating bodies and implementers should follow a sequence of activities laid out by the KAPS size estimation protocol (for example, creation of a National Field Team, capacity building, developing and testing of national guidelines, data collection and analysis, follow up and dissemination of results).
3. Coordinating bodies and implementers should ensure the participation of the communities' at all the stages of the estimation process.
4. Before starting the estimation process, both the National Consensus and Field Teams should perform preparatory work on an individual level among SW and MSM in order to build consensus and ownership, and ensure these groups understanding of the process.
5. The timeframe for the national estimate of KAPS sub-population size should be sufficient to ensure that representative results are obtained.
6. While developing national guidelines for subsequent estimates of KAPS size, the foregoing should be taken into consideration.
7. Develop and implement a plan for necessary data collection on the national level to be used for various estimation methodologies.
8. Consider opportunities to use respondent-driven survey (RDS) sampling methodology during the next round of size estimation.
9. Bear in mind the possibility of including PSE survey questions in bio-behavioural survey (BBS) questionnaires and the synchronisation of these processes to significantly reduce the costs of estimation processes.
10. Consider using 'Unique Object/Event' and 'Network scale up' methodologies during the next round of size estimation.

BiH's Response to HIV and AIDS

Strategic Unity in Preventing and Combating HIV/AIDS

1.43 Despite low HIV prevalence, key stakeholders in BiH, including UNAIDS, believe that there are a number of factors that could stimulate the further emergence and spread of the HIV epidemic at any time. A brief summary of the risk factors that might lead to the spread of the epidemic is discussed earlier in the preceding section 1.37.

1.44 In 2002, as a response to the global HIV/AIDS epidemic and the UN Declaration of Commitment on HIV/AIDS, as well as other international documents, the Council of Ministers, with technical support from the UN Thematic Group for HIV and AIDS (UNTG), established the NAB chaired by the Minister of Human Rights and Refugees (MOHRR) and tasked to develop a strategy to prevent and combat HIV/AIDS and further develop the planning process for its implementation. NAB

⁵ The detailed PSE Report is available separately.

is made up of representatives from different Ministries and international organisations. Each of the two Entities and Brčko District nominated Entity HIV/AIDS Coordinators to facilitate and coordinate the tasks undertaken by NAB. In 2003, the CCM was established, with 33 members of the state, civil society organisations (CSO) and the UNTG; the CCM has initiated the preparation of, and actively contributed to, the development of all grant proposals to the GFATM. In addition to this key task, the CCM has played a crucial role in strengthening CSO capacities, community mobilisation and the inclusion of PLHIV, cooperation with other donors, and raising awareness among the various relevant sectors, especially among policy makers. CCM members and the procedures for their formal appointment are implemented by NAB. NAB also oversees the work of the CCM, and that of government institutions, NGOs and UN agencies in the field of HIV and AIDS [UNAIDS, 2012, *op. cit.*].

1.45 The first *Strategy to Respond to HIV and AIDS in Bosnia and Herzegovina for the period 2004-2009* was adopted in February 2004. The Strategy laid out the framework for the Government and CSO to plan and implement programmes in response to the goals for the country [UNAIDS, 2012]. BiH has been a recipient of GFATM support since Round 5 in 2006 and this has enabled the country to implement a comprehensive HIV response (as discussed in more detail in the sections below).

1.46 More intensive activities to implement the new *Strategy to Respond to HIV and AIDS in BiH for the period 2011-2016* were initiated in mid-2010, when NAB was requested to develop the new strategy. Strategy development was coordinated by the MOCA, together with the three Entity HIV coordinators and the UNTG. Significant contribution was made by the appointed representatives of the FMOH, MOHSW RS, the Department of Health in the District of Brčko, the Public Health Institutes (PHI) in the Federation and the RS, the Infectious Diseases Clinics in Banja Luka, Sarajevo and Tuzla, representatives of civil society and international organisations working with PLHIV [Ibid].

1.47 A key goal of the 2011-2016 Strategy is a gradual decrease in the number of newly infected and the creation of an environment that will ensure a long, qualitative and healthy life for all persons living with HIV. The Strategy's overarching goal is to maintain the HIV rate prevalence below the level of 0.01 %. There are six objectives: [Ibid]:

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

1.48 The VCT guidelines prohibit enforced testing; every test must have the client's informed consent, together with the signature of the counsellor. However, the labour law states that an employer can ask for an employee's health to be checked if deemed necessary; and an employee is obliged to inform the employer about his health status if it would affect his ability to work.

1.49 Harm reduction strategies such as NEP are difficult to implement, as injecting drug use is illegal in BiH. However, since 2006 the Government has approved NSE on a case-by-case basis for harm reduction programmes. Several NGOs have introduced needle/syringe distribution and collection of used needles/syringes in DIC in the RS, with some success. In 2008, the United Nations Children's Fund (UNICEF) supported the development of a national strategy to provide a legal framework for the implementation of harm reduction activities in BiH. The Strategy was adopted in March 2009.

2. GLOBAL FUND SUPPORT TO BiH

HIV Programme Round 5 (2006-2011)

2.1 Given BiH's complex administration, legal framework, decentralised health sector (with no state MOH) and low absorption capacity, in 2006 UNDP was selected by the CCM as the Principal Recipient (PR) for Round 5 of the GFATM HIV grant. The Programme was implemented in cooperation with the FMOH, the MOHSW RS and civil society. The title of the grant was 'Coordinated National Response to HIV/AIDS and Tuberculosis in a War-torn and Highly Stigmatised Setting' and it was successfully implemented in two phases: Phase I, November 2006 – October 2008; and Phase II, November 2008 – October 2011. The overall goal of the programme was to maintain the low level of HIV prevalence in BiH through increased access to high quality services and reduced stigma and discrimination with regard to HIV/AIDS. Implementation of this Programme has contributed to achieving this goal by ensuring earlier HIV diagnosis and enrolment in treatment programmes. The overall ownership of the Programme remained with the BiH Government and the CCM, while UNDP, as the nominated PR, has been responsible for the overall management of the Programme. The total grant budget was US \$ 10,870,928.

2.2 The Programme objectives of Round 5 were:

1. Scale-up information, education, communication/behavioural change, communications (IEC/BCC) and prevention education among youth;
2. Scale-up IEC/BCC in population groups with increased risk;
3. Improve access and quality of VCT;
4. Address HIV/AIDS and tuberculosis (TB) co-infection;
5. Improve harm reduction services;
6. Introduce HIV prevention into Roma communities and for former displaced persons; and
7. Provide universal free access to ART for PLHIV, treatment of OI, hospitalisation, psychosocial counselling and palliative care.

2.3 The main partners in project implementation were: the MOCA, the FMOH, the MOHSW in RS, the FPHI, the PHI in RS, and the NGOs Association XY, UG PROI, AAA, Association Viktorija, Partnerships in Health BiH, Margina, Poenta and World Vision BiH. The key results of the Programme, by objective, are summarised in paragraphs 2.4-2.17 below.

Objective 1

2.4 As a result of the Programme, more than 66,000 young people aged between 14 to 19 years old in elementary and secondary schools received peer education, while an additional 147,977 young people⁶ received information or were able to access information in informal settings. Healthy lifestyle education was introduced into formal education at schools. Both Entities (FBiH and RS) adopted aligned strategies with regard to youth and health. A *Strategy for the Improvement of Sexual and Reproductive Health (SRH) and Rights in FBiH 2010-2019* was adopted in 2010 and the RS is now in the process of adopting a similar strategy. Twenty-one health and information centres were established to provide youth-friendly health services across the country [UNDP/GFATM, 2012].

Objectives 2 and 5

2.5 A considerable number of legislative acts related to the issues of harm reduction were amended. In March 2009, the Council of Ministers adopted the *National Strategy for the Monitoring, Prevention and Elimination of Misuse of Drugs in BiH 2009-2013*. The RS had earlier adopted a similar strategy [*Ibid*].

⁶ As verified by the LFA, October 2011.

2.6 Seven OST centres working with methadone solution were established and have served 642 PWID. Suboxone was introduced in the country and some OST patients switched to Suboxone. Intensive campaigns were conducted, field work performed and training organised for health workers, all of which enabled the distribution/replacement of syringes and needles and the development of related guidelines. As a result, by August 2011, 2,705 persons were being covered by NEP [*Ibid*].

2.7 In order to measure the level of practical results, two behaviour studies were conducted, accompanied by HIV and Hepatitis B and C testing. The studies were conducted at two-yearly intervals, in 2007 and 2009. There were significant differences in terms of those who were not sharing injecting equipment during the past month – 79 % in 2009, compared to only 27 % in 2007. An estimated number of those familiar with an organisation working on HIV prevention among PWID in their town also increased. Only 15 % of them knew about such an organisation in 2007, compared to 43 % in 2009. In this regard, those who received sterile injecting equipment from an NGO increased from one % in 2007 to 14 % in 2009. In addition, the number of those stating an NGO as a key source of provision of injecting equipment increased from zero % in 2007 to four % in 2009. A rough estimate of PWID calculated that there were 7,500 (between 6,000 and 10,000). In terms of incidence, HIV transmission among PWID dropped to third place [*Ibid*].

2.8 This research also showed that Hepatitis C is still a major problem among PWID with 20 % in Zenica having Hepatitis C and 50 % in both Banja Luka and Sarajevo [*Ibid*].

2.9 In 2005, 483 men were included in an HIV prevention programme; by the end of October 2011, this number had risen to 3,639. In addition, only 210 SW were covered in 2005, and by the end of the Programme this number had risen to 1,034⁷. The best results are evident among prisoners since, compared to the initial 100 prisoners in the Programme, 1,138 prisoners were reached by its end. All of the indicators set in 2005 were either reached or exceeded [*Ibid*].

Objective 3

2.10 A joint counselling and testing protocol was developed, while the pre-existing diagnostics and treatment guidelines were used as a starting point for the development of the new protocol. Training manuals were developed, education organised and VCT centre staff were trained. At the same time, media campaigns about VCT were aired [*Ibid*].

2.11 By the end of the Programme, a total of 19 VCT centres were established and new ones were in the process of opening. The design of VCT services was based on their decentralisation and with the aim of bringing VCT centres closer to users. As a result, by the end of October 2011, 28,178 persons had received counselling and testing services through VCT centres, while, in 2010 only, 8,054 people were covered by services provided by VCT centres. Another 122 health workers were trained as VCT advisors [*Ibid*].

Objective 4

2.12 TB and Hepatitis (B and C) remain the most common co-infections in BiH and prevalence rates for TB are as high as 50 % among PLHIV. BiH is well aware that TB constitutes a major public health threat to the country and, given its high incidence in BiH compared to other European countries, TB was given a particular focus within the HIV Programme (as well as being addressed through another GFATM grant covering TB directly under Round 6). Greater cooperation between infectious and pulmonary disease clinics was promoted and the referral systems between these institutions enhanced. All PLHIV were screened for TB and TB prevention medication was provided.

⁷ *Ibid*.

A diagnostic and treatment manual was developed and approved by the ministries of health of the two entities and the health authority in Brčko District. Eleven one-day workshops on HIV/TB co-infection were organised for staff working at pulmonary hospitals, and ten training workshops were organised for Red Cross staff [*Ibid*].

Objective 6

2.13 There is considerable variation in the estimates of the size of the Roma population and one estimate calculated that there could be as many as 80,000 people. In the Roma communities certain life style choices, traditions and customs increase risks of HIV and STI transmission. Hence it was decided to focus on a comprehensive IEC programme with Roma communities under this Objective [*Ibid*].

2.14 The Ministry for Human Rights and Refugees (MHRR) developed an Action Plan to Address Roma Issues in the Areas of Employment, Housing and Health Care (Sarajevo, 2009). Through the HIV Programme, the NGO World Vision participated in the development of the Action Plan. Working with the MOHRR, World Vision and the PMU have managed to ensure that two priority programmes within this Action Plan refer to HIV and other STI, as well as TB prevention. Field or outreach workers have reached 9,873 Roma women through this prevention programme in Banja Luka, Bihaće, Gradiška, Kakanj, Prnjavor, Srebrenica, Sarajevo, Tuzla, Visoko, Vitez and Zenica [*Ibid*].

Objective 7

2.15 Even before the start of the Programme's implementation, there were two organisations in BiH that were working with PLHIV and their families; (i) the Association for Support to Persons and Families of Persons Living with HIV/AIDS (Asocijacija za podršku osobama oboljelim od HIV-a/AIDS-APOHA), registered at the national level but working primarily in the FBiH and Brčko District; and (ii) Action Against AIDS or AAA, working in the RS. These NGOs provided psychosocial support within a programme for PLHIV. In addition, prior to the inception of the Round 5 Programme, HAART was provided throughout BiH and covered through Entity-level health insurance funds [*Ibid*].

2.16 At the beginning of the Programme, 14 PLHIV were using HAART. By the end of 2010, of the 66 PLHIV, 48 persons were on ART, and 18 were being monitored on an ongoing basis but as yet had not reached a stage whereby they needed HAART. By the end of the Programme, 61 people were receiving HAART. In the beginning, all persons were prescribed ART since they had been diagnosed late in the disease's progression and were already symptomatic; however, towards the end of the Programme a large number of asymptomatic PLHIV were identified at an earlier stage of the infection. Early in the Programme, only a small number of patients would survive a year from the discovery of the infection, whereas by the end of the Programme the number of those surviving the first year was 93 % of those infected. The treatment guidelines were amended in accordance with the most recent WHO guidelines. The Programme also equipped all three clinics treating AIDS patients with the ability to monitor CD4 cells [*Ibid*].

2.17 Other overall achievements of the Round 5 Programme included [*Ibid*]:

- Good planning and due attention paid to the Performance Framework;
- A sympathetic and positive response and in-kind support to PLHIV (wood, provision of used IT equipment and so on);
- Of 15 coverage indicators, ten exceeding 100 % were achieved while three indicators exceeded 90 %, one indicator exceeded 80 % and the last, 70 % implementation;
- There was a good match of capacities with objectives; and
- The Round 5 HIV and the Round 6 TB Programmes were well matched, even though no SR was selected for Objective 4, 'Reduce HIV/AIDS Co-infections with Tuberculosis'.

HIV Programme Round 9 (December 2010-November 2015)

2.18 In addition to ongoing projects supported by other international organisations, in 2009 and 2010 UNDP provided support to BiH's national institutions, experts and NGO representatives, and through the CCM developed two successful GFATM applications for Round 9 HIV and TB prevention and treatment programmes.

2.19 As in the previous GFATM HIV grant under Round 5, the approved Round 9 HIV/AIDS GFATM Programme in BiH is based on harm reduction principles, including community outreach, peer-based education, diversified drug treatment services, condom distribution and promotion, addressing stigma and discrimination and providing psychosocial support to PLHIV. Through the implementation of these activities, UNDP, the MOHSW in the RS, the FMOH and local CSOs, together with UN partners such as the Joint United Nations Programme on HIV/AIDS (UNAIDS), UNDP, UNICEF and WHO, seek to strengthen and scale up existing services to ensure country-wide coverage of effective health services, while supporting the development of a national M&E system. In the reporting period multi-sector cooperation had significantly improved, resulting in the greater involvement of civil society in the policy-making process through increased civil society representation in the CCM and NAB.

2.20 Implementation of the Programme was divided into two Phases with timelines and budgets as follows⁸:

Round 9 Phase I:	December 2010 - November 2012	(US \$ 14,965,778,83)
Round 9 Phase II:	December 2012 - November 2015	(US \$ 16,249,519,89)

2.21 The Round 9 proposal was a re-submission of BiH's HIV proposal submitted under Round 8. The Technical and Review Panel (TRP) comments on the Round 8 proposal were taken into account and addressed through additional information and activities in the Round 9 proposal. The goal, objectives and most of the interventions and targets remained the same, but with a greater emphasis on capacity building, M&E, and KAPS such as Roma, returning refugees and migrants.

2.22 The Programme builds on the achievements of the HIV Programme to date, including those of the GFATM Programme funded under Round 5 as well as the Government-supported elements. Five objectives were identified:

- 1. Maximise coverage of effective HIV prevention and care among most-at-risk populations** promoting the shift from HIV awareness-raising among the general population to a more comprehensive approach to supporting ongoing HIV prevention in environments where people are most at risk to HIV. Effective HIV treatment and care for PLHIV from marginalised populations is a key prevention strategy.
 - The Programme seeks to assist PWID by increasing their access to VCT and primary care, and scale up specific harm reduction activities by Year 5 to provide: (i) OST for 1,450 PWID and (ii) access to IEC and NEP for 6,839 PWID (including those on OST). Special attention will be paid to reducing access barriers for female drug users.
 - For SW, the Programme will scale up activities by Year 5 to: (i) target the environment in which SW work, including owners of bars, night clubs, motels/hotels and similar facilities, as well as SW's clients; (ii) remove barriers to access to STI diagnosis and treatment, VCT, maternal and child health (MCH) and primary care; and (iii) ensure regular access to IEC and condoms for 2,127 sex workers.
 - A range of behaviour-based approaches are used to target MSM. Support will be given to emerging community-based organisations (CBO) to provide DIC, outreach IEC, and condoms

⁸ Personal communication with UNDP PR team, November 2013.

and lubricants for MSM. MSM will also be targeted through STI services and outreach to sex sites (Internet and clubs, and so on). These interventions will result in reaching 4,326 MSM by the end of Year 5.

