Republic of Serbia

Republic HIV/AIDS and TB Commission,
Ministry of Health of Serbia,
Institute of Public Health of Serbia
"Dr Milan Jovanovic Batut"

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Status at a glance

Strategic, Policy, and Programmatic Framework

The Republic of Serbia is a democratic state located in the central part of the Balkan Peninsula, on the most important route linking Europe and Asia.
The Republic of Serbia is middle income country with unemployment rate that has reached 20.1% percent in 2012. Belgrade is the capital of Serbia. With a population of 1,659,440 million, it is the country's administrative, economic and cultural center.
It is estimated that almost 24% of the population in Serbia reside in the four key cities of Belgrade, Novi Sad, Nis and Kragujevac.
Serbia has 7,2 million inhabitants, primarily characterized by continuing trends of low birth rates and population ageing. According to the most recent projection for 2012 average age is 42.2 years while the index of population ageing is -125,30. Over the previous decade, the population in Serbia is growing older, has longer life expectancy, and is decreasing in volume. As of January 1, 2013 an estimated number of citizens of the Republic of Serbia (excluding Kosovo under UN resolution 1244) were 7,185,505. This compared to data from 2002, when there were 7,516,346 citizens, represents a population decrease of 4.4%.

The health status of the Serbian population is consistent with other Central and Eastern European countries but below that of Western Europe. Serbia compares well with similar countries in terms of life expectancy at birth (74.7 years at 2012). In terms of principal causes of death, the picture is similar to many developed and transitional economies with high levels of heart disease, stroke, and cancer.

In the past 10 years Serbian society has experienced major changes in moral, cultural, social, economic and general life values and has had to overcome many challenges.
All these contribute to public lack of interest and certain intolerance in relation to vulnerable groups. Much work is dedicated to fighting stigma and discrimination, both in the projects, but also through activities of other stakeholders; however results are not yet encouraging.

After the overall changes in the society in 2000 and as a follow up of the responsibilities undertaken with the adoption of the Declaration of Commitment on HIV/AIDS at the UN General Assembly Special Session on HIV/AIDS (UNGASS) in June 2001, the Government of the Republic of Serbia established its National HIV/AIDS Commission (NAC) in March 2002, which had been newly re-established in June 2004 and revised in 2008. New National Commission for fight against HIV/AIDS and Tuberculosis (NCHATB) was established in August 2013. NCHATB is the governmental multisectorial body with Ministry of Health as Coordinator and comprises of president, vice-president and 22 members, including representatives from the Ministries of Health, Interior Affair, Justice, Education, Labor and Social Policy, Youth and Sport, as well as, representatives from regional and local health authorities, Red Cross of Serbia, NGOs; PLHIV; academic institutions; public medical institutions/organizations and observers from UN agencies. NCHATB is tasked to monitor and evaluate the national response, to formulate strategic directions and to develop proposals of programs for fight against HIV/AIDS and tuberculosis at national level for the Government, and to define priority activities and coordinate programs and projects dealing with the diseases.

The low prevalence rate and socially conservative values means that HIV/AIDS is still a low profile issue in Serbia. Its low ratings on the health and social agendas understandably restrict the level of resources.

The Government of Serbia designed and developed the strategic national response on HIV and AIDS in line with international standards and approaches. It follows the "Three Ones" principles, establishing a single action framework (National Strategy) and a single country wide M&E system. Government also established a single National AIDS coordinating authority. The assumptions underlying the "Three Ones" approach is that HIV/AIDS is a development issue and requires a multi-sectorial response that is integrated into the national development agenda and many strategic documents.

After the broad public debates and consulations with various stakeholders about the most important issues which were conducted throughout the country the new **National HIV Strategy for the period 2011-2015** is adopted at March 2011 by the Government of Republic of Serbia. The Strategy is in line with Joint UNAIDS HIV/AIDS Strategy for 2011-2015, the Global Health Sector Strategy for HIV/AIDS 2011-2015, European Commission Communication on combating HIV/AIDS in EU and neighboring countries 2009-2015, Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia 2004 and other relevant international documents.
The general goal of the National Strategy for response on HIV and AIDS in Serbia are prevention of HIV infection and other sexually transmitted infections, and providing treatment and support to all people living with HIV.

The Strategy recognizes **7 strategic areas:** prevention; health and social protection of people living with HIV (PLHIV); support to people living with HIV; role of local community in the response to HIV; protection of human rights; communication in the area of HIV; and, epidemiological surveillance, monitoring, evaluation and reporting on the national response to the HIV epidemic.
Under the strategic area **Prevention**, Strategy recognize different measurements and activities related to: voluntary counseling and testing; prevention among PLHIV (*positive prevention*); prevention among most at risk population (such as sex workers, men who have sex with men, injecting drug users, prisoners, uniformed persons, youth – especially those vulnerable on HI, etc); and, prevention of blood transmitted infections in health facilities. The objectives of preventive programs are, generally:
• Lowering the number of newly infected and early diagnosis of HIV infections;
• Maintaining a low STI incidence rate;
• Increase in coverage of preventive services and increase in quality of the provided services;
• Creating conditions within state authorities and institutions, and citizen associations for highly efficient response to persons living with the risk for the purposes of reducing this risk.
Further, area of **Health and social protection of HIV infected persons** includes:
• Improvement of life quality of PLHIV;
• Creating conditions for early diagnosis of HIV infected persons resulting in successful treatment, including timely treatment of children born of HIV infected mothers;
• Continued improvement of quality of provided health care services at all levels;
• Securing conditions for timely laboratory testing to monitor successfulness of antiretroviral treatment in PLHIV.

Area of **Support to people living with HIV** includes:
• Recognizing, strengthening capacity and involvement of PLHIV, other civil society organizations and Red Cross in response to HIV epidemic;
• Improving quality of services to PLHIV;
• Improving quality of life of PLHIV by increased accessibility of health services, care and support to PLHIV and their families.
Area of **Role of local authorities in response to HIV infection epidemic** includes:
• Increase of accessibility and coverage of services related to prevention and control of HIV infection and providing support to PLHIV in local communities;
• Strengthening of systematic, continued and planned multi-sect oral response of local communities to HIV epidemic.
Area of **Human rights in the area of HIV** includes:
• Adhere to, protect and promote human rights of PLHIV.
• Adhere to, protect and promote human rights of other sensitive and marginalized social groups
• Lowering social, legal, cultural and socio-economic vulnerability with securing comprehensive participation of PLHIV and other marginalized and vulnerable groups in response to the HIV epidemic.
• Creating discrimination and stigmatization free environment for PLHIV and other vulnerable and marginalized groups.
Area of **Communication in the area of HIV** includes:
• Improving health communication in the response to HIV infection in the field of prevention
• Improving communication with the purpose of lowering stigma and discrimination related to HIV infection.
Area of the **monitoring, evaluation and reporting** include:
• Timely and adequate reaction to the current epidemiological situation.
• Defining effective Benchmarks of HIV infection control supported by evidence on all levels, through securing appropriate data for continued follow-up of epidemiological situation and trends
• Improvement of institutionalized network for data gathering and analysis on the level of Republic/province/region
• Improvement of the system for monitoring and evaluation of successfulness of comprehensive response to HIV infection epidemic
• Development of research capacity of institutions, associations and individuals and support to researches in the area of HIV infection.
The National HIV Strategy is based upon the following **principles**:
• Complete guarantee and protection of human rights based on EU recommendations and other international conventions;
• Equal accessibility of health and social protection to PLHIV in all vulnerable categories of population over the entire territory of the Republic of Serbia;
• Key roles of PLHIV in policy development, planning and evaluation of support and protection program;
• Significant role of young people and other vulnerable population groups in planning, implementation and evaluation of activities set forth in this Strategic plan;
• Prevention of HIV transmission by promotion of healthy lifestyles, lowering risky behavior and strengthening individuals and groups
• Appreciation and respect of specific/different needs, roles, responsibilities and limitations regarding gender identity, ethnicity, persons with special needs and others.
• Privacy protection and confidentiality appreciation at all the levels of activism as set forth by this strategy;

• Respect for the dignity of PLHIV;
• Continued inter-sect oral activities in reaching strategic goals, with all the partners in the public, private and non-profit sectors;
• Integrated response to HIV epidemic through biomedical aspect and socio-economic factors which increased risk of HIV infection;
• Continued education and improvement of skills for all participants involved in implementation process of preventive Benchmarks and
• Sustainability of strategic activities in conditions of reduced international donation/aid.
A new Law on Psychoactive Controlled Substances was adopted in 2010. The National Strategy for fight against drugs for the period 2009-2013 is evaluated and the development of the new National Strategy for fight against drugs for the period 2014-2020 which is in line with the EU Drug Strategy and covers both drug demand and drug supply reduction. is ongoing activity.

The National HIV and AIDS program has been funded from different national sources. Approximately, one third of the funds allocated for HIV/AIDS are covered directly through the Central Government contribution, and two thirds (mainly related to treatment, and diagnostics and monitoring of ART effects) come from Republic Health Insurance Fund.
The Government fully covers the costs of blood screening, routine surveillance on HIV infection and other STIs, prevention activities and costs for VCT services provided by the network of 23 district public health institutes. Routine surveillance and VCT services are covered through Central Government contribution through the MoH budget for implementation of activities of «common interest».
Costs of methadone and buprenorfine for drug dependance treatment, as well as costs for testing on HIV, hepatitis B and C and other STIs by referral is covered by the Republic Health Insurance Fund. Some financial support for OST programme is provided by Ministry of Health through GFATM HIV Project.
In addition, the local and municipal health authorities are increasingly committing resources for implementation of local health programs implemented both by local health institutions and NGOs. It is assumed that this trend will continue and that the additional funds will be available to NGOs from local health budgets in the course of the program implementation.