- With regard to prisoners, average prison terms are brief in BiH, meaning that this population is constantly being replenished. Current activities provide education and limited access to prevention in prisons. Under this proposal, these activities are being scaled up and institutionalised within the Ministry of Justice, reaching a further 2,100 prisoners throughout the life of the project. Trials will be conducted of specific HIV prevention activities addressing the needs of drug users and others at highest risk for HIV. Pre- and post-release programmes will be established and integrated with prison HIV prevention and care activities (especially drug treatment).
 - The Programme also focuses on vulnerable youth, particularly those among the most-at-risk populations, with youth-friendly SRH and social services, and institutionalisation of life skills education for in-school youth⁹.
 - Finally, activities for the Roma population, returning refugees and migrants will be scaled up, focusing on female members of these communities, through VCT promotion and removing barriers to access to HIV prevention and care.
2. **Ensure appropriate prevention, treatment, care and support for PLHIV:** PLHIV groups will be assisted to provide information and support to their own communities, and to increase their involvement in the response to HIV. MCH services will receive support to integrate HIV risk assessment and VCT into antenatal care. Clinical guideline development, currently underway, will form the basis for strengthening clinical services and capacity building to build the ability of the HIV prevention, treatment and care workforce through expanded access to HIV training for nurses and doctors. Linkages with existing programmes, particularly the TB programme, the MCH programme, drug treatment programmes and centres for social work, will be strengthened together with attention to diagnosis and treatment of Hepatitis C co-infection.
 3. **Strengthen the enabling environment for the scaling up of HIV prevention and care:** A formal review of existing legislation has been carried out and technical assistance will be provided to support the adaptation of existing policies and/or the development of new policies and/or legislation to address gaps and conflicts between policies. In Phase I, grants to CBO, faith-based organisations (FBOs) and faith leaders were provided to undertake stigma reduction programmes with their communities. A forum was held in Year 1 of the Programme to develop strategies to support FBOs and leaders in stigma reduction.
 4. **Strengthen the capacity of coordinating and implementing agencies to respond to HIV/AIDS:** The Round 5 GFATM HIV grant demonstrated a significant need for a long-term capacity building programme to support both government and NGO agencies. This will involve mentoring and real-time problem-solving for effective and sustained skills transfer, as well as the development of the national systems required to support the HIV response. Health services have been provided with substantial capacity building to ensure service access for most-at-risk populations to integrated prevention, treatment, care and support services. A capacity development centre will be set up in each Entity to support established and emerging CBO in scaling up prevention and care activities with most-at-risk populations. The technical quality and consistency of the response to HIV in BiH has been strengthened by the establishment of four national technical guidance committees on the following issues: (i) fostering an enabling environment for HIV prevention and care; (ii) vulnerability reduction for populations most at risk; (iii) HIV treatment, care and support; and (iv) M&E. The

⁹ According to the Phase II Request for Renewal; however, these activities were subsequently dropped, as described later in this report.

Programme will enhance service providers' capacity to generate and analyse information by providing annual training programmes on second-generation surveillance, indicator development and M&E.

5. **Ensure blood safety:** Training for health and medical workers on blood safety, the procurement of health commodities for blood safety programmes and public awareness-raising activities have been conducted. Key facilities have been equipped for improved blood safety. The Programme is working to establish three reference laboratories with one key laboratory in each of the administrative units.

Phase I

2.23 Phase 1 of the Programme (2010-2012) helped strengthen institutional and technical capacity at the national level (particularly of key government agencies and NGOs), foster strategic planning and coordination, improve information management systems, and advocate for enabling legislative and policy frameworks. UNDP continued to act as the PR, collaborating with several Government bodies and eight NGOs (AAA, Association XY, Margina, Partnerships in Health, Poenta, UG PROI, Viktorija and World Vision), two international organisations, the International Labour Organisation (ILO) and IOM, and one academic institution (the Faculty of Medicine) as SRs, and one sub-sub-recipient NGO (APOHA). The organisation's name and target key population group are listed in Table 1 on the next page.

2.24 The overall performance of the Programme during the progress update period was outstanding, with a Top Ten indicator rating of 'A1' (115 %) and an average performance rating for all indicators of 'A1' (114 %). This is an improvement over the previous reporting period, when the top ten indicators were rated 'A2' (96 % average performance rate) and the average performance rating for all indicators was 'A2' (100 % average performance of all indicators). Achievements were made across a range of 14 indicators, out of which 12 are rated with the highest ranking, with no indicators rated at a 'B2' or 'C' level. The targets for the 12 indicators were in fact exceeded¹⁰.

2.25 Two indicators that had under-achieved during the previous reporting period improved significantly as a result of strong intervention from the PR to address the weaknesses. The number of KAPS (adolescents, MSM, prisoners, PWID and SW) reached with HIV prevention increased noticeably from 42 % (the average) during the previous reporting period to around 120 % during the second semester of 2011. Greater numbers of Roma, migrants and refugees were reached with HIV prevention activities as the three HIV information centres became fully functional. During the reporting period, World Vision (one of the SR) opened three HIV centres for the Roma population and reached 2,371 people. All persons in need of ARV are receiving treatment. 63 persons were put on ARV treatment as opposed to the 50 planned, thanks to a larger coverage by the VCT services. During one of the last On-site Data Verification (OSDV) covering the period December 2010 to June 2011, the Local Fund Agent (LFA) verified three indicators in five sites and rated all indicators with an 'A'.

2.26 The overall rating from the Grant Rating Tool was 'A1' but, due to some weaknesses in financial reporting, the disbursement was downgraded to 'A2'¹¹.

2.27 Under Phase I, new VCT, DIC and Detox centres were refurbished and equipped with the most needed furniture and IT equipment, which enabled their members to perform their activities with more quality and without technical obstacles. These centres are mainly within the PHI which ensures sustainability of the established activities. All members who provide services to clients

¹⁰ BiH CCM Request for Renewal of HIV Grant, Phase II Round 9, November 2012

¹¹ *Ibid.*

received training on their role and the activities to be performed. The most important fact is that all public service providers who deliver services to KAPS understand the importance of their roles and the need to report regularly on a monthly basis. Activities in 2011 and 2012 resulted in an improved quality of work as well as enhanced quality of reported data. All activities resulted in not just more accurate data on HIV and AIDS patients, but also an increased number of detected HIV+ cases in BiH in comparison to 2010¹².

Table 1: List of Sub-recipients and Target Populations

Federation of BiH		
Name of Organisation	Target Population Phase I	Target Population Phase II
APOHA	PLHIV (psychosocial support, provision of essential supplies)	As Phase I
Association XY	MSM Prisoners Youth	MSM Prisoners
Federation of BiH Public Health Institute	Operational research (OR), BBS, OST treatment, and monitoring of OST centres M&E reporting,	As Phase I
ILO	Policy Development	Policy makers and labour inspectors (Phase I only)
IOM	Migrants Mobile populations	As Phase I
Margina	PWID	PWID PWID in prison SW Youth (Phase I)
Partnerships in Health	PLHIV (training for health – gynaecologists, nurses -and non-health – social workers -service providers, including on occupational exposure; refresher training; provision of essential supplies (vitamins, wood, etc.); PMTCT, VCT including refresher training for VCT counsellors)	As Phase I
UG PROI	PWID SW	As Phase I
World Vision	FBOs Roma	As Phase I
Republika Srpska		
Action against AIDS-	MSM PLHIV (psychosocial support, provision of essential supplies (vitamins, food, wood, etc.) SW	As Phase I
Poenta	PWID	As Phase I
RS Public Health Institute	OR, BBS, OST treatment, and monitoring of OST centres, M&E reporting	As Phase I

¹² *Ibid.*

Viktorija	Prisoners PWID	As Phase I
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Source: Personal communication with UNDP team, November 2013.

2.28 In parallel, government SR were supported to implement activities related to conducting situation analyses and surveys, and the organisation of training. Much time and effort was invested in the PHI and new SR, with the aim of enabling them to implement programme activities smoothly. The PR participated in SR project management teams meetings, where suggestions were given on project implementation and management. Furthermore, financial and programmatic monitoring of all SR (through checking all expenditures and invoices) is conducted monthly/quarterly on a regular basis, and this practice will continue under Phase II¹³.

2.29 The PR succeeded in completing almost all Programme activities planned for this period. Due to the fact that the quantity indicators had been reached, the PR worked on strengthening the quality of work and services offered to clients, such as care and support to PLHIV. For example, under Objective 2, the HIV Programme also offers incentives (living support that includes support in the shape of vitamins, firewood, food, drugs, and clothes) to PLHIV that fulfil criteria established by the National HIV and AIDS Coordinators¹⁴.

2.30 In order to guide programming, gaps in strategic information about KAPS were addressed in Phase I through a range of qualitative and quantitative research initiatives. The research conducted resulted in more accurate population size estimates for KAPS, and investigated the barriers to accessing HIV prevention and care. Activities in 2012 were devoted to further improving activities among KAPS with the aim of quality assurance¹⁵.

Phase II

2.31 The description of Programme priorities under Phase II provided below is extracted from the BiH CCM Request for Renewal of Round 9 HIV Grant in November 2012 and remains mostly unchanged, with some minor edits:

Objective 1: Maximise the Coverage of Effective HIV Prevention and Care among Most-at-risk Populations

People Who Inject Drugs

2.32 Four NGOs provided NEP to PWID in Phase 1. Two covered FBiH (Margina and UG Proi), while in the RS NEP were operated by Poenta and Viktorija.

2.33 Through their activities the field workers and secondary mediators (gatekeepers and peer educators) distributed sterile injecting material and condoms, as well as providing counselling, field education, promotion of HIV testing and testing for other STI. DIC for PWID established in Phase I will continue to operate under the second phase: Bihaće, Brčko, Mostar, Sarajevo, Tuzla and Zenica in the FBiH; and Banja Luka, Bijeljina, Doboj, Prijedor and Trebinje (which will be reconstructed in the extension period) in the RS.

2.34 In Phase II, the Programme will focus on the prevention of both parenteral and sexual transmission of HIV among PWID through the following activities:

1. Increase coverage of harm reduction programmes for PWID, both geographically and within PWID communities;

¹³ *Ibid.*

¹⁴ *Ibid.*

¹⁵ *Ibid.*

2. Expand the content and range of services to be provided;
3. Enhance the quality of services and strengthen quality control;
4. Facilitate the integration of services provided at the community level with medical facility-based services,
5. Advocate public health and drug policy reform to address existing constraints in scaling up harm reduction for PWID; and
6. Effectively prevent further sexual transmission of HIV through implementing HIV prevention services for the sexual partners of PWID.

2.35 In parallel with the increasing availability and quality of prevention services for PWID planned during Phase 2, there will be an increase in the target number of new PWID to be reached. Increasing the coverage and variety of services means a commensurate increase in staff such as outreach workers and gatekeepers who are directly responsible for implementing field activities. In some cities, there is more than one NGO working in the same geographical location; Mostar, for example, is a city divided into two parts and each part has duplicate structures and institutions such as hospitals, schools and so on.

2.36 Outreach work will be extended to new geographical locations to reach PWID who had never previously accessed services, especially in rural areas and small towns. Service provision to address clients' essential needs and facilitate their access will be provided through outreach and DIC. The delivery of this expanded package of services will include NEP and prevention through outreach work and DIC; condom distribution; provision of specialised assistance and counselling/advisory services through psychologists, social workers and lawyers; peer counselling and education; motivational counselling; safer behaviour workshops; participatory development; distribution of IEC materials; case management; VCT referral; and other health services.

2.37 To increase and maintain regularity of access to services, the Programme will provide services tailored towards various subgroups of PWID with a particular focus on gender and youth-sensitive services offering services for female and young PWID. For female PWID, interventions will additionally provide specific SRH services, including family planning (FP). Particular attention will be paid to tackling issues related to GBV.

2.38 At least 100 pharmacies will be involved in the delivery of harm reduction services. A new model of peer-driven interventions will help to reach new PWID subgroups such as young and/or female PWID, and stimulant users. The Programme estimates that under Phase II, as a result of these activities, coverage of PWID clients should increase by between 10 to 15 % at the very least.

2.39 Outreach work will be implemented by outreach workers, peer educators and gatekeepers who are familiar with the sub-culture of drug users through either their professional experience of working with this population, or through personal experience of drug use (by themselves or a family member). It is believed that services providers who actually come from these groups are able to establish better contact with clients, overcome barriers and lack of trust, and influence behaviour change. In particular gatekeepers, through their own adoption and acceptance of safer models of behaviour, will be able to provide assistance to outreach workers in reaching hidden populations of addicts and establishing first contact more easily.

2.40 Phase II is not only concerned with broadening the coverage of prevention activities; the Programme will make an effort to ensure sustainable funding through further strengthening inter-sector and multi-sector cooperation. Ownership of the country's HIV Programme will not only help towards the Government's longer term support of the Programme, but will also help the Entities and Brčko District to change the general population's attitudes and behaviour towards PWID. Moreover, since such collaboration will involve different institutions, organisations and Government

departments in Programme activities, a better enabling environment for PWID will be fostered – one that addresses their human rights, medical care and future service sustainability. Interventions in this regard include:

- Development of a policy document on harm reduction;
- Standardisation of the package of services for DIC and outreach work;
- Accreditation of services and service providers;
- Analyses of the cost-effectiveness of harm reduction services;
- Developing a process of negotiation with different level of government;
- Developing tools and methodologies for the process of transferring Programme jurisdiction as a model for sustainable service delivery; and
- Organisation of thematic meetings to develop capacities among Government and NGO service providers to move towards a non-UN PR and better equipped ministries to ensure sustainability of quality services.

2.41 Annually under Phase II, 20 peer educators will be selected from among PWID in FBiH and trained by the NGO Margina with the aim of increasing access to hard-to-reach PWID. The training will cover HIV and AIDS, hepatitis, sexuality, drug use, how to reach clients and motivate them to change their behaviour, methods of active listening, non-judgmental communication with clients, questions of confidentiality and the referral of clients in situations when the peer educator is unable to resolve issues.

2.42 These trained peer educators will represent their PWID clients and will later take on the role of gatekeeper. In this way, the numbers reached with services will increase and link to a larger number of existing networks among PWID. The participants will come from different areas in BiH and thus will ensure larger geographical coverage. Working with marginalised and vulnerable populations, it is important to note that in addition to their vulnerability and their frequent overlap with other bridging populations (such as SW, for example), PWID are at high risk of HIV and continued peer education is of great importance.

Sex Workers

2.43 In Phase I, services were provided to SW through two NGOs (AAA in the RS, UG Proi in FBiH). During Phase I's implementation period, the needs of SW were addressed through outreach activities and IEC materials, as well as through IEC materials, vouchers for free HIV testing and condoms to prevent HIV transmission. Various 'entertainment facilities' and their owners were targeted, as well as gatekeepers and SW's clients with the aim of removing barriers to accessing STI diagnosis and treatment; information about VCT services was provided through peer educators (who distributed vouchers for free VCT services), MCH as well as primary care services.

2.44 In Phase II, in addition to activities implemented by AAA and UG Proi, interventions aimed at SW will also be implemented by Margina; the three NGOs will cover different sites throughout the country.

2.45 In order to achieve more impact, in Phase II the Programme will:

- Increase coverage of HIV prevention activities through community outreach and service provision programmes for SW both geographically and among subgroups of SW;
- Expand the content and range of services to be provided;
- Enhance the quality of services and implement quality control;
- Facilitate the integration of community level services with medical facility-based services;
- Address stigma and discrimination among health care providers to encourage SW to have better access to mainstream health and other services; and

- Prevent further HIV transmission through implementing quality HIV prevention services for SW's clients.

2.46 The Programme aims at sustaining and enhancing community-level outreach and services for SW through peer educators/outreach workers and gatekeepers, who are able to reach, build trust, maintain relationships with and provide cost-effective services to the most-at-risk women. This population will be targeted using new outreach techniques and strategies, with the goal of preventing both sexual and parenteral transmission. The basic package of services (information booklet, lubricants, condoms and counselling with a outreach worker) will be upgraded by establishing two DIC for SWs in FBiH (Sarajevo and Zenica) and one in the RS (Banja Luka); pregnancy testing; more targeted IEC, developed through the participatory involvement of SWs; social, legal, vocational and self-support services; referrals for HIV-testing and drug treatment; SRH and FP services; and advice and counselling on issues related to violence. These services will strengthen prevention and decrease morbidity.

2.47 The DIC will provide women with a range of free community services, including psychosocial support and counselling, resources about HIV and AIDS and drug abuse, and access to sexual health and primary health care. A particular focus will be on the prevention of violence against SW. Services will include support services for victims of violence (legal, medical, psychological); referral to shelters for women, in particular victims of domestic violence; free access to psychological counselling for couples (SW and their partners); educational programmes about conflict prevention and resolution; and training on communication skills for SW and battered women.

2.48 Under Phase II, a total of 60 peer educators from among SW will be identified and trained by AAA to increase service outreach to SW. Topics to be covered by the training include HIV and AIDS, sexuality, drug use, Hepatitis, STI, VCT, how to reach clients and motivate them to change their behaviour, methods of active listening, non-judgmental communication with clients, confidentiality and referral of clients in situations beyond the remit of the peer educator.

2.49 Peer educators who attend these trainings will represent the SW population and will later assume the role of gatekeeper, similar to the envisaged work with PWID as described above – reaching more people, linking to a larger number of existing networks, widening geographical coverage and addressing the needs of bridging populations.

2.50 Finally, there will be an advocacy campaigns to foster creation of an enabling environment in which HIV and AIDS prevention, treatment, care and support services for KAPS and PLHIV can be implemented effectively. Advocacy will be undertaken on the following topics:

- Decriminalisation of drug use and voluntary sex work;
- Remove the administrative penalty currently charged for those found guilty of providing sexual services for money;
- Free access to STI treatment for SW;
- Access to barrier methods (lubricants with microbicides) to prevent HIV transmission; and
- Ensuring a comprehensive service on harm reduction, particularly NEP, provision of lubricants, and so on.

MSM

2.51 In Phase 1 MSM were covered by preventive activities conducted by the NGOs XY Association in FBiH and AAA in the RS. These activities consisted of field work, running DIC, and working through the internet (the so called cyber outreach work), as well as providing various training related to HIV and AIDS. Field work conducted in Banja Luka, Bihacé, Brčko, Dobo, Mostar, Prijedor, Sarajevo,

Tuzla and Zenica consisted of providing information on sexual-health services, with special emphasis on HIV and AIDS and other STI. Activities at the XY Association's DIC included counselling and referral for Hepatitis B and C, HIV and syphilis testing.

2.52 During Phase I there was only one DIC in FBiH providing services for MSM; during Phase II this limited access will be expanded through the opening of three more DIC in FBiH and one in RS., enabling many more MSM to be reached. Likewise under Phase II geographical coverage will be expanded in 2013 to include two new project sites, Čapljina and Travnik, in FBiH.

2.53 The outreach approach is a specific method that aims to reach key populations who are unwilling or unable to use traditional services, such as STI clinics and others provided through health facilities, and promote access to these services. This method facilitates the promotion of health through:

- Increasing awareness of risky behaviour;
- Encouraging the reduction of risky behaviour; and
- Providing prevention services tailored to individual needs.

Outreach work in BiH, as in most countries with concentrated epidemics or clear groups of KAPS, is delivered through networks of CSO.

2.54 For behaviour change messages, outreach is often conducted through face-to-face interviews or group education sessions in the DIC or working area, informal meeting places or local community venues. The team's outreach activities include discussing HIV prevention, distributing condoms and providing vouchers for HIV free testing at the local VCT clinic or drop-in outreach testing. VCT services and condom promotion and distribution will continue to be provided at a DIC located near popular meeting places for MSM in the above-listed towns.