The first HIV project financed by Global Fund for the Fight against AIDS, Tuberculosis and Malaria was implemented in 2003 –2006 and two further projects financed through the Global Fund are currently underway (2007- 2012 and June 2009-June 2014). Projects are worth nine and twelve million euros respectively.

Ministry of Health was responsible for implementation of R6 GF funded HIV project in the period 2007-2012. Together with NGO Youth of JAZAS Ministry of Health is responsible for implementation of R8 GF funded HIV project in the period June 2009-June 2014.

Overall goal of the HIV Project supported by GFATM 6th round is to halt the spread of HIV among all vulnerable groups and to provide care, support and treatment to PLHIV.

The overall project goal will be achieved through focus on four objectives:
1. To prevent HIV transmission in people involved in high risk behaviors;
2. To ensure continuity of care and treatment services for PLHIV
3. To create supportive environment for HIV prevention and care; and

4. To strengthen the capacity of the health system for development of the effective, efficient and accessible HIV/AIDS services.

In order to achieve these objectives the Project will scale up existing and set up new prevention programs, support PLHIV and their families and support National M&E System.

This Program is focusing on the risk groups that have been under increased risk due to the social determinants of health, such as poverty, marginalization and involvement in high risk behaviors, and are often hard to reach with mainstream activities or non-mobile health services. These groups include: 1) injecting drug users (IDUs), 2) men who have sex with men (MSM), 3) commercial sex workers (CSWs) , 4) Roma youth 5) prisoners, 6) institutionalized children and children without parental care and 7) people living with HIV/AIDS. All these target groups are highly vulnerable, stigmatized and discriminated, and are not likely to benefit from mainstream prevention activities.

GFATM R8 HIV project tends to build on so far achieved results and activities initiated in the R6 HIV project such as: NEP and MMT programs for IDU, out-reach activities and counseling among SW, out-reach activities and counseling among MSM population, out-reach activities and peer education among Roma youth, HIV comprehensive activities and VCT in prisons, Health Life Skills Based Education among institutionalized children, psychosocial and other means of support to PLHIV, etc. The new services that will be provided to groups at risk for HIV and that are not provided within the 6th round of the GFATM grant are: drop-in centres for IDUs, SW, MSM and MARA; distribution of lubricants for MSM; sensitization trainings for police, social workers and medical staff on how to provide services to most-at-risk groups; training of VCT staff in positive prevention; establishment of the system of surveillance of resistance to ART; training of medical doctors in ART prescribing;training of social workers in provision of the legal support to PLWHA; procurement of STIs tests in order to establish STI surveillance system; reduction of stigma by carrying out de-stigmatization mass-media campaigns; training of judges, public prosecutors and lawyers in HIV/AIDS and gender-related discrimination; strengthening the M&E system by employing two staff in the national AIDS office; participation of civil society representatives in international meetings and conferences.

The GFATM HIV Projects from R6 and R8 application, boosted cooperation among key stakeholders in the country. The process scaled up communication and consultation between governmental and NGO sector. In the HIV Projects implementation, the members of vulnerable groups are involved in overseeing the program implementation as CCM members and they act as peer educators within the prevention programs. They also participate in implementation of planned studies and evaluation activities to ensure their feedback on the effectiveness of activities implemented through these programs.

Specific preventive programmes among military force implemented by Military Medical Academy in Belgrade is funded by USA Government.

In order to monitor the results of the undertaken activities ***in the reporting period 2012-2013***, and progress of national response to HIV and AIDS in line with National HIV and AIDS Strategy, as well as, in line with Political Declaration on HIV/AIDS 2011 and other international declarations and action plans, Serbia selected 22 core indicators for reporting (table 1), as well as, some additional relevant indicators.

Table 1. List of core national indicators reported for the period 2012 - 2013

Name of indicator	Value	Source of data	Note
1. ECDC 2014 Dublin Declaration Questionnaire /Part a and Part B and WHO policy questions	/	National HIV/AIDS and TB Commission, interview	
2. Percentage of sex workers reached with prevention programs	69% in 2013 65.5%in 2012	Survey among most at risk populations for HIV and among PLHIV, Ministry of Health and Institute of Public Health of Serbia, 2013	In Belgrade
3. Percentage of female and male sex workers reporting the use of condom with their most recent client	91% in 2013 90.5%in 2012	Survey among most at risk populations for HIV and among PLHIV, Ministry of Health and Institute of Public Health of Serbia, 2013	In Belgrade
4. Percentage of sex workers who received an HIV test in the last 12 months and who know their results	49% in 2013 65.5%in 2012	Survey among most at risk populations for HIV and among PLHIV, Ministry of Health and Institute of Public Health of Serbia, 2013	In Belgrade
5.Percentage of sex workers who are HIV-infected	1.6% in 2013 2% in 2012	Survey among most at risk populations for HIV and among PLHIV, Ministry of Health and Institute of Public Health of Serbia, 2013	In Belgrade
6.Percentage of men who have sex with men reached with prevention programs	51% in 2013 50% in 2012	Survey among most at risk populations for HIV and among PLHIV, Ministry of Health and Institute of Public Health of Serbia, 2013	In Belgrade
7. Percentage of men reporting the use of condom the last time they had anal sex with a male partner	62% in 2013 58% in 2012	Survey among most at risk populations for HIV and among PLHIV, Ministry of Health and Institute of Public Health of Serbia, 2013	In Belgrade
8. Percentage of men who have sex with men who received an HIV test in the last 12 months and who know their results	36% in 2013 44% in 2012	Survey among most at risk populations for HIV and among PLHIV, Ministry of Health and Institute of Public Health of Serbia, 2013	In Belgrade
9. Percentage of men who have sex with men who test positive for HIV	8.3% in 2013 4.4% in 2012	Survey among most at risk populations for HIV and among PLHIV, Ministry of Health and Institute of Public Health of Serbia, 2013	In Belgrade
10.Number of syringes distributed per IDU per year by NEP	16	Programme data, Youth of JAZAS, GFATM HIV Project, 2013	

11. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected drugs	83% in 2013 85% in 2012	Survey among most at risk populations for HIV and among PLHIV, Ministry of Health and Institute of Public Health of Serbia, 2013	In Belgrade
12. Percentage of injecting drug users reporting the use of a condom the last time they had sex	32% in 2013 31% in 2012	Survey among most at risk populations for HIV and among PLHIV, Ministry of Health and Institute of Public Health of Serbia, 2013	In Belgrade
13. Percentage of injecting drug users who received an HIV test in the last 12 months and who know their results	19% in 2013 25% in 2012	Survey among most at risk populations for HIV and among PLHIV, Ministry of Health and Institute of Public Health of Serbia, 2013	In Belgrade
14. Percentage of injecting drug users reached with prevention programs	14.5% in 2013 20% in 2012	Survey among most at risk populations for HIV and among PLHIV, Ministry of Health and Institute of Public Health of Serbia, 2013	In Belgrade
15. Percentage of injecting drug users who test positive for HIV	1.5% in 2013 1.7% in 2012	Survey among most at risk populations for HIV and among PLHIV, Ministry of Health and Institute of Public Health of Serbia, 2013	In Belgrade
16. Total number of people on OST in all OST sites Total number of OST sites	2460 29	Programme data, IPHS, 2013	
17.Number of HIV-positive pregnant women who received antiretroviral drugs during the past 12 months to reduce mother-to-child transmission	3	PMTCT programme data, GAK Narodni front, 2013	Estimated number of HIV+ pregnant women is less than 10 in 2013
18.Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	100%	PMTCT programme data, GAK Narodni front, 2013	
19. Distribution of feeding practices (exclusive breastfeeding, replacement feeding, mixed feeding/other) for infants born to HIV-infected women at DTP3 visit	All 3 infants were on replacement feeding (100%)	PMTCT programme data, GAK Narodni front, 2013	
20.Percentage of people diagnosed with HIV infection who need antiretroviral treatment and who receive it	97%	RHIF, Departments for HIV infection treatment, 2013	Denominator: All diagnosed HIV cases in need for ART
21. Percentage of people with HIV infection who already need antiretroviral treatment at the time of diagnosis (Late HIV diagnosis)	46%	Surveillance data, IPH of Serbia, 2012	Denominator: All diagnosed HIV cases in 2012 with remark that 81% of cases hadavailable/reported information on CD4 count at time of Dg
22. Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	78%	Routine surveillance data/National AIDS register, IPH of Serbia, 2013	

Data for some of the core indicators were extracted from the last cycle of integrated bio-behavioral surveillance surveys among defined populations most at risk for HIV (IDU, SW and MSM) conducted in 2013. The results of IBBSS conducted in 2012 had been reported through GARPR 2013. Also, there are some qualitative analysis on behavior practice and other risk factors at the same time for some of these MARPs as well as data on behavior, quality of life and needs of PLHIV.