2.55 DIC offer IEC sessions; training and workshops; peer education presentations; psychological counselling through a psychologist; basic counselling provided by trained MSM counsellors; a help line; internet outreach for information provision and referral to Association XY and other services; cyber outreach work (Planet Romeo, a popular website for gay men); VCT referral; and distribution of educational materials, condoms and lubricants. Additionally, a dermatologist visits the DIC to provide services regarding STI. The expansion of DIC under Phase II is reflected in increased targets.

2.56 During Phase II implementation, plans are underway to identify 100 peer educators from among the MSM population in both Entities, and train them through AAA and XY Association. Additionally, 32 MSM will be trained on advocacy; participants will be able to participate in advocacy workshops with the aim of helping local government to make the HIV prevention programme sustainable in the MSM communities. The training will increase MSM participants' advocacy knowledge and skills/tools. 48 social workers will be trained on MSM issues and 32 MSM will be trained as counsellors to assist participants to improve their communication skills in order to identify risky behaviour and to facilitate communication with clients.

2.57 Other activities to be implemented by these NGOs include training for MSM counsellors and development of their guidelines, advocacy and HIV toolkits; this is intended to ensure the sustainability of project activities by providing MSM with the skills and knowledge needed to represent the interests of the MSM population.

2.58 Workshops for social service providers will provide participants with the opportunity to develop a minimum service package for HIV prevention among MSM; again, an activity which will contribute towards the sustainability of community activities among target populations.

Prisoners

2.59 Activities on HIV prevention among prisoners in Phase I were implemented by two NGOs, Viktorija in the RS and Association XY in FBiH. Prevention activities were based on peer education; prisoners were trained to implement project activities within the prison, informing and educating their contemporaries about HIV, STI and blood borne infection. The prisoners also had access to condoms, lubricants, and printed educational materials.

2.60 Within Phase II an additional NGO, Margina, will be introduced to implement activities for PWID in prisons and all three NGOs will continue working with HIV preventive activities in the prisons in both Entities. Prevention activities will be based on peer education¹⁶ and mobile teams will be provided to enable prisoners to take HIV tests.

2.61 70 trained peer educators from among prisoners, and 91 professional prison staff, will be trained and enabled to organise monthly educational sessions with other peers. Modules, developed and taught by the peer educators themselves, will be put into a manual for peer educators and educational posters used as a tool to transfer knowledge to others, adapted to the conditions in which prisoners live and for use in both closed and open spaces.

2.62 In Phase II, Association XY will start to implement peer education activities in the only female prison, located in Tuzla. Activities will also focus on training for prisons' professional staff on reducing risk among prison staff, and how to make prevention programmes more effective and sustainable by linking prisoners' vulnerability with the level of risk within the prison. The establishment of an HIV Protocol/Guidelines for Prisons will integrate all approaches used with HIV infected prisoners, reducing stigma and discrimination towards HIV-positive prisoners, explaining risks in contact with prisoners who are potentially infected by HIV or any STI, raising awareness on HIV in general to decrease the risk of infection among prisoner and staff alike.

2.63 Magazines for prisoners will be produced as an important communication tool where prisoners can publish their own articles sharing experiences, knowledge and thoughts regarding the HIV prevention programme.

2.64 An additional activity in Phase II will be the monitoring of injecting drug use in prisons and after release, through Margina and Viktorija. This mechanism reduces the possibility of "losing" the client into his community on his release from prison. It uses the networking system of institutions and NGOs in order to improve the monitoring of clients and their needs. Likewise, efforts will be made to strengthen the role and capacity of social welfare centres in post-penal protection and networking between these centres, NGOs and correctional facilities. Once again, these activities will help towards the Programme's sustainability after the end of Phase II.

Youth

2.65 A key part of Phase I activities were interventions addressed to in-school and out-of-school youth. The rationale for this was that adolescents are facing the most turbulent period of their lives when they are at their most vulnerable; for example, many of them are at odds with their parents from different reasons. Youth living in hostels or care centres are growing up in particularly hard conditions that affect their physical and mental health; growing up outside the family unit can be traumatic in most cases whether the reason is death of their parents, they come from a

¹⁶ Peer education is an approach in HIV education and prevention recommended by numerous experts and organisations dealing with HIV education in prisons. Research shows that peer educators recruited from the prison population are as efficient in their work as professional HIV educators, the only difference being that prisoners prefer educators from among their peers as they are members of the same group.

dysfunctional family, separation from family due to abandonment, abuse or neglect, and poverty. In addition, youth in collective accommodation centres face stigma and discrimination from their peers who treat them in a different way.

2.66 Adolescents are under the most intensive peer pressure, and this makes them particularly at risk; especially because, at the same time, they are starting to use alcohol and drugs and are beginning to have sexual relationships. Youth growing up in hostels or care centres are often subjected to hard conditions and their access to quality information is severely limited. Their social environment does not give them adequate support for healthy growth; they often lack the daily care and support needed to help them reach objective decisions, and this therefore puts them at increased risk of HIV infection. In fact, results from a behavioural study¹⁷ conducted in Bosnian Institutions for Collective Accommodation showed that youth in these institutions have limited knowledge about HIV (only 29.1 % correctly answered questions on HIV) and HIV-related services (only one person out of 392 respondents had been tested for HIV).

2.67 Orphans, street children and other young people living in collective accommodation were identified as a KAPs in Bosnia's second *Strategy to Respond to HIV and AIDS in Bosnia and Herzegovina for the period 2011-2016*. Likewise, at the same time a majority of these youth are living below the poverty line which is also a target group defined by the Strategy as a key population at risk.

2.68 Under Phase I, youth activities were implemented by Association XY. Activities targeted vulnerable youth in both school (age range 10-24) and out-of school (age range 14-24) settings. Activities were based on life skills education with a focus on assisting SRH and social services to become more gender-appropriate and youth-friendly. With Global Fund support, 26 youth-friendly health centres were established and operational, providing educational/promotional activities and medical services.

2.69 Information centres were established within local NGOs and were responsible for educational and promotional activities such as: regular peer educational presentations in elementary and secondary schools; educational activities at university faculties; educational activities with parents and school staff; out-of-school activities with vulnerable groups; various events for youth (concerts, street activities, etc.); the ongoing distribution of condoms and educational materials; and all conducted with a youth-friendly approach.

2.70 The medical centres comprised teams of qualified health workers working within local health institutions. They were in charge of providing medical services such as networking and collaboration between medical centres and NGOs at the project locations; gynaecological and counselling services to young people; referral to other institutions, especially VCT centres, for testing for HIV and hepatitis.

2.71 The youth-friendly health centres were set up to provide high quality health services tailored to the specific needs of young people, especially vulnerable groups. These centres are also in charge of promoting healthy lifestyles as well as protecting the SRH and rights of young people, including prevention of HIV and other STI. However, under Phase II these activities were dropped at the request of the GF who did not consider youth to be a priority group to KAPS. Another reason for dropping this activity was that it was expected that HIV education would be assumed into the regular school curriculum.

¹⁷ UNICEF BiH (2008): Behavioural research conducted among adolescents in collective accommodation in Bosnia and Herzegovina in 2008, funded by the GFATM.

Roma

2.72 During Phase I World Vision BiH, in cooperation with the Roma Council and Roma Network, established three Roma HIV Information Centres, which proved to be an essential partnership in the successful implementation of project objectives. In addition, 20 outreach workers from the Roma communities were trained to work in Roma communities, ranging from regular outreach work (group and individual information sharing, educational and counselling sessions) to peer education using specially designed educational boards. The project has country-wide coverage with particular emphasis on remote Roma communities which, prior to this project, had no access to any information related to HIV and AIDS.

2.73 The outreach workers reached more than 4,000 Roma community members with information on HIV prevention and VCT. Of this number, 257 Roma have used VCT services and have been tested for HIV and hepatitis C. Over 40,000 condoms were distributed, along with approximately 15,000 IEC materials. In addition, seven round tables and 10 public events and awareness raising sessions were conducted for Roma community members, ensuring project visibility and providing relevant information to the Roma population. Over 80 health and social workers were sensitised to work with Roma communities in order to better respond to Roma health needs.

2.74 In Phase II, the Programme will continue to expand activities through the full participation of the Roma HIV Information Centres, partners, volunteers and other stakeholders. The Roma project will provide continuous support to the three Roma HIV information centres, support the field activities of 25 Roma outreach workers covering 28 Roma communities, expand outreach by trained Roma outreach workers to five new communities and equip the five new outreach workers with the knowledge and skills required to launch outreach activities in new communities. Finally, the project will sensitise and mobilise Roma community leaders and opinion makers

2.75 It is expected that, by the end of Phase II, 6,000 Roma beneficiaries will be reached through field activities and 60,000 condoms will be distributed, together with IEC materials.

2.76 The Roma HIV prevention programme was designed based on the *National Action Plan for Roma Health Protection*; this project is the direct implementation of Objective 3, Provision and Implementation of Preventive Measures Aimed at Improving the Health Status of Roma National Minority: Measure 1.1.2. Sexually transmittable diseases with emphasis on HIV/AIDS. The Action Plan also envisages the use of Roma mediators to gain better access to Roma communities and to improve the general health of this vulnerable population. It is expected that BiH health institutions will continue to use the experience, capacities and skills of Roma outreach workers as mediators in the future, following the end of Phase II.

Migrants and Mobile Populations

2.77 In Phase I this activity was implemented by the International Organisation on Migration (IOM).

2.78 Due to their geographical mobility and long periods of separation from their sexual partners, migrants and mobile populations are at high risk of STI, including HIV, regardless of their behaviour in their homes of origin. Risks are embedded in the transient nature of migrants' lives: the longer the time spent and the frequency of travel away from home, the higher the probability of engaging in risky sexual behaviour. Other factors, such as the characteristics of lifestyle and work environment related to specific profession such as long-distance truck driving, may increase the odds of infection. The Phase II IOM interventions focus exclusively on migrants and mobile populations, which have been identified as among the most at risk in BiH.

- 2.79 Three important lessons have been learned from the first phase of implementation.
- First, it is important to collect baseline information on the knowledge, attitudes and practices of target populations in order to design appropriate outreach and prevention activities and to measure change and impact over time. Though this information was unfortunately not available for the first phase, IOM will use the results of a survey of truck drivers currently being implemented by the Entity Public Health Institutes and conduct a similar survey amongst labour migrants (no specific research regarding HIV/AIDS knowledge, awareness and behaviour has previously been conducted with this group in BiH) for this purpose.
 - Secondly, though IOM successfully built an informal network for communication and information sharing by and between partners including NGOs, media representatives and the public health sector, the network has been somewhat weakened by the absence of migrant representatives and representatives of crucial governmental institutions that work on a daily basis with migrants and mobile populations. Given that HIV/AIDS and mobility is a complex, evolving, and multi-faceted field, requiring the involvement of a wide variety of sectors and sub-groups, IOM intends to carry forward and enhance the role of the Health and Mobility Network while also providing professionals and decision-makers in the various sectors with practical tools to provide services that address the needs of migrants and mobile populations in the field of HIV/AIDS risk reduction and prevention.
 - Finally, unless the successful approaches to tackling HIV and AIDS and mobility are embedded in the current and future strategic documents of BiH, the sustainability and longevity of successful best practices will be lost. As such, IOM will work with relevant stakeholders and partners to develop a detailed action plan for implementing interventions that will prevent HIV/AIDS among mobile populations from becoming a high social and economic cost in the future.

2.80 The overall goal of the second phase is to provide prevention and treatment services that effectively and appropriately address the needs of migrants and mobile populations, while ensuring that these services in the health care and non-health care sectors will continue to support migrants in the long run.

2.81 Outreach workers will continue to disseminate information through one to one and group discussions, provision of written information and condoms to migrant sub groups including transport workers, labour migrants, immigrants, and armed forces personnel. VCT for transport workers will be augmented and made sustainable through cooperation with the Service for Indirect Taxation, the VCT centres and NGOs. Transport workers often face difficult working conditions which raise their health risk and leads to disadvantages in terms of access to health care. IOM will establish two pilot Counselling and Information Points at customs terminals which have the highest volume of transit. The Counselling and Information Points will make available low cost/free pre-packaged STI information kits. IOM will work in cooperation with the Entity PHI, the VCT centres in Banja Luka and Sarajevo, AAA in Banja Luka and Partnerships in Health in Sarajevo to organise information dissemination, counselling and testing. All counselling activities carried out by NGOs will be organised in close cooperation with the Entity PHI in order to provide them with the four indicators that they are required to collect (including counselling pre and post test, number of tests, number of individuals that return for results).

2.82 IOM will design tool kits for institutions and organisations in healthcare and non-healthcare to provide support and services to migrants and mobile populations in the long run.

2.83 A practical and user friendly guidebook will be developed on Health and Mobility that will provide step-by-step "how to" for working with mobile populations, providing counselling and safeguarding human rights. Each workshop undertaken as part of the project will be based on The

Health and Mobility Guidebook and the guidebook will be widely promoted. It will provide guidance not only to all participants of the programme and at workshops, but also to all future stakeholders in the various institutions and organisations that work with migrants and mobile populations.

2.84 In-depth interactive HIV/AIDS and Mobility workshops will be organised and tailored to the needs of participants within healthcare and non-health care institutions and businesses. Institutional beneficiaries of these workshops will include HIV/AIDS Local Coordinators; community-level healthcare workers; professionals in ministries addressing border security, immigration, asylum, counter-trafficking, and customs; counsellors in employment institutions and the State Agency for Labour and Employment; and private sector companies with a focus on transport and construction.

2.85 Given that HIV/AIDS and mobility is a complex, evolving, and multi-faceted field, requiring the involvement of a wide variety of sectors and sub-groups, IOM intends to carry forward and enhance the role of the Health and Mobility Network. IOM proposes to augment its membership to include (i) first and foremost representatives of migrants and migrant communities; (ii) local-level health care sector participants; (iii) representatives of governmental institutions that are not in the health care system (such as the State Coordinator against Trafficking in Human Beings, the Ministries of Security, Foreign Affairs, and Human Rights and Refugees, Employment Institutes and the Agency for Labour and Employment); and (iv) representatives of the private sector such as transport and construction companies that employ migrants.

2.86 In order to ensure that migrant voices are heard and that migrants' needs are specifically included in strategy development, IOM will work over the course of the three years with the Health and Mobility Network to identify gaps in national policy as they relate to HIV/AIDS and mobility. These efforts will culminate in the third year of the project when the Health and Mobility Network will participate in workshops designed specifically to develop recommendations and a concrete and detailed action plan for the mainstreaming of specific measures addressing migrants and mobile population in HIV and AIDS national strategies. Given that migrants have been identified as one of the most at-risk groups in BiH, and yet have only earned a passing mention in the existing strategy, it is of utmost importance that very specific recommendations – i.e. a detailed and practical action plan – exist to address the particular risks arising through mobility.

Objective 2: Ensure appropriate prevention, treatment, care and support for people living with HIV and AIDS

Integrated Prevention, Treatment, Care and Support (IPTCS) for PLHIV

2.87 In Phase 1 activities relating to PLHIV were delivered by one SR and two sub-sub recipients (SSR) in regard to the provision of living support to PLHIV: Partnerships in Health, and APOHA and AAA. Living support included the provision of vitamins, wood, food, drugs and clothes, and – through AAA and APOHA - the formation of psychosocial assistance through support groups.

2.88 In Phase II the two NGOs which were formerly SSRs have now become SRs. The main reason for this is that it provides the PR with easier access to and direct oversight/coordination of relevant PLHIV activities.

2.89 Based on the positive results of the living support activity under Phase I, the provision of the vitamins, drugs, food, hygiene products and other items to PLHIV will be continued. PLHIV needs are identified in collaboration with the clinicians and on the basis of their social status, i.e. if employed or not, and so on. To ensure transparency and coordination with the Infective Diseases Clinics, consultations with these professionals take place twice yearly. Medications are stored within the Infective Diseases Clinics, while the in-kind goods are provided directly to the beneficiaries. A

mechanism for control that will prevent overlapping and duplication will be established in cooperation with the National Coordinators, Infectious Disease Clinics, AAA and APOHA.

2.90 This component also aims to boost prevention efforts among PLHIV including, but not limited to, provision of social support to PLHIV, therapy for OI, as well as monitoring of therapy and drug resistance. Since the number of new HIV infections significantly increased during 2012, strengthening of those efforts in 2013 and beyond is of key importance. Those actions are supported by other activities such as study tours for health providers treating HIV and AIDS across the country, their capacity building, and so on.

2.91 In order to fully address issues pertaining to treatment and care, Partnerships in Health has developed a training methodology which contains an obligatory module to address stigma and discrimination towards PLHIV as well as KAPs.

2.92 AAA and APOHA provide support to empower PLHIV which to develop relationships with the HIV-positive community, with their close social circles and within the larger community. PLHIV who have gone through all the empowerment steps are able to participate in all activities conducted by AAA and APOHA, especially peer consultancies. Having reached a certain level of empowerment, PLHIV will be encouraged to become members, employees, and even board members, of AAA and APOHA. As both organisations become stronger through PLHIV empowerment, the organisations themselves will be able to participate in international HIV networks.

2.93 Psychosocial counsellors and PLHIV deliver outreach work, which includes visiting their homes, visits during hospitalisation, and in other situations as needed. This activity is implemented by APOHA.

2.94 Moreover, plans are underway to develop PLHIV leadership and advocacy to increase PLHIV participation in the country's response to HIV. PLHIV groups will be assisted to provide information and support to PLHIV. Small grants will be provided to PLHIV groups for operational support and establishing local projects aimed at stigma reduction, positive prevention and advocacy. New models of negative impact mitigation will be established in Phase II, notably Sustainable Living Development, which includes vocational training, provision of tools and materials related to sustainable living, and networking. This will enable low-income PLHIV (defined through the evaluation of social status conducted by the PHI) to create a sustainable environment for themselves by employing newly acquired skills and knowledge.

2.95 A Regional Case Registry will be developed, linking BiH's clinical centres with the entire country through the three different health systems (regions, cantons and Brčko District). This activity could play an important role in caring for PLHIV, reinforcing and maintaining their adherence to quality therapy, and the management of data related to ART. If properly implemented, the Regional Case Registry will demonstrate that it is possible to prescribe ARV using a mentorship system for prescribers when needed; patients may be referred, as appropriate, to specialist (examination, biological tests and radiological examinations, hospitalisation) and palliative care. Networking care facilities and developing partnerships are critical to strengthening the care continuum for PLHIV.