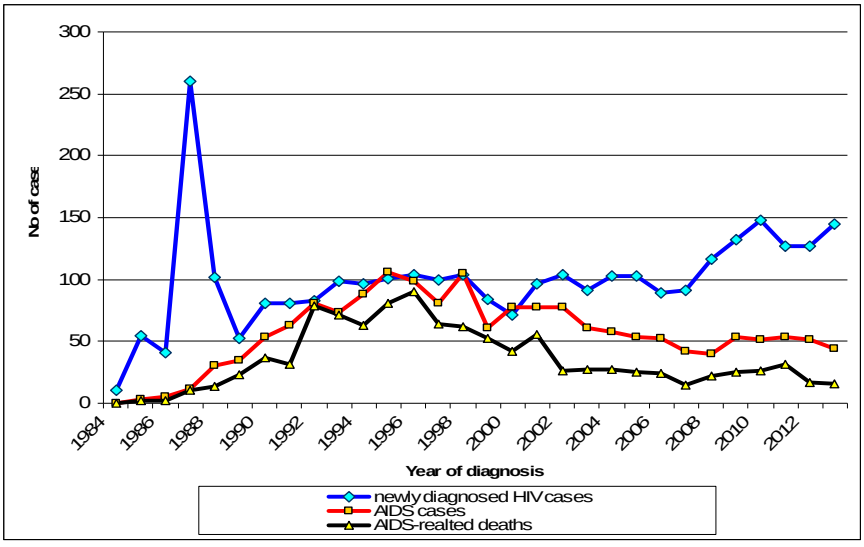
Overview of the HIV/AIDS epidemic

Epidemiological overview

The first AIDS cases were registered retrospectively in 1985. According to current data released by the Institute for Public Health of Serbia "Dr Milan Jovanovic Batut" (the National Institution that has the mandate for surveillance and monitoring and evaluation of the national HIV response) the cumulative number of HIV-infected people reported till 31st December 2013 was 2998, of whom 1691 developed AIDS while 1156 died (1060 AIDS-related deaths and for 96 HIV infected people is reported to be died from cause not related to HIV).

In the period 2012-2013, 272 newly diagnosed HIV cases, 95 AIDS cases and 33 AIDS-related deaths were reported to IPH of Serbia, as well as 9 non-HIV related deaths. The decreasing trend of AIDS cases and AIDS-related deaths in the last decade is mainly the result of the introduction of HAART which is available for all eligible PLHIV and fully covered by Republican Health Insurance Fund since 1997 (*graph 1*).

Graph 1. Newly diagnosed HIV cases, AIDS cases and AIDS related deaths by year of diagnosis, 1985-2013



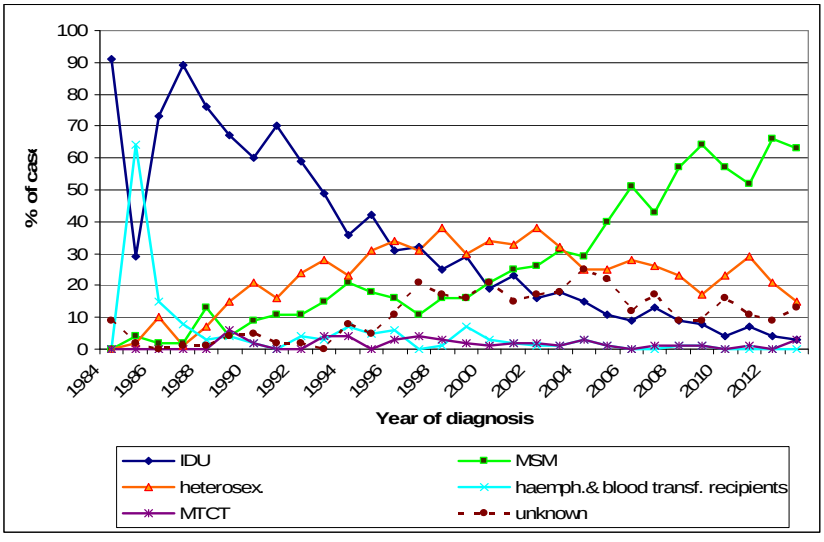
Source: IPH of Serbia "Dr Milan Jovanovic Batut", 2014

In the period 2002-2013 a total of 1376 newly diagnosed HIV cases were reported in Serbia (1175 males: 201 females or males to females ratio is 6:1). Increasing trend of newly diagnosed HIV cases is notified (148 cases in 2010, 127 cases in 2011, 127 in 2012 and 145 cases in 2013 versus 91 cases in 2003) mostly due to promotion of VCCT and increasing number of tested most at risk for HIV people. More than half of all HIV cases diagnosed in period 2002-2013 lived in Belgrade (754 cases or 55%), and in region of Vojvodina (265 cases or 19%) where the greatest number of people had been tested on HIV.