2.96 All PLHIV trainings, workshops, trainers, institutions and curriculum for social workers and employees of the social services sector will be secured with the permission of the National Coordinators on HIV and AIDS. MOH will prioritise the health facilities for participation. Based on the turnout, training sessions may be repeated whenever necessary in order to meet the relevant indicator.

2.97 Under Phase II the sustainability of the PLHIV social support component will be addressed throughout the involvement of the social welfare and social service providers. This decision has been made on the basis that the majority of PLHIV belong to marginalised and poor population groups; hence continuation of the living support is of vital importance. The Programme will make every effort to ensure the sustainability of this component after the end of Phase II through working in close collaboration with Ministries of Social Welfare, who have already been consulted and are supportive of the component.

PMTCT

2.98 As a recognised high-impact intervention, the PMTCT component remains one of critical importance to the Programme. This component addresses the uptake of VCT within the health care system; encouraging pregnant women who might be at risk to choose VCT while at the same time discouraging mandatory HIV testing of pregnant women.

2.99 One key intervention relates to the elimination of new HIV infections in children. The PMTCT component will build on expanding its efforts with gynaecologists, obstetricians, midwives and pregnant women. Health care providers will initiate HIV testing and counselling for pregnant women identified as being at higher risk of HIV exposure according to national guidelines (provider-initiated counselling and testing, or PICT). In all cases, information about MTCT and HIV testing will be given to all pregnant women during antenatal information sessions. Another activity under this component is a 'school' for pregnant women, who will be taught about healthy life-styles and HIV prevention by gynaecologists and midwives. The 'PMTCT schools' should result in an even stronger involvement of the pregnant women in their pregnancy, with greater attention paid to risky behaviour and PMTCT; finally, it should increase number of pregnant women going for HIV tests.

VCT

2.100 Under Phase II, workshops on in-service training in VCT as part of antenatal care for gynaecologists and midwives will be conducted as a continuation of Phase I activities.

2.101 The VCT network is composed of 23 VCT centres (of which 22 are operational), providing counselling and testing services across the country. Until now, VCT services have only been provided within public health care facilities. To improve outreach towards KAPS the VCT centres, in collaboration with CSO working with KAPS, will improve service quality through introducing on-site testing for KAPS in the PWID DIC, MSM centres, Roma communities, prisons and other sites as appropriate. These activities will be coordinated with civil society, who will mobilise their clients to attend the selected locations.

2.102 The VCT clients to date have largely comprised MSM, PWID and SW, as well as the general population. It is not always easy to know when someone requesting an HIV test is a member of one of the KAPs because, although the NGO provides the client with a voucher for free and anonymous testing at a VCT centre, many KAPs do not present the voucher for fear of stigma and discrimination. Since one of the Programme's targets is number of vouchers given out by NGO rather than numbers of clients presenting vouchers at the VCT clinics, it is impossible to obtain an accurate figure for KAPS who have been tested at a VCT centre. However, the Programme does collect data regarding the number of vouchers presented by migrants, MSM, PWID, Roma, SW and youth.

2.103 In order to increase the service's reach to KAPS, the VCT network will introduce a new service: Hepatitis B vaccination for KAPS. Currently Hepatitis B vaccination is provided for newborn infants and for some professionals at high risk of exposure, but it is not provided for KAPS. It is expected that this new vaccination programme will incentivise KAPS to use VCT services. Vaccination

will be provided for an estimated 900 clients per year. Additionally, VCT counsellors and health service providers will receive a further training on the principles of harm reduction which will enable them to provide more effective counselling services to PWID; and a mobile VCT unit will be set up to compliment the existing static VCT services and increase KAPS HIV and Hepatitis B and C testing.

2.104 Following the end of Phase II, the public health care system will continue to provide VCT services, including vaccinations for KAPS, to ensure the sustainability of this component. Continuity of treatment and availability of drugs, vaccines and medical products will further build the procurement and supply capacity that is being provided through this Programme.

2.105 Certification of the VCT centres will be initiated in Phase II. This process includes development of the standard operating procedures (SOP) for the centres, and strongly supports ongoing efforts with regard to quality assurance. The SOP will be developed by Partnership in Health, as well as a schedule for more frequent monitoring and supervision visits. A number of training, workshops and staff tours for various medical and non-medical staff, as well as development of curricula, brochures and guidelines are envisaged under Phase II. If these efforts do not result in sufficient and measurable improvement, Partnerships in Health will request the respective MOH to consider other geographical locations for VCT centres and/or to appoint different VCT counsellors.

2.106 The 7th Regional Conference on HIV and AIDS will be organised in collaboration with the UN, including UNAIDS, academic, public and civil sector (PHI, Infective Diseases Clinics, and Partnerships in Health) largely co-funded by the UN, civil society and private sector. The previous six regional conferences have served as a platform for the exchange of knowledge, experiences and development of new initiatives largely aimed at KAPS. The Conference fulfils other important functions. It provides a unique opportunity for KAPS to share their invaluable experiences and provide feedback on how service delivery can meet their needs. KAPS still remain largely hidden from the public eye, which presents a formidable obstacle in project implementation as the exact size and dynamics of the populations are unknown.

2.107 The Regional Conference also provides a platform for the exchange of knowledge and ideas for individual practitioners, stakeholders and organisations from the Western Balkans region. It is an excellent basis for the further expansion of the existing network of organisations, not only for practitioners to learn from others how to work more efficiently but to fight for the sustainability of the country and regional response to HIV.

Objective 3: Strengthen the Enabling Environment for Scaling up HIV Prevention and Care

2.108 In Phase I advocacy activities were implemented by the International Labour Organisation (ILO) and stigma activities by World Vision. Under the second Phase, however, workplace activities were not approved by the GF and hence the World Vision programme remains the sole implementing agency under this objective.

Work with FBOs

2.109 World Vision, in cooperation with the Inter-Religious Council, has completed a stigma assessment on the attitudes of the Catholic, Jewish, Muslim and Orthodox faiths towards PLHIV. This assessment clearly demonstrates the existence of inflexible and intolerant attitudes, prejudices, and significant social distance exhibited by all religious groups towards HIV-positive people. According to the assessment findings, 20 % agree with the statement that PLHIV should not be allowed to raise children; and over 60 % agree that no education or treatment should be wasted on HIV positive people as their life span is short. Systematic ongoing awareness programmes for representatives of

religious communities and churches were recommended in order to foster greater inclusion, support and dignity for PLHIV.

2.110 During Phase I World Vision succeeded in sensitising and mobilising faith leaders by utilising the Channels of Hope methodology (targeted faith response to HIV and AIDS), adapted and contextualised to different religious views and moral teachings, and approved by the leadership of all four religious communities and churches. This methodology, accompanied by specially designed stigma reduction workshops and active collaboration with the Inter-religious Council, prepared a common ground for the initiation of adequate faith-based responses to HIV and AIDS on a national level and opened a discussion on the importance of the active involvement of religious leaders in HIV prevention and stigma reduction activities.

2.111 A significant effort towards building the capacities of faith workers and changing the attitudes of religious believers and FBO representatives has been made. Over 40 faith workers and faith teachers were sensitised to ensure that themes such as HIV prevention and stigma reduction were included in religious ceremonies in all four faith communities, including regular faith education in primary and secondary schools.

2.112 Furthermore, as a result of the Stigma Reduction component, four pilot projects on HIV-related stigma reduction in faith communities have been prepared, funded and implemented by targeted FBO in communities all over BiH. Project data show that over 40.000 representatives of faith communities and churches were introduced to the faith-based response to HIV/AIDS and related stigma, and were reminded about moral teachings that prevent faith believers from stigmatising and discriminating against PLHIV. Over 1,100 faith workers, FBO representatives, and believers were trained on areas of HIV prevention in stigma reduction, in faith context.

2.113 In the second phase of implementation, World Vision is expanding project outreach activities and coverage through direct engagement with the four FBO identified and recommended by the Inter Religious Council. Leaders of the four FBO have strong relationships and wide-spread faith networks in their communities, which is necessary for the effective continuation and wider geographical coverage of the project.

2.114 Overall, further mobilisation of FBO, faith communities and churches will involve training, mentoring, other forms of technical assistance and, above all, awareness rising, to strengthen the common understanding and approaches in HIV prevention. This is essential for increased utilisation of quality prevention services within the existing health care system and creation of an enabling environment to improve the faith communities' involvement in responding to these issues. The focus of Phase II, therefore, is again one of sensitisation and mobilisation of FBOs, using the Channels of Hope methodology for a targeted HIV response.

Objective 4: Strengthen Coordinating and Implementing Agencies' Capacity to Respond to HIV/AIDS

2.115 Under Phase I, activities to support this objective were implemented by the Public Health Institutes in FBiH and RS.

Supervision of OST Centres

2.116 The first case of methadone treatment was recorded in 1989 in Sarajevo but the OST programme was suspended during the war. Today in FBiH there are six OST centres that deal with detoxification and provide replacement therapy with methadone and Suboxone (Bugojno, Mostar, Sanski Most, Sarajevo, Tuzla and Zenica,,) and two in the RS (Banja Luka and Doboje). Each day 681

persons receive methadone substitution and 246 receive Suboxone substitution, through 15 staff at the OST centres.

2.117 OST centres are very important not only for weaning PWID off injecting drugs, but also for the local community in terms of the improvement in behaviour (theft, violence), of PWID.

2.118 PHI employees perform quarterly monitoring visits to supervise record keeping, reporting on the consumption of alternative and substitution therapies, their storage and management, client registration and outreach activities, including prison visits. The introduction of OST in prisons is planned for the whole of the country under Phase II.

Development of OST Guidelines

2.119 The current OST programme lacks a standardised national OST protocol, needed to ensure harmonisation of existing local OST guidelines and efficient implementation at all levels. Under Phase II plans are in place to establish a multidisciplinary team to develop comprehensive national OST guidelines based on practices which ensure efficient treatment, ways of preparation, recommended dosages and monitoring. This will ensure strict control, better monitoring and management of opioid substances and OST reserves, as well as a more realistic estimate of needs. The guidelines will also recommend and ensure the application of updated standards of the knowledge and skills required for the efficient implementation of OST in all centres.

Municipal CSO Health Councils

2.120 In accordance with the Objective 2 of Phase I (Strengthening the Cooperation of Public Health Institutes with Local Communities), the FBiH PHI established two Municipal Health Councils (MHC), each composed of eight members from Government and NGO, whose activities were mainly related to the organisation of working meetings, round tables, etc. With the aim of better and more efficient coordination of the parties involved in the implementation of HIV/AIDS-related activities, the current membership of the established MHCs will be reduced to two members (a Municipal Coordinator and Assistant) and the same approach will be used to set up four more MHC. The MHC team will develop local action plans with the aim of stronger advocacy and influence on local decision makers, mobilising resources, while at the same time they will be functionally linked to other organisations, such as service delivery points in local communities (VCT, methadone centres, NGO, Resource Centres and so on).

2.121 Under Phase I in RS, two Municipal Health Councils were established in RS, composed of five members from Government and NGO.

M & E

2.122 Under Phase II it was been planned to further strengthen the capacity of the Entity M&E Units which, in Phase I, were established at the PHI.

2.123 While the work of the M&E Units in the first Phase is mainly based on the monitoring of activities implemented with GFATM support, in the second Phase it is expected that the M&E Units take over the monitoring of the Action Plan for the implementation of BiH's national HIV/AIDS Strategy for 2011-2016. The M&E units will prepare the annual M&E plan, identify the resources needed to implement the plan, and identify potential problems in the implementation of the plan. The PHI will provide the technical and logistical support needed for the functioning of the M&E Units, linking the M&E Units with other parties delivering HIV interventions.

2.124 The PHI will also convene meetings of the M&E Units in order to improve the reliability of data required for an effective HIV response, and provide technical support for the establishment of scientific and methodological guidelines.

Research

2.125 In a country with a low prevalence of HIV infection, surveillance of the population at risk is crucial for monitoring the epidemic and providing the evidence base which informs the development of targeted and tailored interventions. Survey data allow comparison with other countries, monitoring the achievement of the Millennium Development Goals, and the design of national HIV programmes. Survey data are key tools for a timely and effective response to the epidemic. Under the Programme's second phase, therefore, three BBS and one OR are planned.

BBS among Roma Population as a Population at Risk

2.126 According to estimates by the BiH MHRR, between 30,000 and 40,000 Roma currently reside in the country, although this number is very difficult to determine because of the mobility of the population. As well as being very mobile, the Roma population has specific traditional cultural, social and economic characteristics. There are many indicators that point to the existence of high risk practices among this population group, such as early debut of sexual contact, early marriage, multiple partners and so on. To date in BiH, no research has been undertaken related to sexual behaviour among the Roma which would confirm the above assumptions and allow a better response to STI and HIV for this population. The PHI plans to conduct a BBS on a sample of 3 to 5 % of the Roma population aged between 15 and 49 years of age; approximately 500 Roma.

Behavioural sentinel surveillance (BSS) among PWID

2.127 The PHI plays a significant role in planning and conducting research, strengthening second generation surveillance through the implementation of BSS covering the three key target KAPs (MSM, PWID and SW). In the second Phase, two studies will be undertaken whose results will allow the monitoring of trends in risk behaviour and provide a sero-epidemiological profile of HIV in BiH. Data from two BSS conducted in 2007 and 2009 among PWID in three cities, and the third BSS in 2012 covering five cities, show the constant risk of Hepatitis C and HIV prevalence among PWID; although the data show some growth, figures are still low among this population. Data trends show progress in HIV prevention among PWID in BiH (a noticeable increase in the use of harm reduction services, although pharmacies still represent the major source of sterile injecting equipment for PWID).

2.128 The high prevalence of Hepatitis C suggests the need for better coverage of Hepatitis C testing. There has been progress in reducing risky practices relating to injecting drug use, but not in terms of reducing risky sexual behaviour (decrease in the use of condoms, decrease in knowledge of those who know the ways for HIV transmission).

2.129 Due to multiple risk factors, subsequent research is needed to enable the design of targeted programmes to reach this vulnerable population, utilising a gender and age-sensitive approach (to date, over 85 % of respondents were older than 25 years and male) and proactive outreach strategies.

2.130 In the second stage of Phase II implementation (2015), a BBS has been planned for PWID, which will allow the collection of data about a population at high risk of STI and HIV, and comparison of these data with data obtained in previous research, to analyse behaviour trends among PWID and the development of a timely response to these trends. The research will be conducted in five cities (Banja Luka, Bijeljina, Mostar, Sarajevo and Zenica), and will cover approximately 1,000 PWID.

BBS among MSM and SW

2.131 Participation of homosexual modes of HIV transmission in relation to all modes of HIV transmission has increased in the past few years, indicating the need for closer observation of this population group. The MSM population is highly stigmatised in Bosnia and for this reason also hard to access; however, two BBS were undertaken in 2008 and 2010, funded by the GF and implemented by UNICEF.

2.132 BSS conducted among MSM populations generally show a relatively good knowledge of routes of HIV transmission and increased protective sexual behaviour (higher condom at last anal sex with men, an increase in the use of lubricants, an increase in those tested in the last 12 months who know the test result, a growth in the rates of those who are reducing the number of sexual partners and random partners, a reduction in sexual activity while under the influence of drugs, and so on). It is evident of behavioural change, but still insufficient; over 82 % of condoms are supplied through NGOs, but their clientele still demonstrate risk-taking behaviour (sexual intercourse under the influence of alcohol, unprotected sex with a woman, and so on).

2.133 Research on SW, another group which is hard to access and at high risk for HIV infection and other STI, will be undertaken at the same time. This will enable the monitoring of HIV and STI trends, and allow more timely and effective oversight. So far, in all three studies among SW populations, the average age of patients was 27 years; urban SW are relatively well educated, mostly unemployed (51.8 %), with 10 % being students. There is an increase in the age of sexual debut (19 years), but a decrease in the age of first paid sexual intercourse (21 years).

2.134 All three BSS show relative progress in HIV prevention among SW: increased condom use at last vaginal intercourse (87.7 %), but not for oral (eight %) and anal (66.1 %). There is a rising trend of image of low self risk of HIV infection (11 %). Almost 60 % of SW have never been tested for HIV, and all three studies indicate low rates of those tested in the previous 12 months who knew their HIV test result. For the next research, RDS methodology is planned; however, its application will pose challenges due to the lack of SW social networks. Significantly, in the future to be able to identify the factors that contribute to risky behaviour among MSM and SW, the Programme will expand its partnerships with NGOs and the development of effective interventions such as early detection and HIV prevention through VCT, and new skills in outreach activities (rapid-testing, mobile teams, and others mechanisms).

Survey of HIV Stigma and Discrimination

2.135 In 2010, the PHI in FBiH conducted a study of stigma and discrimination among health care workers in the private and public health sector, which confirmed a high level of stigma towards PLHIV. Subsequently, a number of activities to combat stigma and discrimination were implemented such as public awareness campaigns, numerous trainings, information, educational materials, sensitising decision-makers and so on. Under Phase II there are plans to redo this study in 2015 in order to obtain comparative data.

Scholarships, Exchange Visits, Study Tours, Conferences and Pilot Grants

2.136 Originally in Phase II, a number of study tours, exchange visits and attendance at conferences were planned; however, these were not approved by the GFATM. Nonetheless, small grants will be provided to organisations to support PLHIV activities such as livelihood support, condoms, social services and so on. This activity will also build the capacity of PLHIV organisations.

3. PROGRAMME EVALUATION: SCOPE, OBJECTIVES AND METHODS

Evaluation Goals and Objectives

- 3.1 The purpose of the evaluation, as described in the Request for Proposals, was threefold:
- To determine the impact and outcome of the HIV programme in Bosnia and Herzegovina to-date, including an assessment of quality of services provided;
 - To define the most effective interventions going forward to yield an impact on the epidemic; and
 - To produce a report on the validation of the National Population Size Estimates of PWID, MSM and SW in Bosnia and Herzegovina that will be submitted to NAB for approval.

The evaluation took place at the same time as a validation of the population estimate size, both undertaken by the APMG Team. Hence, while this report is the final Evaluation Report, there is also an Inception Report and a PSE Report plus two papers: (i) Paper I: Summary of Interviews and Fieldwork; and (ii) Paper II: Summary of Findings, Conclusions and Recommendations. The latter paper was presented at a stakeholder meeting held at UNDP on Tuesday 10 December 2013, and again on the same day at a meeting of NAB.

Evaluation Approach

3.2 Collaborative and participatory processes are core elements of all APMG's work. Employment of a range of methodologies including document reviews, focus group meetings, interviews and field investigations promotes inclusion and ensures that the evaluation is consistent with gender equity principles and good development practice.