In recent years increasing trend of reported sexual transmission was notified among newly diagnosed HIV cases (87% in 2012 and 78% in 2013 versus 27% in 1991) and decreasing trend of newly diagnosed HIV/AIDS cases among IDUs (4% in 2012 and 3% in 2013 versus 70% in 1991). Additionally, regarding the HIV transmission categories among newly diagnosed HIV infected people reported in the period 2002-2013 in Serbia, there is clear increasing trend among MSM (66% of all reported HIV cases in 2012 and 63% of all reported HIV cases in 2013 versus 26% in 2002 and 11% in 1991) partly due to increasing number of MSM tested in VCCT sites. At the other side, there is decreasing trend among newly diagnosed HIV cases among IDUs (3% of all registered HIV cases in 2013 versus 16% in 2002) the most likely due to extensive harm reduction programmes implemented within GF HIV projects (*graph 2*).
In 2012 no one case of MTCT had been registered while in 2013 four HIV positive children aged 2 to 16 years had been registered in whose HIV infection is transmitted from HIV positive mothers who did not know their positive status during pregnancy and breastfeeding.

In the period 2002-2013 out of 1376 reported HIV cases in Serbia one third were aged 20-29 (427 HIV cases) at the time of HIV diagnosis. In the same period only 18 cases aged 15-19 (1% of all reported cases) were notified, as well as 15 HIV cases among children aged less than 15. The trend of newly diagnosed HIV infected persons in the age group 20-29 is increasing (28% in 2013, 32% in 2011 and even 47% in 2008 versus 22% in 2002).

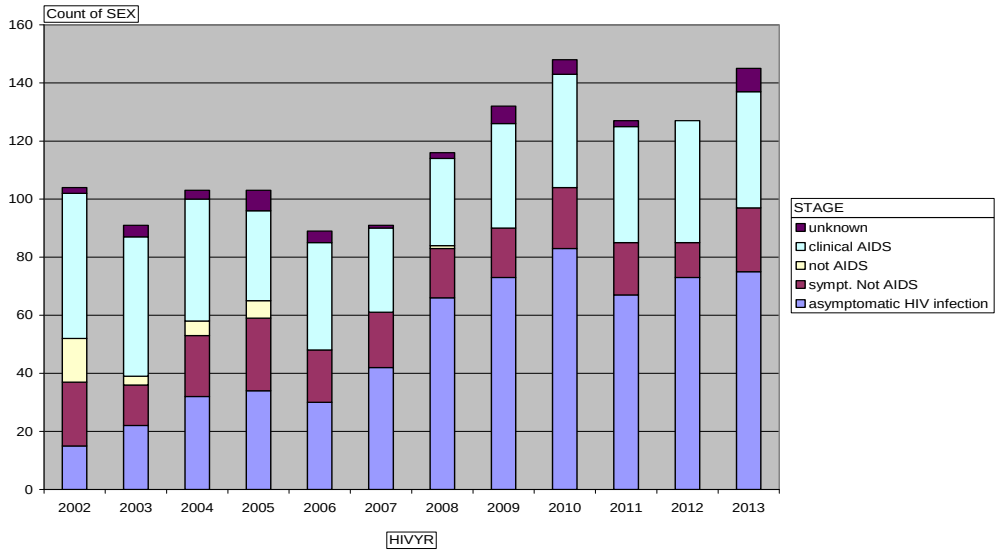
Graph 2. Newly diagnosed HIV cases by reported mode of transmission and year of diagnosis in Serbia, 1984-2013



Source: IPH of Serbia "Dr Milan Jovanovic Batut", 2014

Majority of the people infected with HIV in the past were diagnosed at the stadium of clinical AIDS (more than 70%), but in a recent years that trend is changing. Moreover, in the period 2002-2013 there is clear increasing trend of asymptomatic HIV infected persons at the time of diagnosis (75 cases or 52% of all newly diagnosed HIV cases in 2013 versus 14% in 2002) and decreasing trend of newly diagnosed HIV infected people in stadium of clinical AIDS (40 cases or 28% of all newly diagnosed HIV cases in 2013 versus 48% in 2002) (*graph 3*). The possible explanation for this trend is promotion via mass media of friendly and highly professional VCT services at all district IPHs which resulted in reduction of stigma and discrimination associated with the HIV testing. The second reason could be increasing availability of free of charge voluntary confidential or anonymous HIV testing with counseling during the whole year, not only in health facilities but also in drop-in centers or in mobile medical units for key population most at risk for HIV (IDU, MSM and SW).

Graph 3. Newly diagnosed HIV cases in Serbia by clinical stadium of HIV infection, 2002-2013



Source: IPH of Serbia "Dr Milan Jovanovic Batut", 2014

Out of the total of 1691 reported AIDS cases in a period 1985-2013, three quarters (76%) are males; three quarters lived in Belgrade, 39% were IDUs and 42% were aged 30-39, followed by age group 40-49 (25%).

In the period 2002-2013 a total of 639 AIDS cases had been reported in Serbia (512 males: 127 females). Out of them 210 AIDS cases were reported among MSM, 142 among heterosexuals and 150 among IDUs. In the same period a total of 281 AIDS-related deaths had been reported (229 males: 52 females) and out of them 93 case among IDUs and 70 among MSM. During 2012, as well as, in 2013 out of total number of reported AIDS-related deaths around half were reported among HIV infected persons in whom AIDS is diagnosed previously, in the period 1995-2012.

The number of PLHIV is continuously increasing due to reduction of deaths and increasing number of newly diagnosed HIV infected persons, so at the end of 2013 there are registered 1842 PLHIV for whom there is no information on death. Estimated PLHIV prevalence in population aged 15 and more was less that 0,1% at the end of 2013.

The HIV epidemic in Republic of Serbia is moving to concentrated epidemic among MSM according to the available data from routine surveillance, as well as, according to data provided from specific surveys conducted among defined MARPs in 2008, 2010, 2012 and 2013. The HIV seroprevalence among tested sample of IDUs in Belgrade, Novi Sad and Nis were less than 5% in the period 2008-2013. At the other side the registered hepatitis C prevalence was high, especially among sampled street IDUs in Belgrade (61% in 2013 versus 77% in 2010 and 69% in 2008). As we expected the highest HIV seroprevalence was registered among tested MSM in Belgrade during the last integrated bio-behavioral surveillance survey conducted in 2013 (8.3% with 95% CI 5.6-11.0) and it was almost twice higher in comparison with HIV seroprevalence found among sampled MSM in Belgrade in 2012 (4.4% with 95% CI1.4-6.4). HIV seroprevalence among sampled CSWs in Belgrade was almost the same in 2013 compared with results obtained in 2012 (1.6% versus 2%).There is still risky behavior among IDUs related to sharing equipment for injecting or not using sterile equipment, as well as not consistent using condoms with different sexual partners, as well as, not satisfying safer sexual behavior in MSM population. Also, the percentage of survey respondents from key MARPs who reported being tested on HIV in the past 12 months was pretty low except for SWs. The results from surveys conducted in 2013 imply a high level of stigma and discrimination which might influence on testing practice especially among those populations which are already the most socially marginalized.

Knowledge, attitudes and sexual behavior among general population and young people

National Health Survey households based have been conducted in 2013. The data are still processing. We expect that the results related to HIV/AIDS and sexual behavior will be available till the end of 2014.

Impact indicator

Key most-at- risk populations: Reduction in HIV prevalence

In 2013, within the GFATM R6 HIV Project implemented by Ministry of Health of Serbia, fourth integrated bio-behavioral surveillance survey among street IDUs aged 18 and more who injected drugs in the past month were conducted in Belgrade, Novi Sad and Nis by IPH of Serbia in partnership with local NGO and health institutions (sample size was 399 respondents in Belgrade, 300 in Novi Sad and 295 in Nis). Respondent Driven Sampling methodology was successfully applied. The results showed that estimated HIV seroprevalence among respondents was 1.5% in Belgrade (1.7% in 2012, 2.4% in 2010 and 4.7% in 2008), 1% in Nis (4.5% in 2012 and 1.6% in 2008) while in Novi Sad no one of respondents was infected with HIV (0% in 2012 and 0.3% in 2008). The estimated seroprevalence of hepatitis C was 61.4% in Belgrade (77.4% in 2010 and 74.8% in 2008) and 54.7% in Nis (60.5% in 2010 and 58.4% in 2008) while in Novi Sad it was 50.2% (51.6% in 2008). (*MoH and IPHS, Surveys among most at risk populations, 2008, 2010, 2012 and 2013*).
For planning purposes a median estimate within the national minimum and maximum was selected to give a national estimate of 30,383 IDU aged between 15 and 59 years in the Republic of Serbia within a range of possible 12,682 to 48,083 IDU individuals in Serbia in 2009 (*IPH of Serbia, 2011).*