3.3 To create a positive environment for dialogue, APMG used Appreciative Inquiry (AI) methodology throughout the evaluation. This approach combined a rigorous examination of data with a focus on the strengths and achievements of programmes and institutions to determine ways to build on those strengths for increased effectiveness. At the core of the AI methodology was an examination of what has worked, drawing out the successes and progress that implementing partners and beneficiaries identified. It is APMG's experience that this positive starting point revealed different information and brought enthusiasm to the task of evaluation rather than an immediate focus on problems, barriers and obstacles. It engaged programme staff and other stakeholders in a constructive dialogue that acknowledged and rewarded the considerable effort that has brought them to this point in the Programme's implementation. It was not a substitute for an objective and rigorous examination of progress and process, but complemented this by developing an evaluation environment that was constructive and participatory. It ensured that positive processes and outcomes were identified, analysed and reproduced.

- 3.4 Evaluators, partners and sponsors were attracted to the AI approach as it:
- Engaged stakeholders in structured dialogue to develop evaluation questions;
 - Reframed evaluation tools to strengthen qualitative data collection;
 - Increased use of evaluation results and learning; and
 - Complemented and strengthened the evaluation process.

3.5 APMG designed and focused the evaluation criteria in two main areas: effectiveness (outcomes and impact) and efficiency. A mix of quantitative and qualitative data collection methods promoted triangulation as demonstrated in the attached Evaluation Matrix (Annex 1)

Work Plan

3.6 The major tasks of the evaluation fell into three phases:

Phase 1: Inception

Phase 2: Intensive Data Collection

Phase 3: Analysis and Reporting

Phase 1: Inception

3.7 The APMG Team initially developed a protocol for all phases of the work, in consultation with the UNDP PR team and NAB/CCM. The protocol included drafts of all evaluation questions, instruments, focus group guides, plans for visits, numbers of interviewees and timelines. This phase also included preparing guidelines for deciding on the inclusion and exclusion of documents for review and agreeing this protocol with the UNDP PR. Subsequently, the Team commenced the desk review of documents relevant to the Programme. This included – but was limited to – the findings from the 2012 RSQA; the 2012 BBS among MSM and SW, prisoners and PWID; documents related to Programme activities (including coverage and quality of services provided to key populations); and Global Fund financing reports. The full list of sources and bibliography are in Annex 2.

Phase 2: Intensive Data Collection

3.8 The agreed methodology, matrix and instruments developed in the Inception Phase guided the Intensive Data Collection phase of the evaluation. The Team undertook a two and a half week mission in-country, including field visits, to meet with the organisations and individuals identified in Phase 1. These visits encompassed both Entities of the Federation and Republika Srpska as well as Brčko District. The level of contact was in line with that identified in Phase 1 and involved electronic distribution of surveys as well as the facilitation of individual and organisational (focus group) interviews.

3.9 More detail regarding the evaluation criteria and the fundamental questions which the Team addressed (as outlined in the TOR) is set out in the aforementioned Evaluation Matrix (Annex 1). Throughout the Intensive Data Collection Phase, the team worked with the UNDP PR to report on progress, discuss preliminary findings and organise extra interviews as deemed necessary.

Phase 3: Analysis and Reporting

3.10 The APMG Team analysed the quantitative and qualitative data collected from the desk review and in-country and engaged with UNDP on any early significant findings from the programme evaluation. The Team ensured that the collation, analysis and presentation of data were compatible with that discussed in Phase 1 and the Final Evaluation Matrix. A comprehensive yet concise draft evaluation report summarising the findings, conclusions and recommendations was submitted to UNDP for consultation and feedback on 9 December 2013. As previously noted, the Team Leader presented the key findings, lessons learned and recommendations to a meeting of key stakeholders, NAB and CCM representatives on 10 December 2013 with guided discussion on the findings for the purpose of information sharing and data validation.

3.11 Based on feedback from the UNDP PR and the NAB/CCM, the draft report was revised. The final Programme Evaluation Report with recommendations for further strategies to ensure progress towards impact for Phase Two of the Programme and beyond will be submitted to UNDP by 20 December 2013.

4. EVALUATION FINDINGS

4.1 The Evaluation Team's findings are presented under the following headings:

- (a) Social, economic and political factors;
- (b) Target Groups.
- (c) HIV Programme service delivery;
- (d) VCT and ART provision;
- (e) Stigma and discrimination; and
- (f) Staffing and training.

Social, Economic and Political Factors

4.2 The socioeconomic situation in BiH is poor. Although the World Bank classifies the country as upper-middle income, this masks the true economic situation in which official unemployment is stated to be low but unofficial unemployment is said to hover around 40 %. The gap between rich and poor is growing as shown by the Gini coefficient¹⁸ which started to rise in 2004 and reached 36.21 in 2007. No later data are available but a worsening situation can be inferred from recent World Bank economic data.

4.3 The health system is fragmented due to the political and governmental organisation comprising the two Entities of the Federation BiH and the RS, and one administrative department (Brčko District), resulting in one centralised administrative Entity (the RS) and one decentralised Entity (F) working with a total of 183 ministries. This means an extremely complex and challenging environment in which to provide unified and cohesive services with heterogeneous policies and procedures, and equitable services throughout the two Entities and one department; and it makes coordination among players difficult. As a result, there is a system-wide inability to address problems due to the economic and socio-political situation. There are therefore gaps in service provision, which are described below.

4.4 At the State level, the Conference of Health Ministers meets quarterly, representing the Federation, RS and Brčko, and plays an advisory role. While this makes the health sector operate more efficiently than other sectors, the public health system remains weak and extremely bureaucratic, with PHC underfunded at 2.5 % of the health budget, and therefore considered to be of low status.

4.5 Poor primary health care will continue to exacerbate the gaps between the rich and the poor and lead to greater inequalities in health. It also implies that the country may be at risk of epidemics such as polio and other diseases which require action at the primary health care level.

4.6 Fragmentation in administrative organisation in BiH's health sector appears to be one of the main reasons why not all citizens are covered by the health protection system. Numbers varied depending on who the Evaluation Team talked to, but a conservative estimate appears to be that approximately 20 % of the population do not have health insurance and this is a serious impediment for the HIV Programme's ability to provide coverage to all target groups.

¹⁸ The Gini index measures the extent to which the distribution of income (or, in some cases, consumption expenditure) among individuals or households within an economy deviates from a perfectly equal distribution. A Gini index of 0 represents perfect equality, while an index of 100 implies perfect inequality. BiH is ranked 93rd in the world.

Target Groups

4.7 In accordance with the identified needs, under Round 9 the target groups included the general population but particular emphasis was placed on the following key populations exposed to increased risk of HIV infection: MSM, PWID, SW and their clients, asylum seekers, refugees, prisoners, IDP, the transient population, young people and persons who live on or below the poverty line. It also includes those persons exposed through a professional capacity to HIV: healthcare workers who come into contact with bodily fluids as well as other professionals such as policemen, soldiers, correctional officers, fire fighters, rescue service officers and members of associations and foundations that provide harm reduction services and similar. In addition, the BiH HIV/AIDS Strategy 2010-2016 indicates that significant attention should be paid to the Roma population due to their marginalisation and youth - particularly adolescents and primary school pupils in rural areas. However, it should be noted that no programme exists at the State level capable of targeting all these populations; but in Phase II the target groups have been cut to exclude the general population, young people and those exposed to HIV in their professional capacity.

Youth

4.8 Youth, previously a target group under Round 9, ceased to be so in Phase II. Support to 26 youth-friendly clinics offering life skills approach, implemented by Association XY, was suddenly dropped under Phase II with no exit strategy. When the activities aimed at supporting the 26 youth-friendly clinics were abruptly cut at the end of Phase I, no exit strategy was put in place. While youth *per se* are now not a target group as they do not all belong to one of the six primary target groups identified under Phase II (migrants and refugees, MSM, prisoners, PWID, Roma, SW), the Phase II programme originally also included a seventh category: vulnerable youth.

4.9 The abrupt closure of the youth-friendly centres was one of the most frequently mentioned issues during interviews. Not one person felt that it was a good idea. The Team were told that knowledge concerning SRH, including STI and HIV, among youth still does not appear to be sufficiently high; this was a common theme brought up by many of the Team's interviewees. Indeed, there are three factors that support continued interventions aimed at youth: (i) the generally low level of knowledge of SRH issues including STIs and HIV; (ii) the high level of stigma and discrimination that stops KAPS seeking help; and (iii) the possibility that many young people will grow up to become members of one of the KAPS populations themselves, or go into work in the health care field.

4.10 Given high levels of stigma and discrimination, rising levels of abortion and STI (primarily Hepatitis B and C infections), plus the likelihood that some youth are the future health workers and uniformed workers in BiH (and others may become members of KAPS), it seems premature to have cut all support to working with youth.

Roma Population

4.11 Global Fund support has without a doubt brought health services, and especially HIV, closer to the Roma community. This has helped raise awareness of HIV among marginalised societies. Even so, there remain some remote Roma communities that have yet to be reached, and this situation is likely to prevail due to a lack of funding.

4.12 Roma population activities were included in Round 5 and their coverage expanded in Round 9 to extend health services for Roma women, including SRH and HIV. World Vision, an international NGO, has partnered with a Roma NGO and succeeded in getting Roma representation on the CCM (see Best Practices – Box 1). The project has built capacity among 25 outreach workers and three HIV

centres covering 50 municipalities with the highest Roma population. Since the beginning of Round 9, 6,904 Roma have been reached. Their programme is comprehensive, including SRH as an entry point for bringing Roma women into health facilities, and specialist skills have been built in dealing with administration, PWID, advocacy, public speaking. Also, IEC materials have been produced in the Romany language, respecting their culture.

BEST PRACTICES – BOX 1

World Vision – HIV Prevention Efforts Reaching Out to Most Vulnerable Minorities of Roma

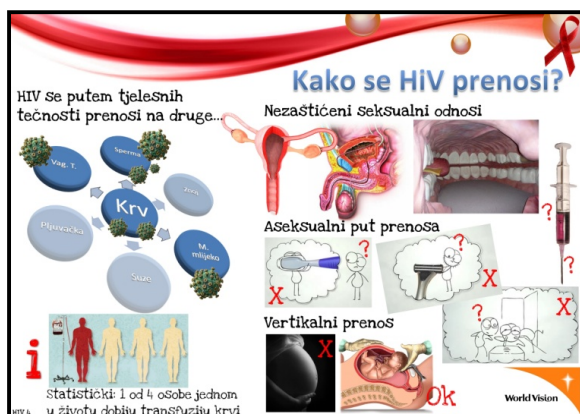
ORGANISATION: World Vision’s second activity with the HIV Programme started under the Global Fund Round 5 grant is with the Roma population. World Vision started actively working with and inside Roma communities in its earlier days in BiH (1999). This work included a SRH and rights project for Roma women, Roma communities and refugees. This activity provided a strong foundation for their latest HIV prevention intervention funded under Round 9.

GOAL AND OBJECTIVES: The project aims to ensure the sustainable prevention of HIV transmission amongst Roma, the largest and the most vulnerable minority in BiH, by information sharing within Roma communities, counselling, organising visits to VCT centres, distributing of materials; sensitising and mobilising Roma communities of the need for HIV prevention; street actions and awareness campaigns on HIV prevention and healthy lifestyles; and building the knowledge and skills needed to expand activities in new communities.

MODEL: The intervention relies on extensive outreach activities and creation of a supportive environment through involving Roma community members, thus increasing the sense of local ownership and at the same time building their capacities. This approach results from intensive work between WV BiH and Roma NGOs, joint strategic planning and the enrolment of Roma women and youth in community work, creation of an outreach system in Roma communities, and sensitisation of Roma leaders, and community members. In 2006, WV BiH, BOSPO, and 50 Roma NGOs also designed the National Action Plan for Roma Health.

Since 2011, World Vision and Roma community leaders have established three HIV Information Centres in the country employing a total of 25 outreach workers and three coordinators and each covering up to 13 municipalities. The activities of the Centres include education, information-sharing, promotion, and awareness-raising on HIV and AIDS prevention in selected Roma communities, monitoring of outreach activities, insuring access to Roma communities, empowering and liaising with other Roma leaders, cooperation with relevant health institutions regarding different health issues and organising public events and round tables.

Outreach workers who have been extensively trained on the topics related HIV, safe behaviour, SRH and rights, and provided with the necessary information materials and condoms, regularly visit selected Roma communities and provide information and education - talking to community members in streets, going from door to door, or inside the houses when they are invited in. They distribute information materials and condoms and accompany and support their clients to VCT sites for HIV and Hepatitis testing and counselling.



Taking into account the high level of illiteracy among the Roma population in BiH and large number of community members who never attended (17.1 %) or never completed (35.7 %) primary school (World Vision’s Situation Analysis of Roma in BiH, 2006), this model has been specially designed to address the illiteracy level. This innovative approach uses a special set of 11 posters (seven on HIV and four on STI related issues) designed and developed to equip each outreach workers going to local communities. One such poster, covering ways of HIV transmission, is included here as an example.

Another important element of the model is the

recruitment of outreach workers from among young people with a special focus on Roma girls and young women who have completed secondary school education who can also 'lead by their own example'.

In addition, special information sessions for Roma community members are held regularly at the HIV Information Centres and gather substantial audiences. Themes and topics for such sessions are selected based on the needs of the target groups and different experts, including medical doctors and peers, are invited to speak.

Considerable attention is paid to the work with community leaders as well as state officials and medical workers outside Roma communities seeking to bridge the gap and sensitise participants on existing health needs, culture, and effective approaches for working with Roma communities. This work has been performed through a series of special workshops and round tables conducted across the country

RESULTS: Each year almost 5,000 individual Roma community members are reached, 45,000 condoms and IEC materials distributed and over 200 referrals to VCT are made as a result of the project. A team of 25 outreach workers operates in the country providing IEC and personal experiences for Roma of different ages. Finally, several hundred medical workers, state officials, and community leaders have benefitted from the opportunity to start a dialogue on health-related issues and the broader needs of the integration of Roma into BiH society.

CONCLUSIONS AND LESSONS LEARNED: While the very first BSS among the Roma population in BiH is still under way at this moment, much anecdotal evidence suggests significant positive behaviour change in Roma communities across the country that has occurred as a result of this intervention. The most frequently quoted successes include the breaking of stigma and taboos that earlier surrounded issues of HIV/AIDS; a shift in unprotected sex and other risky behaviours (such as tattooing) towards safer practices; and an increased number of Roma tested for HIV and Hepatitis. Finally, the HIV Prevention intervention goes beyond health and achieves the even greater impact of enhancing dialogue between Roma and ethnic majorities in BiH seeking to promote the integration of Roma into Bosnian society.

Source: Muradif Biberović, Head, ROMANO DROM NGO/Roma HIV Information Center, Zivinice; Slavica Bradvić-Hanušić, GFATM Grant Lead, World Vision-BiH, November 2013.

4.13 76 patronage (mobile) TB nurses work on directly observed treatment, short course (DOTS) among Roma communities and Roma TB outreach workers work with patronage nurses. Both HIV and TB outreach workers train together and this helps ensure that services are complementary.

4.14 Again, there are issues of sustainability once the Global Fund supported component of the HIV Programme finishes. Roma NGOs will continue to need to work closely with Government to absorb outreach workers into the national health system, as they are the eyes and the ears of the communities they serve, the bridge between the Roma community and local health clinics. The outreach workers are a great resource and could do even more, such as offer rapid testing, and so on. However, outreach workers are clearly frustrated that they do not have sufficient means to meet their clients' needs, particularly with regard to SRH.

4.15 There is little involvement of the education sector beyond life skills programmes in schools and it appears that information on HIV and SRH is not currently available in schools. If and when it is introduced, there is the added problem that school drop outs occur mainly among the Roma population who are already vulnerable (due to stigma and discrimination), and through early marriage among Roma girls. More attention must be given to reaching Roma children, as the Evaluation Team was told several times by the Roma DIC and young Roma girls working there, that parents learn from their children. There is a need for peer education among young people from rural areas and young Roma who do not have access to health IEC.

Other Minority Populations

4.16 Throughout the past decade, this region has been used by human traffickers both as a destination and as the major transit route to Western Europe. Although the number of women trafficked to and through BiH has reduced significantly, the number of domestic victims of trafficking has increased, according to several interviewees.

4.17 There are rising numbers of illegal immigrants from Arab countries, China, Kenya, Kosovo and Somalia among others. Due to the economic situation, many Bosnians go abroad for work. Some returning migrants come back infected with HIV, although this number appears to be falling; according to IOM, in 2003 72.7 % of returning migrants with HIV infection were infected abroad but by 2012 this had dropped to 52.3 %.

4.18 VCT is now available for truckers at three customs borders/posts through the IOM component of the HIV Programme. Anecdotal evidence from the staff at the mobile clinic in Sarajevo indicate that the programme aimed at Bosnian truckers and migrants, which only started last year under Phase II, has been successful; 404 truckers were tested in 2012 under Phase I and, since Phase II started, 800 truckers were tested in 2013. However, attrition rates were high because many did not return several weeks later for their results. Since the rapid test was introduced in 2013, increasing numbers of Bosnian truck drivers are coming for testing and most return within the hour for their results. The change to rapid testing, therefore, appears to have had a positive impact. Syphilis and Hepatitis C testing is also offered; those testing positive are referred for treatment. To date there have been no HIV positive tests.

HIV Programme Service Delivery

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

4.20 Approximately 65 % of the HIV Programme is funded through the Entities and District, and 35 % through the Global Fund. Treatment (ART) will continue because it is offered through Entity and District facilities but prevention efforts are not sustainable without funds from the GFATM, especially as there is little or no practical Entity/District financial support for NGOs and any effective prevention interventions aimed at KAPS can only be delivered through NGOs. Likewise, public VCT clinics are staffed by Entities/District employees who receive salary top-ups from the Global Fund; unless the Entities/District is willing and able to assume these salaries or make VCT centre staffing an integral part of PHC with direct budget support, it is unlikely that these services would continue to be offered after the end of Phase II. Most staff in the VCT centres visited by the Evaluation Team commented on the stigmatising attitudes of their colleagues in other hospital departments towards the VCT centre staff; most seemed to have scant understanding of or sympathy towards those infected with HIV or seeking testing, and most thought the extra funds for the VCT centres would be better used elsewhere.

4.21 Given the nature of the HIV epidemic in Bosnia, the Programme should continue to focus on ensuring that all KAPs know their HIV status so that, if positive, they can immediately start treatment. Not only is this a good first line prevention strategy but it supports current thinking on Treatment as Prevention. Thus both prevention and treatment are equal priorities in the context of a concentrated epidemic, especially given the fact that for some KAPs, such as MSM, long-term prevention through behaviour change and condom promotion is difficult. Reducing the amount of HIV in the population becomes an equally high priority. However, the numbers of KAPs accessing VCT remain low.

4.22 Unlike any other disease, both the HIV and TB Programmes have succeeded in bringing together a wide array of stakeholders from several sectors with differing roles, opinions and agendas, both at the Government level as well as CSOs. However, unlike TB, which is viewed more as a direct health issue and addressed largely through actions within public/private health delivery, successful HIV programming requires a multi-sector response. In countries with concentrated epidemics, the health sector needs non-health organisations that can assist it to bridge the chasm between traditional health services and ones that appeal to 'hidden' populations with risk behaviours that are often regarded as abhorrent; in particular, successful HIV programmes require a skill set that is capable of tackling the prevailing stigma and discrimination which inevitably affects working in concentrated HIV epidemic situations. Nonetheless, in spite of the convolution of governmental organisations, there is significant collaboration among the various players both at a Governmental and non-governmental level. Bosnia's HIV Programme is a role model for multi-sector collaboration in the face of complex political and organisational challenges. HIV is the only health programme (other than TB, which as discussed is less complex and not multi-sector) to have a national (state) level HIV programme and supporting Strategy in place.

4.23 UNDP has performed well as a PR in the current system of political intricacy. Its neutrality has enabled it to successfully bridge the delicate tightrope between Entities. It is doubtful that a local structure would have been able to achieve so much simply because of this political complexity.

4.24 Although development and monitoring of the National HIV/AIDS Strategy functions at the state level, planning and coordination has been done at the Entity level. However, while data have been rigorously collected, little or no analysis has taken place.

4.25 The Evaluation Team were informed that many regulatory issues have been solved through the development of policy papers on different aspects of HIV, and treatment guidelines covering many marginalised populations.

4.26 The HIV Programme established 23 VCT centres (of which 22 are functional) within Government health institutions. NGOs cover the service provision gaps for hard-to-reach populations, who would not otherwise be catered for by Government services. The Programme has identified and strengthened NGOs administratively resulting in 12 SRs offering a combination of services covering all six target populations with HIV testing and referral for ART, Hepatitis C and occasionally Hepatitis B testing, provision of condoms and lubricants, IEC materials, NEP, and OST. Services are delivered through the Government VCT centres and ART clinics, DIC, outreach work through outreach workers and gatekeepers from target populations. Migrants and mobile populations are also addressed through mobile VCT. The Programme recognises that civil society strengthening is critical to the continued success of interventions, and has made provision for small grants to incipient and/or grassroots CBOs in Phase II. Additionally, the Programme has built national capacity and delivered advocacy and media campaign.

4.27 The HIV Programme is viewed as extremely successful in terms of meeting or exceeding its targets; however, there are strong arguments that some targets are in fact not the correct ones and some were set at relatively low levels. That said, it must be recognised that the setting of appropriate target levels is rendered difficult because PSE remains problematic¹⁹.

¹⁹ During Round 9 Phase I of the grant, the GF had a different approach in regard to targets which focused on the number of people receiving services through the Programme. For Phase II the GF has a new approach which is based on the percentage of coverage of KAPs. Hence the approved targets in the Phase II Performance Framework were set in accordance with available data from Round 9 and the PSE conducted in 2012 by the Public Health Institute, even though the data did not represent national figures. As an example, no

4.28 For the Programme to continue to build on its success, there is a need for ownership of the Programme within the health sector as a whole and not just with the Government staff who are paid incentives to work on HIV. The Team's impression is that NGO sustainability is doubtful without GF funds.

4.29 Seven to eight years after the start of implementation of Round 5, HIV prevalence remains low. The HIV prevention programme, largely delivered by NGOs, targeted KAPs before a concentrated epidemic broke out and thus it is reasonable to assume that it has contributed significantly to keeping HIV prevalence low (according to UNAIDS 2012 Country Progress Report). However, there is no actual evidence base for this.

4.30 Surveillance and data collection are a problem because there is no systematic methodology for data collection and monitoring and the quality of data is inconsistent and variable.

VCT and ART Provision

4.31 The Global Fund has provided a considerable amount of equipment, testing kits, PCR, CD4 machine, reagents, and technical support including computers. It is surprising, therefore, that due to a lack of equipment and training, ART resistance testing is not available for patients. The guidelines say resistance testing should be done before starting ART. Currently, clinicians and laboratory workers do not know how ART affects patients.

4.32 While there is no problem regarding a sufficiency of single-use instruments (SUI), there appears to be an issue regarding a consistent availability of gloves and masks, and sharps boxes; however, some people felt there was no problem with availability. Hence there were several differing opinions on this issue.

4.33 NGOs offer clients vouchers for VCT services at Government clinics. For monitoring use, the unit of measurement is the number of vouchers distributed rather than how many are exchanged for VCT. However, as previously mentioned, this does not reflect an accurate picture of how many KAPs attend VCT services since clients do not need to present a voucher to receive services.

4.34 Although VCT centres have increased the number of people coming in for tests, many of these come from the general population or for mandatory testing (immigrants and emigrants). Most Government VCT centres are barely used by KAPs (although this varies considerably between centres). VCT centres have mostly been located at state health care facilities. This has not been very effective in terms of covering hidden populations but it is useful as part of a long-term sustainability strategy as doctors are paid and testing centres established by the state and will continue working after GF support is discontinued.

level of coverage has been universally agreed as sufficient for all situations. Some have suggested that NEP coverage rates of 20–33 % are sufficient; others have suggested that “high coverage sites” are those where 50 % of PWIDs have been reached by one or more HIV prevention programmes. However, now the PSE data have been validated and the preliminary results of the Census conducted in 2013 are available, the Programme has been able to revise its targets accordingly. Hence the national size of the MSM population has been estimated as 4,300 – 9,500 persons (average value 6,900) and the target set for Year 5 is 4,326 (63% coverage in accordance with the average value); the national size of the PWID population has been estimated as 9,500 – 15,500 persons (average value 12,500) and the target set in Year 5 is 6,839 (coverage 55% in accordance with the average value); and the national size of the SW population has been estimated as 2,500 – 5,500 persons (average value 4,000) and the target set for Year 5 is 2,127 (coverage 53 % in accordance with the average value).

Stigma and Discrimination

4.35 Currently, there is no IEC strategy to tackle behaviour change and stigma and discrimination which cannot be addressed by training alone. Yet, similar to surrounding countries, stigma and discrimination against PLHIV and KAPs is identified as one of the main obstacles in the country's HIV response. In rural areas there is an even higher level of stigmatisation and prejudices expressed towards KAPs. Surprisingly, according to the MICS3 2006, 64.2 % of women and girls in BiH support at least one of the discriminatory attitudes towards PLHIV. Research has been done on stigma and discrimination but, to date, there has been no follow up. The failure to analyse and act on the data collected by Partnership in Health is demoralising to those who provide the data as they have no way of knowing how the data are used, what the results show, and so on.

4.36 HIV services are not targeted specifically to meet women's needs. Far fewer women are seen than men (excluding FSW) and there are no linkages with SRH other than condom distribution. Yet teenage pregnancy is rising among Roma women, and abortion is high among adult women.

4.37 There is a need to address gender issues, although BiH has not yet seen a rise in infection among women. There is also a need to focus on people with disabilities.

4.38 Stigma and discrimination is also viewed as high among health workers of all cadres. However, health workers have to deal with many different types of sub-populations and this is not always recognised. Staff in VCT centres report that they are themselves stigmatised. On the positive side, there has been a big change over the past six years with an increase in understanding and respect for confidentiality.

4.39 The HIV programme is not integrated into primary health care and thus working in the provision of VCT is considered to be an extra job and not part of medical staff's job description. Government human resources to deliver the HIV programme rely on subsidies/incentives from the GFATM. An incentives scheme is not sustainable and exacerbates stigma and discrimination within the health system.

4.40 On the positive side, HIV stigma reduction intervention has resulted in mobilising and supporting for over 500 faith leaders, faith teachers and FBO representatives and over 5,000 community members have received information through printed informational and educational materials, public events, and radio shows (see Best Practice – Box 2)

BEST PRACTICES- BOX 2

World Vision - Consensus Building via HIV Stigma Reduction in Religious Communities

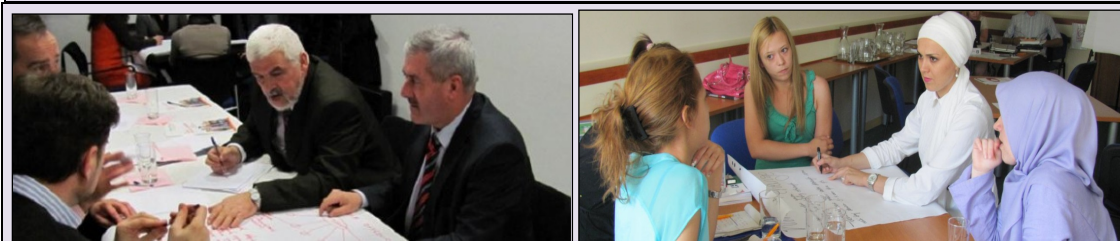
ORGANISATION: World Vision is an international Christian humanitarian organisation dedicated to working with children, families and communities to overcome poverty and injustice worldwide; and works in partnership with communities in their struggle to establish the right relationships, diminish poverty, and have society embrace those that are disenfranchised. World Vision launched its activities in BiH in 1991 and currently has 30 ongoing projects countrywide with an annual budget of about US \$ 5 million. World Vision became a SR under both the Round 5 and Round 9 GFATM grants and is successfully implementing two interventions on HIV/AIDS Prevention and Stigma Reduction within the ongoing Round 9 Programme.

GOAL AND OBJECTIVES: The key goal of the HIV Stigma Reduction intervention was to involve representatives of the key four FBOs (Jewish, Muslim, Orthodox and Roman Catholic) in the implementation of the country's HIV Programme through sensitising religious leaders and their communities to the needs of people affected by HIV/AIDS, and mobilising them to implement activities on HIV prevention, advocacy, care and support.

At the initiation of the project in 2010, a baseline Stigma Assessment was conducted in cooperation with the Inter-Religious Council in 32 municipalities through sampling 1,600 interviewees. The survey proved that HIV-related stigma and discrimination prevail among believers in all churches and the four faith communities. The most common causes for this included insufficient knowledge of HIV and the virus transmission as well as incorrect interpretation of morals and other aspects of faith related to HIV. This assessment served as a basis for further joint and more systematic engagement of churches and faith communities.

MODEL: Throughout the project, a specially designed and contextualised model and methodology, 'Channels of Hope', was used. Initially developed by the Christian AIDS Bureau for Southern Africa as a tool to assist Christian communities, World Vision has successfully adapted the original training manuals and developed four faith-tailored packages for Jewish, Muslim, Orthodox and Roman Catholic communities. The manuals, each 300 pages long, contain health-related information as well as quotes from related holy books. The full endorsement by the leadership of all faith groups was achieved by involving them in the manuals' review and adaptation process.

Simultaneously, a series of workshops to sensitise faith leaders from the four main religions were held as part of the intervention initiation. Additionally, a series of meetings with religious leaders of all four religions have resulted in the formation of a Working Group within the Inter-Religious Council with the aim of addressing HIV-related issues in faith communities and churches. In September 2010, a Channel of Hope workshop was attended by 30 representatives of all four faith communities, where an agreement was reached that each of the faith entities need trained Channel of Hope facilitators.



Accordingly, 21 faith leaders were selected and trained as Channel of Hope facilitators to facilitate workshops for their own constituencies and beyond. Experienced facilitators from World Vision took the lead, with health care experts working hand in hand with faith experts as co-facilitators to bridge the gap between health and moral/religious aspects associated with HIV. Subsequently, faith-specific initiatives representing each of the four faith communities were developed by leaders of the four religious groups and funded as pilots in Phase I. These initiatives envisaged further peer education and roll-out of the model in different religious communities.

RESULTS: HIV Stigma Reduction Intervention has resulted in mobilising and supporting for over 500 faith leaders, faith teachers and FBO representatives who adopted knowledge and skills in order to address stigma associated with HIV and AIDS, and respond to the needs for prevention, care and support in their communities. In addition, over 5,000 community members have received information through printed informational and educational materials, public events, and radio shows.

Pilot stigma reduction projects implemented by FBOs within the four faith communities have trained an additional 1,100 priests, imams and faith teachers and have disseminated information and relevant messages about HIV-related stigma to over 40,000 community members.

CONCLUSIONS AND LESSONS LEARNED: In a country such as BiH with a traditional, patriarchal, closed and multi-ethnic society where religious beliefs play an important role in forming societal patterns, faith leaders and faith workers have proved to be key agents of change that go beyond a successful HIV response and has a much broader positive impact. Such leaders form the correct social values and norms which are necessary for combating HIV-related stigma and discrimination, and influence public attitudes and behaviour in health and other fields. By providing faith workers with the tools needed to spread constructive messages of tolerance in line with their faith doctrines, the Project has initiated a powerful process with the potential to reach all segments of society and has already had visible and strong non-health impacts of peace and consensus building.

"Faith leaders became aware of the complexity of (HIV) topic and are very committed to the task, despite its sensitivity, when it comes to the need for articulating these issues in churches and faith communities. I believe

that, thanks to this workshops, the forthcoming small projects on HIV and stigma reduction in faith communities will be well implemented.” (Representative of IRC.)

“I have been working as an imam for over 10 years and in my speeches I have never mentioned this topic. That is going to change.” (Imam)

“Since my childhood I did not have the chance to spend time [with] or talk to people who weren’t orthodox. In 2010, I got involved in World Vision’s project of stigma reduction towards people living with HIV and AIDS. I attended the first meeting that was organized by World Vision and [the] Interreligious Council as a representative of [the] Serbian Orthodox Church. Besides me, there were also representatives of other traditional churches and religious communities in Bosnia and Herzegovina. During the meeting, and as a result of my prejudices that stem from the war, I was very vigilant and suspicious regarding the possible cooperation and joint stance for solving this big social problem. Through the Stigma project, however, I became close and befriended representatives of other religions and my hard stance from the beginning completely changed. Two years [have passed] since the start of the project. We held many joint seminars and workshops on HIV and AIDS and [the] accompanying stigma. From our cooperation, one big friendship grew between me and the World Vision staff, representatives of the Islamic community, [representatives of the] Roman Catholic Church and Jewish Communities. After completing the Channels of Hope training in 2011, I held over 40 workshops for priests and orthodox believers” (Serbian Orthodox Priest)

Source: *Slavica Bradvić-Hanušić, GFATM Grant Lead, World Vision-BiH, November 2013.*

Staffing and Training

4.41 The number of UNDP PR PMU staff was halved at the start of Phase II. The Programme went from 13 people in PMU and 13 SRs, to six PMU staff and 12 SRs. The challenge of the programmatic M&E of 12 SRs spread between two Entities and one District operating different health system organisations, plus the heavy project management workload generated by managing 12 SRs, means that PMU staff are over-stretched. Indeed, staff are so busy monitoring the SRs and coping with GF bureaucratic requirements that they have little if any time for wider programmatic issues.

4.42 A considerable amount of training has been offered over the past seven years; however, this has not been based on a capacity building needs assessment. The lack of a comprehensive training plan means that training is ad hoc and uncoordinated. This applies to both medical and non-medical professionals within Government services as well as NGO staff. Under Phase I, little had been done to harmonise training and this has resulted in an unnecessary repetition and duplication of training among the SRs. For Phase II there were several discussions at the CCM/LFA/GF level regarding capacity building for health and non-health professionals as well as for SRs. The originally proposed training plan, designed in accordance with the GF-approved HIV budget for Phase II, has been cut back in an effort to harmonise trainings. In addition, a questionnaire to assess the quality and benefits of the training was developed by the PHI’s M&E Units during Phase I. This will continue to be implemented during Phase II. To date, findings show that although many training sessions had similar or the same titles, or were conducted in the same facilities, there was no duplication of participants. Nonetheless, this does not negate the need for a training needs assessment or full training plan.

4.43 The Global Fund has supported education for primary and secondary health care providers; but, without such support in future, the provision of this type of education will likely discontinue.

4.44 There is not enough local capacity for diagnostics, and especially for the diagnosis of latent infections. However, medical professionals are not obliged to take any training to extend their licences.

5. RECOMMENDATIONS

5.1 The Evaluation Team's recommendations are presented under the same headings as the findings in the previous section:

- (g) Social, economic and political factors;
- (h) Target Groups.
- (i) HIV Programme service delivery;
- (j) VCT and ART provision;
- (k) Stigma and discrimination; and
- (l) Staffing and training.

Social, Economic and Political

5.2 CCM and UNDP should take a more pro-active role in coordinating partners' efforts within the transition period, especially on the issues of sustainability of ongoing efforts, gender sensitising of existing services, and advocacy at local level. This may require creating additional working groups at the level of NAB/ CCM.

5.3 To better support CSOs in their advocacy efforts at local level, their advocacy skills must be developed and appropriate mechanisms designed and introduced. This could be through representation, coordination of efforts and support of working groups and other events that would bring state and CSO members together and assist in developing the transition to state funding plans and amending relating legislation (e.g. ensuring a legal framework for social contracting, development of social enterprises etc.) to the extent possible.

5.4 To achieve sustainability, changes in policy and budget allocation at Federal and RS level will be required.

5.5 Efforts should be made to increase collaboration with other international and local stakeholders (for example, World Bank, EU, Swiss Agency for Development and Cooperation) engaged in overall health system strengthening in order to ensure better coverage and inclusion of KAPs with regard to health and social security coverage.

Target Groups

Youth

5.6 A KAPB survey should be undertaken to ascertain the level of knowledge and understanding of SRH, including HIV, among young people. Their attitudes towards KAPs and PLHIV should also be explored in order to determine the level of stigma and discrimination among youth. Such surveys would inform the development of a BCC strategy to work with young people and foster a more conducive environment for rolling out information sessions on SRH, HIV and stigma and discrimination towards KAPs and PLHIV. Topics should include modules on gender issues, including GBV. The KAPB survey should also be used to identify and work with NGOs who work with young people in the informal sector, and who would be willing and able to run education sessions with young people.

5.7 The decision to close the youth-friendly clinics should be reconsidered, including examining the possibility of reopening these with non-GFATM funds. Failing this, a strategy for the inclusion of life skills programmes, or educational sessions that used to be run at the youth-friendly centres, should be developed and efforts made to establish alternative venues to hold such sessions.

5.8 More involvement of the Ministry of Education is key to getting the right messages to children in the formal education system. HIV mainstreaming in the education system could be strengthened by, for example, establishing a dialogue with education ministries working through other partners such as the United Nations Population Fund (UNFPA) and UNICEF. Through this mechanism an appropriate life skills programme should be developed with a focus on SRH (including STIs, HIV and adolescent pregnancy) and stigma and discrimination, for in-school and out-of-school (non-formal sector) young people. The programme should also take account of the needs of Roma youth.

Roma Population

5.9 The provision of community-based outreach workers to visit Roma women should be continued, with efforts made to encourage Roma women to take up services. Necessary resources – for example, mobile clinics, transport provision, other incentives – should be made available to enable outreach workers to be able to visit Roma populations in hard to reach areas.

5.10 The HIV Programme should continue to advocate for the provision of health insurance coverage for all Roma, and support Roma CBOs to do so.

Other Minority Populations

5.11 Data on migrants should be collected and used to inform the development of targeted interventions.

5.12 The population target group should be expanded to include all truckers, not just Bosnians. New ways should be devised to reach truckers; for example, peer leaders (young men chosen from among the trucker population willing to distribute IEC materials to their peers and accompany their colleagues to mobile VCT) would be a good way of assisting the mobile clinics to widen their clientele base.

HIV Programme Service Delivery

5.13 To ensure programme sustainability once GFATM has withdrawn and to enable the HIV/AIDS Programme to become embedded within the health system, a Transition Strategy and Operational Plan must be developed and adopted by the final year of the Global Fund grant. Development of the Strategy should commence with undertaking a Stakeholder Analysis to identify activists, supporters, possible opposition and stumbling blocks. Above all, such an Analysis will bring stakeholders together, ensure that no-one is left out, raise awareness and deepen support for the Programme, and engender consensus-building and ownership.

5.14 The Strategy must define who in BiH will be responsible for follow up and sustaining activities. The Strategy must also ensure that prevention efforts remain the focus for the foreseeable future, with attention paid to defining the most effective interventions going forward to yield an impact on the epidemic, and building and sustaining the capacities of the Government entities and CSOs to deliver these interventions. This will call for working with Government and CSO partners to identify the most effective interventions and to build support for their sustainability. Emphasis should be placed on building capacities of CSOs working with the most excluded and marginalised populations, such as MSM and Roma, with special attention to community mobilisation.

5.15 The development of a Transition Strategy must be accompanied by a Capacity Needs Assessment and Capacity Development and Training Plan.

5.16 Giving equal priority to prevention and treatment has two implications for future programming:

- (i) the availability of rapid testing should be expanded and introduced across the board, and offered through outreach workers, DICs and mobile clinics to ensure that access becomes easier for all KAPs; and
- (ii) the Government will have to commit to funding all ART and OI, include the drugs on the list of essential medicines, and guarantee that health insurance coverage is there for those most in need.

5.17 The numbers of PLHIV will increase, albeit slowly, and care must therefore be taken to ensure that they are supported and that their physical and psychological needs are met through a comprehensive service delivery model that encompasses clinical and psychosocial interventions.

5.18 UNDP should continue to manage the Programme through the Transition phase, working hand in glove with Government and NGO counterparts to ensure a smooth transition. Job sharing, job shadowing and job swaps would be some of the innovative ways for the PMU to expand the capacity of the counterparts to assume control of HIV Programme delivery. Study tours might be arranged for Government and NGO staff to similar and/or neighbouring countries who have also moved, or are in the process of moving, from an independent, international PR to a local one..

5.19 The necessary regulatory framework must be in place before the end of Transition phase. In order to achieve this, policy guidelines with regard to KAPs, ART and OI service provision should be reviewed and updated, with minimum training standards established.

5.20 Government staff should not have to be paid incentives to work in VCT clinics; rather, these tasks should become incorporated into regular job descriptions. This will contribute towards greater ownership of the HIV Programme within the Government health service.

5.21 A PSE should be repeated for the three major KAPs (MSM, PWID and SW), but also including a fourth, the Roma, in 2014 or 2015, aided by the census results and using the PSE Manual prepared by APMG..

5.22 The CCM should establish a Working Group with M&E responsibility (this is also a condition of the Global Fund vis-à-vis the CCM) who will meet on a regular basis and work with the three PHIs to develop a national M&E strategy with realistic and manageable targets, and design a feedback mechanism so that data are not just collected but analysed and fed back into the system.

5.23 This Working Group should also be mandated to review the existing body of research undertaken during the past seven to eight years to identify gaps in research and determine future research needs in order to provide the evidence base that can be used to inform the design of the most effective and targeted programme interventions.

5.24 Mechanisms for data quality and control and data accountability must be part of this.

VCT and ART Provision

5.25 Full coverage of ART must be assured within Transition Strategy, including provision for resistance testing, and transfer of all responsibility concerning ARVs and drugs for OIs to Government, reflected in the list of essential medicines for the Entities/District as appropriate, and liaison with appropriate bodies to ensure complete coverage of ARV patients through health insurance.

5.26 The Transition Strategy must ensure adequate coverage of gloves, sharps and other necessary equipment during Transition Strategy with clear guidelines on protocol for minimum standards and identification of responsible parties following completion of the transition phase.

5.27 During the Transition phase, Global Fund subsidies to Government VCT centres staff should be phased out and the Government should take over the future costs of human resources for VCT centres are met by the Government. This implies a review of the level of use of the VCT facilities and closure of some facilities as appropriate.

5.28 The introduction of widespread rapid testing by non-medically qualified professionals (such as outreach workers and gatekeepers, staff running DICs and mobile clinics, and so on) is a key strategy for improving uptake of HIV testing among KAPs. If current legislation cannot support the provision of rapid testing through non-medical personnel, efforts should be made to review and revise the existing regulatory framework to allow such provision. The HIV Programme should change the unit of measurement/indicator from the vouchers given out to the number of vouchers exchanged for services.

Stigma and Discrimination

5.29 A stratagem to address stigma and discrimination and foster behaviour change should be an integral part of the Transition Strategy. A good way to start would be to review and follow up on previous research undertaken on stigma and discrimination. Where successful interventions have been identified (such as the work of World Vision through FBOs, this new Stigma and Discrimination approach could build on current successes, developing tools and models of working with on HIV and other health-related issues. A BCC strategy should include use of multimedia and in particular newspapers, television, radio and Internet.

5.30 A different approach might be needed to address stigma and discrimination in health-related settings. Identification of influential and respected 'champions' or agents of change from among peers should help with publicising and addressing the key issues that affect stigma and discrimination in medical settings.

5.31 The HIV Programme should consider how best to liaise with PHC services offering SRH to ensure that HIV is addressed within the context of wider STI.

5.32 There must be a focus on gender sensitisation of services in the Transition period, including design, development, relating training and integration of gender sensitive services into current programmes and projects (which could encompass very simple and easy ideas such as holding women's days at DIC and childcare facilities, or women's health sessions within ongoing training/education activities at those DIC).

Staffing and Training

5.33 The GFATM/UNDP should maintain the number of staff agreed to be necessary to ensure the smooth transition of the HIV/AIDS Programme from being largely GFATM-supported to other sources of funding, over an agreed time period but probably not less than five years.

5.34 As mentioned in several preceding sections, a training/capacity building needs assessment must be undertaken and used as the basis for developing a comprehensive training plan for all staff – Government, UNDP, CSO, FBO and others as necessary.

5.35 The Transition phase must follow through with the interventions outlined in Phase II of Round 9 to build the capacities of CSOs in terms of intelligent management, fundraising and other support to strengthen CSOs' ability to multi-sectoral collaboration and changes in legislative framework as beforehand.

5.36 The Entities/District as applicable should agree to integrate the HIV training syllabus into existing health worker training curricula to strengthen knowledge among health professionals, including tools for combating stigma and discrimination.

5.37 The aforementioned BCC Strategy and implementation plan must also be an integral part of the Transition Strategy, including a focus on communication techniques.

5.38 Finally, the HIV Programme should review the curriculum for joint TB/HIV patronage nurses/outreach worker training to ensure the inclusion of SRH and STI.

Evaluation Matrix

Criteria and assessment		Indicators			Means of verification						
					2012 IBBS studies among IDUs, FSWs, MSM and Prisoners	Programmatic document review	Interview: key population orgs	Interview: NACs	Interview: Govt Ministries	Interview: CCM	
Effectiveness	1	Has there been a change in outcomes and behaviours, positive or negative?	1.1	Knowledge of HIV status among Key Populations	X	X	X				
			1.2	Condom use at last sex with non-regular partner	X		X				
			1.3	12-month ART retention by ART treatment cohorts by year by risk group		X		X			
	2	Has there been an increase in coverage of key intervention services, and have these reached groups at risk?	2.1	ART coverage		X		X			
			2.2	PMTCT coverage, including coverage with ART to reduce mother-to-child transmission of HIV		X		X			
			2.3	Management of HIV/HCV and HIV/HBV co-infection		X		X			X
			2.4	Opportunistic infections prophylaxis coverage		X		X			X
			2.5	Prevention interventions coverage (harm reduction, methadone, testing, condom provision, etc.) by risk group	X	X	X	X			X
	3	Has access by age, sex, equity and quality of key intervention	3.1	Equity by age, sex, rural/urban, and subgroup (e.g. FSW/IDU, MSM/SW)	X	X				X	

Criteria and assessment		Indicators				Means of verification				
		3.2	For each risk group: defined service package, service delivery, frequency, service providers, package of services implemented according to design, implementation issues			X	X	X		X
Impact	4	Has there been a change in disease burden, positive or negative?	4.1	Mortality by ART treatment cohorts by year (among people on ART and among total reported cases)		X			X	
			4.2	Morbidity (including opportunistic infections)		X			X	
			4.3	Incidence for each risk group		X			X	
			4.4	Prevalence for each risk group		X			X	
Efficiency	5	What was the GF contribution in scale up of resources, increase of coverage of key intervention services, improvement of service quality and outcome?	5.1	GF financing to-date		X				X
			5.2	Service delivery and other activities, population groups targeted and areas the funding has contributed to		X			X	X
Efficiency	6	What were the other competing explanations and hypotheses of changes in outcomes and impacts, positive and negative?	6.1	Financial contributions according to budget for national, donor/partner and Global Fund sources		X			X	X
			7	How can contributions of the Global Fund be redirected to better contribute to outcomes and impact? What are the management recommendations?	7.1	Re-programming, priority groups and high-impact interventions		X	X	
			7.2	Best package of services for high-impact interventions		X	X		X	X

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Mission Schedule

Monday 11 November 2013
Federation Ministry of Civil Affairs (FMOCA) Dr Šerifa Godinjak CCM Chairman, and Head of Department for European Integration and International Cooperation, Sector for Health in the FMOCA INTERVIEW
UNFPA Daniela Alijagić, M&E Programme Analyst INTERVIEW
IOM Mirsada Zećo, Medical Programmes Coordinator; and Mladen Kakuca, Project Officer INTERVIEW
NGO PROI -Sarajevo Samir Ibišević, NGO President, and Uliana Bakh, Programme Director INTERVIEW
Association XY Ismir Hodžić- Project Coordinator; Nedžad Džebo, MSM OW; Darijo Krmek, MSM OW; and Kerim Dževlan, MSM counsellor. INTERVIEW
UNDP PR PMU Team Meeting Nešad Šeremet, HIV/AIDS Programme Manager; Džanela Babić, HIV/AIDS Monitoring and Evaluation Expert; Ivana Stojadinović, HIV/AIDS Procurement Associate; Šejla Branković-Merdžo, HIV/AIDS Finance Associate; Nejlja Sakić Kadić, HIV/AIDS Finance Associate; Saša Potežica, HIV/ AIDS M&E Assistant; and Arijana Drnić, HIV/AIDS Monitoring and Evaluation Data Collection Clerk BRIEFING AND DISCUSSION
Tuesday 12 November 2013
UNICEF Selena Bajraktarević, Programme Officer INTERVIEW
World Vision Slavica Bradvić Hanušić, Grant Lead; Alma Buzuk, Finance Officer; and Maja Grujić, Health and Advocacy Programme Manager INTERVIEW
Medical Faculty, University of Sarajevo Prof. Dr. Semra Čavaljuga, epidemiologist INTERVIEW
UNAIDS Mirza Musa, former UNAIDS Focal Point INTERVIEW
Kakanj HIV Centre Mujo Fafulic, HIV/AIDS Roma Centre Coordinator INTERVIEW
Partnerships in Health Damir Laličić, Project coordinator INTERVIEW
Integrated Prevention, Treatment, Care and Support (IPTCS) Amer Paripović, Project Officer PLHIV

INTERVIEW
Wednesday 13 November 2013
Public VCT and ARV Centre Dr Vesna Hadžiosmanović, clinician and infectologist at Infectious Disease Clinic Sarajevo; VCT centre coordinator INTERVIEW
PWID and OST Centre Dr. sci.med. Nermana Mehić- Basara, Director of the Institute for Alcoholism and Substance Abuse of Sarajevo Canton; Prim. Spec. Dr. Senija Selman; Magbula Grabovica, Head Nurse; Džemail Mehmedspahić, Medical technician INTERVIEW
World Health Organisation Dr Haris Hajrulahovic, Head of WHO Country Office INTERVIEW
APOHA Zvezdana Jakić, Director and Psychosocial Counsellor; Mersha Huseini, Psychosocial Counsellor; Adis Delibašić, Psychosocial Counsellor; Ćamil Osmanagić, Project Officer; Melisa Bulbul, Psychosocial Counsellor; Alden Husković, OW; and Sanela Ablaković, Finance Manager INTERVIEW
IOM - visit to border customs mobile VCT for truckers at Halilović Mirza Habul, activist/peer educator; Ševala Suljagić, medical technician; and Mirsada Zećo, Medical Programmes Coordinator, IOM INTERVIEW AND OBSERVATION
Thursday 14 November 2013
FBiH MOH Dr Zlatko Čardaklija; Federal HIV Coordinator in the MOH INTERVIEW
CCM Meeting Presentation and Discussion of Draft PSE Paper
Monday 18 November 2013
UNDP Regional Office, Mostar Bozena Bóhm Kaltak INTERVIEW
FPHI, Mostar 1. Dr Zlatko Vućina, Head of the centre for health management PHI FBiH, HIV/AIDS Resource Centre Coordinator in FBiH 2. Dr Jelena Ravlija, Manager of the Department of Epidemiology PHI FBiH HIV/AIDS Programme Coordinator INTERVIEW
UNDP Regional Office Banja Luka Goran Vukmir, Head of Regional Representation Office, UNDP
RS PHI 1. Dr Jovan Živković, Epidemiologist 2. Dr Ljubica Jandrić, M&E Officer 3. Jelena Medar Petrović, Senior Pharmaceutical Officer, RS MOHSW INTERVIEW
Public Health Institute, Mostar, FBiH Emilija Primorac, Nurse -Expert Associate for immunisation, HIV/AIDS M&E Assistant, VCT Site INTERVIEW

<p>NGO Margina, DIC for PWIDs and SWs, Mostar</p> <ol style="list-style-type: none"> 1. Natasa Dadajić, Project Coordinator for PWID 2. Denis Dedajić, Regional Coordinator for SW and Prisoners, 3. Mirza Efendić-Programme Officer for PWID 4. Leo Jurić, OW for SW and Prisoners <p>INTERVIEW AND OBSERVATION</p>
<p>NGO Margina, DIC for PWIDs and SWs, Mostar</p> <p>FOCUS GROUP WITH PWID</p>
<p>NGO Margina, DIC for PWIDs and SWs, Mostar</p> <p>FOCUS GROUP WITH SW</p>
<p>Tuesday 19 November 2013</p>
<p>RS PHI Banja Luka</p> <p>Dr Slobodan Stanić, Director of Public Health Institute in RS; HIV/AIDS Resource Centre Coordinator RS</p> <p>INTERVIEW</p>
<p>VCT Site, State Hospital of St. Luka, Doboj, Republika Srpska</p> <p>Dr Svjetlana Adzić</p> <p>INTERVIEW</p>
<p>OST Site, Doboj, RS</p> <p>Dr Ferhad Hadžiibrahimović, Department of Psychiatry, General Hospital, Doboj, physician specialist –psychiatrist</p> <p>INTERVIEW AND OBSERVATION</p>
<p>PHI VCT Centre Banja Luka</p> <ol style="list-style-type: none"> 1. Dijana Knežević, nurse, VCT counsellor 2. Dr Milan Petrović, VCT counsellor <p>INTERVIEW</p>
<p>POENTA Banja Luka</p> <ol style="list-style-type: none"> 1. Viktor Bjelić, Finance Manager 2. Tanja Oljača, Data Clerk 3. Miroslav Petrović, Programme Manager <p>INTERVIEW AND OBSERVATION</p>
<p>AAA Banja Luka</p> <p>FOCUS GROUP WITH YOUNG MSM</p>
<p>NGO PROI –Bihach</p> <ol style="list-style-type: none"> 1. Samir Ibišević, NGO President 2. Panka Vojnikovic, DIC Operator 3. Nevzeta Ibrahimpašić, VCT counsellor <p>INTERVIEW</p>
<p>Roma HIV DIC, Zivinice, FBiH</p> <p>Muradif Biberović, HIV/AIDS Roma Centre Coordinator</p> <p>INTERVIEW</p>
<p>Wednesday 20 November 2013</p>
<p>PHI Brčko</p> <p>Dr Mirjana Kuzmanović, Epidemiologist</p> <p>INTERVIEW</p>
<p>Action Against AIDS NGO (AAA), Bjeljina, RS</p> <p>Asmira Mulaimovic, Outreach Worker</p> <p>INTERVIEW</p>
<p>VCT Site, Bjeljina, RS</p> <ol style="list-style-type: none"> 1. Dr. Aleksandra Radojčić, VCT counsellor

2. Srđan Ilić, VCT counsellor INTERVIEW
PRO1 DIC Brčko District– FOCUS GROUP WITH PWID AND DIC OPERATOR
NGO PROI, Bihac focus group with PWID Samir Ibišević- President of Association PROI INTERVIEW AND FOCUS GROUP
NGO Poenta, Banja Luka Željko Marjanac, Director, and 12 PWID FOCUS GROUP WITH PWID
NGO AAABanja Luka, Seđan Kukolj, President of AAA INTERVIEW AND FOCUS GROUP WITH 2 FSW
Thursday 21 November 2013
NGO Margina, DIC for PWID and SW, Tuzla, BiH Denis Dedajić, President FOCUS GROUP WITH 4 SW AND 2 GATEKEEPERS
NGO Margina, DIC for PWID and SW, Tuzla, BiH 1. Dinjko Stojaković, police inspector 2. Adnan Mustedanagić, police inspector FOCUS GROUP WITH 2 POLICE INSPECTORS
NGO Margina, DIC for PWID and SW, Tuzla, BiH FOCUS GROUP WITH SW
VCT and ARV Site, Tuzla, FBiH Dr Sana Šabović, Infectologist at Clinic for Infectious Diseases in Tuzla, HIV/AIDS VCT Coordinator INTERVIEW
NGO Margina, DIC for PWID and SW, Tuzla INTERVIEW AND OBSERVATION
OST Site, Tuzla Dr. Mevludin Hasanović, Head of Psychiatry Clinic in Tuzla INTERVIEW
Friday 22 November 2013
FBiH MOH Dr Ćardaklija, Federal HIV Coordinator in the MOH INTERVIEW
LFA Dr Narcisa Pojskić, UNOPS INTERVIEW
UNAIDS Mirza Muso, former UNAIDS country coordinator INTERVIEW
UNDP PR PMU Dr Nešad Seremet, Programme Director INTERVIEW
Tuesday 26 November 2013
UNDP PR PMU Nešad Šeremet, HIV/AIDS Programme Manager Džanela Babić, HIV/AIDS Monitoring and Evaluation Expert Ivana Stojadinović, HIV/AIDS Procurement Associate

Šejla Branković-Merdžo, HIV/AIDS Finance Associate
Nejla Sakić Kadić, HIV/AIDS Finance Associate
Saša Potežica, HIV/ AIDS M&E Assistant
Arijana Drinić, HIV/AIDS Monitoring and Evaluation Data Collection Clerk
DEBRIEFING ON EVALUATION FINDINGS, CONCLUSIONS AND RESULTS

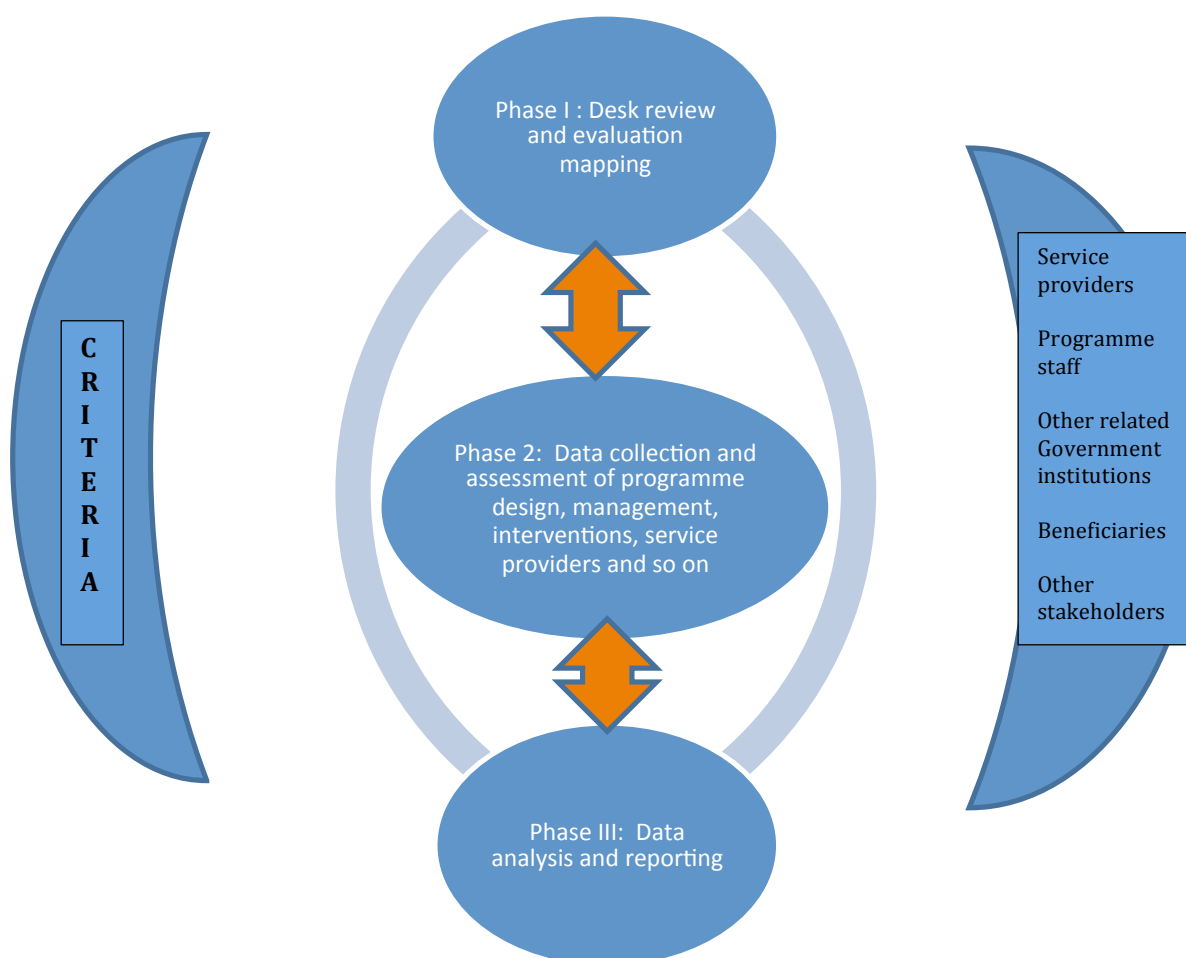
The Conceptual Framework for the Evaluation

The programme evaluation is divided among the three phases as follows:

1. Desk review of existing documentation and development of protocols for fieldwork, including design of questionnaires and identification of target groups/programme beneficiaries to be interviewed; the team will review, inter alia, programme design, management and implementation, including by PR, Sub-recipients and Sub-sub-recipients (SR and SSR), Government and other significant stakeholders (for example, relevant donors);
2. Fieldwork for further data collection, referring to the implementation and service provision levels and stakeholders defined in the TORs and through the desk review above; and
3. Data analysis, resulting in a report describing the programme and its interventions, lessons learned and recommendations for future programming.

The relationship between these three phases is depicted in Figure 1 below.

Figure 1: Overview of the Programme Evaluation Framework



Methodology

Collaborative and participatory processes will be core elements of this evaluation. Employment of a range of methodologies including document reviews, focus group meetings, interviews and field investigations will promote inclusion and ensure the evaluation is consistent with gender equity principles and good development practice.

To create a positive environment for dialogue, the evaluation team will use Appreciative Inquiry (AI) methodology throughout the evaluation. This approach combines a rigorous examination of data with a focus on the strengths and achievements of programmes and institutions to determine ways to build on those strengths for increased effectiveness. At the core of the AI methodology is an examination of what has worked, drawing out the successes and progress that implementing partners and beneficiaries can identify. It is the team's experience that this positive starting point reveals different information and brings enthusiasm to the task of evaluation rather than an immediate focus on problems, barriers and obstacles. It engages programme staff and other stakeholders in a constructive dialogue that acknowledges and rewards the considerable effort that has brought them to this point in the project's implementation. It is not a substitute for an objective and rigorous examination of progress and process, but complements this by developing an evaluation environment that is constructive and participatory. It ensures that positive processes and outcomes are identified, analysed and reproduced. Evaluators, partners and sponsors are attracted to this approach as it:

- Engages stakeholders in structured dialogue to develop further the evaluation questions, and to validate them;
- Reframes evaluation tools to strengthen qualitative data collection; hence every tool that is developed will need to be adjusted according to the context and the target population;
- Increases use of evaluation results and learning; and,
- Complements and strengthens the evaluation process.

Use of the AI method will assist the evaluation team to determine if the planned activities will in fact produce the expected outputs – for example, if they are consistent with each other with regard to the definition of components (activities and outputs) - from the point of view of their logical sequence, temporal dimension, and the requisite organisation for the achievement of results. It ensures:

- Review of the programme at two levels:
 - Level 1: Governance through the Country Coordinating Mechanism (CCM), Programme Steering Committee (if such exists), PR Project Management Unit (PMU) organisation and structure, SRT and SSR organisation and structure; monitoring and evaluation (M&E) framework.
 - Level 2: Programme implementation, including PR and SR/SSR, service delivery staff and mechanisms for programme coordination and support.
- Clear definition of the milestones of the programme, inputs, processes, outputs and outcomes or results associated with each milestone.
- Clear definition of the indicators associated with each programme objective, expected outputs, results and impact according to the Programme Performance Framework (PPF), related annual work plans and time line.
- Clear assignment of responsibilities for the achievement of each of the components and subcomponents at the implementation level.
- Clear definition of responsibilities for the achievement of the activities and assigned tasks.
- Clear tracking of progress toward meeting the programme's performance goals and objectives by service delivery area (SDA).

The evaluation team will select and focus the evaluation criteria on two main areas: effectiveness (outcomes and impact) and efficiency. A mix of quantitative and qualitative data collection methods will promote triangulation; both the qualitative and the quantitative information will interact to produce an explanation of the results as demonstrated in Table 1 below, *Assessment Criteria and Methods* (page 10). The methodology for the evaluation will also ensure an examination of the programme's adherence to the GF principles regarding value for money and equity of service provision.

The Global Fund was designed to provide effective and efficient funding to combat the three diseases (HIV, malaria and tuberculosis). It is committed to the principles outlined in the Paris Declaration on aid effectiveness and to continuing to strengthen measures to improve the value for money of services delivered. Through its demand-driven approach, the Global Fund supports country-owned solutions, enabling local stakeholders to identify the most appropriate and efficient ways to manage their programmes. Ensuring value for money at every stage of the financing chain is a priority for the GF and UNDP, extending from donors to the people who benefit from service provision. Increasing value for money throughout the grant life cycle in turn improves the efficiency of grant implementation and programme services directly.

Phase I: Desk Review

The evaluation team will undertake an extensive and in depth desk review of documentation related to the Programme, as well as the national environment in which the Programme operates.

Phase II: Data Collection

To be able to provide an objective measurement of performance, several dimensions of the Programme will need to be assessed.

First, at the Programme management level, two types of assessments will be conducted:

- **Activity-based**, measuring the %age of activities completed, as well as the correlation of the expected inputs and processes with the expected outputs, results and impact (the Programme's approved PPF); and
- **Time-based**, measuring the %age of completed activities and tasks, outputs and outcomes, and expected impact in the defined time frame.

Second, criteria-defined assessments will be conducted with various stakeholders, grouped as follows:

- **Programme beneficiaries:** target groups and key affected populations (KAPSs) such as men who have sex with men (MSM), people who inject drugs (PWID), sex workers (SWs), people living with HIV (PLHIV), and caregivers;
- **Service providers:** health care professionals including medical personnel and people providing psychosocial and palliative care who are not medically trained (counselling staff and service providers from community-based organisations (CBOs), others as appropriate;
- **Decision-makers at the national level:** federal authorities and key stakeholders from, inter alia, the Ministry of Health (MOH), Ministry of Finance (MOF), the CCM and other development partners.; and
- **Decision-makers at the local level:** this includes republican, community and district health authorities and sub-national governmental structures.

The set of predefined criteria will be applied through a variety of methodologies such as semi-structured interviews, focus groups and, in specific cases, small surveys within selected communities.

Commensurately, health care providers will also provide a significant data source through the evaluation team's review of selected HIV-related services facilities.

The criteria that will be used to assess impact are:

- Relevance
- Effectiveness
- Efficiency
- Sustainability
- Coherence
- Beneficiaries (Programme target groups)
- Service providers
- Rights-based approach

Application of the criteria by stakeholder levels will be as follows:

Relevance:

National decision-making level, including management and steering committee level:

- ✚ What is the Programme's relevance in terms of advocating for and facilitating national HIV prevention and treatment?

Service providers:

- ✚ To what extent is the training component appropriate in response to the training needs of the target groups?

Programme beneficiaries/target populations:

- ✚ To what extent is the Programme relevant in terms of contributing to improve beneficiaries' wellbeing, quality of life improvement and behavioural change?

Effectiveness:

National decision-making level, including management and steering committee level:

- ✚ To what extent is the Programme's governance structure suitable to implement in an effective, transparent and participatory way and to promote upstream policy change in the areas of concern?

National decision-making level:

- ✚ To what extent is the Programme effective in facilitating the adoption of new policies, policy changes, quality improvement and governance of the health system in line with relevant Programme objectives and goals defined in the approved grant application, and international best practices and standards (i.e. UNAIDS, UNFPA, UNICEF, WHO)?

Regional and community decision-making level:

- ✚ To what extent has the Programme contributed to health authorities and other institutions promoting HIV prevention and treatment, and behaviour change, as well as informed decision-making on resource mobilisation and sustainable planning in line with international standards?

Service providers:

- ✚ How effective is the Programme in improving service providers' knowledge and skills in selected aspects of service provision and in terms of quality of care against the indicators set in the Programme's logical framework and in line with international standards?
- ✚ To what extent have trained service providers (individuals) modified their regular practices related to various Programme interventions against set indicators and in line with international standards? What are the enabling/constraining factors that facilitated/hindered this behaviour change?

- ✚ In the service facility workplaces where trained practitioners work, to what extent have regular practices related to selected Programme interventions been modified in line with relevant international standards?
- ✚ To what extent has the Programme contributed to the improvement of overall resource management in the relevant service facilities?
- ✚ To what extent has there been an improvement in terms of coverage of target populations, quality of care and the Programme beneficiaries' behaviour change?
- ✚ To what extent is the M&E system effective in reinforcing skills application and tracking of both human resources and skills?

Efficiency:

- ✚ Does the HIV Programme use its resources in the most economical manner to achieve its objectives? Are the available resources (financial, human and/or technological) adequate to meet Programme needs?

Sustainability:

National decision-making level:

- ✚ To what extent do the MOH and other Government agencies demonstrate ownership of the Programme?
- ✚ To what extent is the Programme part of national policies and strategies in order to facilitate the MOH's mainstreaming and/or integration of HIV prevention and treatment into the BiH health system, therefore assuring sustainability of the results achieved?

Sub-national decision-making level:

- ✚ To what extent does the MOH at the region, district and community levels demonstrate ownership and capacity for resource mobilisation to be able to consolidate and sustain achievements and the expansion of Programme interventions within their catchment areas?

Service providers:

- ✚ To what extent are the changes in the quality of care offered by health providers expected to last? What are the bottlenecks and gaps in the continuum of care that hinder service providers' capacity to provide ongoing quality and equitable HIV-related services?

Beneficiaries (target populations):

- ✚ To what extent are the behavioural changes among beneficiaries expected to last? What factors exist that are likely to assist or obstruct sustainable changes? What are the bottlenecks and gaps in the continuum of care that hinder the capacity of target populations to access and use quality HIV related services for themselves and their peers or partners?

Coherence:

- ✚ To what extent is the Programme contributing to and in line with health sector national policies and plans?
- ✚ To what extent does the Programme facilitate synergies and avoid duplication with interventions and strategies promoted by other development partners?

Programme beneficiaries:

- ✚ To what extent do beneficiaries perceive any overall change in access to counselling, testing and treatment at the community and household level (especially in terms of improved health care provision, improved provision of prevention and health promotion information and tools, increased seeking of health care, decreased costs of health care and ease of access to health services)?
- ✚ To what extent have beneficiaries increased the frequency of their participation in HIV prevention and health care (through visits by outreach workers and health seeking

behaviour) as a result of perceived improvement in HIV service provision quality and as a result of reduced costs and improved access to services?

- ✚ To what extent have beneficiaries changed their behaviour and reduced risky practices as a consequence of improved counselling and other services?
- ✚ To what extent is the communications strategy efficient in terms of reaching the target groups as compared to its cost

Service providers:

- ✚ To what extent is the training system, including follow up/ in service training, efficient in terms of resource absorption as compared to the results achieved

Rights- based approach (RBA):

- ✚ To what extent does the Programme take account of the RBA to programming?
- ✚ To what extent does the Programme consider equity (i.e. its focus on the most deprived areas, areas with high HIV prevalence or incidence) and facilitate the beneficiaries' access to HIV-related services?
- ✚ To what extent does the Programme consider gender equality throughout the planning and implementation process?
- ✚ To what extent is the Programme facilitating the use of the RBA to inform policies and planning within HIV prevention, treatment, care and support at central and sub-national level?

Value for money

If time allows, the evaluation will also try to obtain information on how value for money has been achieved, through asking the following questions:

- ✚ **Has there been a change in disease burden, positive or negative?**
 - ✓ Mortality by antiretroviral (ART) treatment cohorts by year (among people on ART and among total reported cases)
 - ✓ Morbidity (including opportunistic infections)
 - ✓ Incidence
 - ✓ Prevalence
 - ✓
- ✚ **Has there been a change in outcomes and behaviours, positive or negative?**
 - ✓ 12-month antiretroviral medicines (ARV) retention by ART cohorts by year
 - ✓ By risk group
- ✚ **Has there been an increase in coverage of key intervention services, and have these reached groups at risk?**
 - ✓ ART coverage
 - ✓ Prevention of mother-to-child transmission (PMTCT) coverage, including coverage with ART to reduce mother-to-child transmission of HIV
 - ✓ Management of HIV/HCV(hepatitis B virus) and HIV/HBV (hepatitis C virus) co-infection
 - ✓ Opportunistic infections (OI) prophylaxis coverage
 - ✓ Prevention interventions coverage (harm reduction, methadone, testing, condom provision, etc.) by risk group
- ✚ **Has access by age, sex, equity and quality of key intervention services improved?**
 - ✓ Equity by age, sex, rural/urban, and subgroup (e.g. FSW/PWID, MSM/SW)
 - ✓ For each risk group: defined service package, service delivery, frequency, service providers, package of services implemented according to design, implementation issues

- ✚ **What are the factors (political, legal, cultural or contextual) affecting implementations (facilitating and impeding successful implementation)?**
- ✚ **What was the GF contribution in scale up of resources, increase of coverage of key intervention services, improvement of service quality and outcome?**
- ✚ **What were the other competing explanations and hypotheses of changes in outcomes and impacts, positive and negative?**
 - ✓ Financial contributions according to budget for national, donor/partner and Global Fund sources
- ✚ **How can contributions of the Global Fund be improved to better contribute to outcomes and impact? What are the management recommendations?**
 - ✓ Re-programming, priority groups and high-impact interventions
 - ✓ Define best package of services for high-impact interventions