Results from repeated bio-behavioral survey among a total of 1000 MSM aged 18 to 59 who have anal sex with male partner in the past 6 months which was conducted using respondent driven sampling methodology in three cities in 2013 showed that HIV seroprevalence among surveyed MSM in Belgrade was 8.3% (4.4% in 2012, 3.9% in 2010 and 6.1% in 2008), 5.3% in Novi Sad (2.7% in 2012, 2% in 2010 and 2.4% in 2008) while in Kragujevac it was 6.3% (*MoH and IPHS, 2013).*
For men who have sex with men for planning purposes a median estimate within the national minimum and maximum was chosen as the most appropriate giving a national estimate of 55,447 MSM within a range of a possible 20,789 to 90,104 individuals in Serbia in 2009 aged between 20 and 49 years (*IPH of Serbia, 2011).*

Bio-behavioral survey among a total of 400 SW both sex aged 18 and more who reported selling sex in the past 12 months which was conducted in two cities in 2013 within Ministry of Health /GFATM HIV Project showed that the HIV seroprevalence among respondents in Belgrade was 1.6% (2% in 2012, 0.8% in 2010 and 2.2% in 2008) and 0.7% in Novi Sad (*MoH and IPHS, 2013).*
For planning purposes on a national level it was estimated that there were 3,901 sex workers aged 18-49 with a possible interval estimate of 1,775 to 6,027 in Serbia in 2009 (*IPH of Serbia, 2011).*

National Response to the HIV and AIDS epidemic

Although the Government has adopted multi-sectorial approach, and appointed NCHATB to lead the response, the Ministry of Health is the institution that has probably contributed most to the national HIV and AIDS response over the past few years. National surveillance system has been improved and the scaling-up and decentralization of treatment and prevention services across the country has been done.

The response to HIV/AIDS was one of the first areas where Government included the civil society since the very beginning of national efforts to combat the epidemic. The proven partnership was further intensified with the creation of the National AIDS Commission in March 2002, joint formulation of the and GFATM 1st round proposal (where side by side Government and civil society organizations were nominated to act as implementing partners), and especially from June 2004 when reformed NAC was created the first comprehensive National Strategy for Fight against HIV/AIDS in period 2005-2010. The climax of the civil society engagement was noted especially in the period 2003-2006 (GFATM 1st round HIV/AIDS Program implementation) when civil society organizations were actively working with marginalized and hard to reach populations most at risk for HIV, and a couple of new NGOs were created.

In addition to the basic requirement for the National response on HIV epidemic, the task of Youth of JAZAS Belgrade as PR is that with the part of civil society in Serbia systematically work to strengthen human and organizational capacity, development of policies and procedures and sustainable development, especially of PLHIV sector which is in Serbia still extremely unstable and completely dependent on money that comes from the Global Fund. Only a consistent application of this principle can enable that organizations involved in the national response to HIV will ready wait for the 2014 and the departure of the Global Fund from Serbia.

As a result of the second phase of the implementation of GF supported HIV program some key surveys were conducted, many documents developed, broad education of mass-media representatives as well as many national campaigns had been held related to different prevention and anti-stigma and anti-discrimination issues.
Within the GF HIV Project drop-in centers for the key vulnerable populations (IDUs, SW, MSM and MARA) were established and this is very important part of HIV and STI prevention. Opioid maintenance treatment is now decentralized and OST is available in 8 primary healthcare centers but also on secondary and tertiary health care level (a total of 29 health facilities provide OST). Since March 2010 buprenorphine were registered from National Drug Agency as drug for treatment of opiate addiction and since 2012 introduced in OST. Treatment for substance use disorders is financed through health insurance (detoxification, maintenance therapy, inpatient treatment of drug dependence and treatment of drug-induced psychoses). Within the GF HIV project lubricants are procured and are on regular bases provided to MSM and SW.
The cooperation with prisons through GF HIV project implemented by Ministry of Health has been lifted to a higher level, and those services available in the community are now available in prisons as well (education, VCT services, IEK material, MMT etc).

In 2010, the Ministry of Health, through this project, conducted KAP study on HIV/AIDS that covered 1,500 health professionals in 100 health institutions at all levels of health care. Result indicate that health professionals who received education on HIV/AIDS issue possess higher level of knowledge and are more familiar with protection measures and actions to be taken in case of accident that can lead to HIV infection. In addition, health professionals who have provided services to PLHIV have less stigmatizing opinions. Medical technicians and nurses know less about HIV and have more negative opinions than doctors. However, there is still a need to work on improving the knowledge of health professionals.

Within the GF HIV project, trainings were held focusing on the health professionals' supporting approach to HIV vulnerable groups, and in particular MSM. In addition, positive prevention approach for PLHIV has been introduced for the first time. Trainings in this area were held for health care workers, and a brochure on positive prevention was designed. The new strategy recognizes positive prevention within prevention activities.

The Office for Cooperation with Civil Sector has started its work in 2011, and it will work on standards and procedures to enable sustainability of work of NGOs and will contribute to the quality of services delivered. Within GF HIV project, there are constant efforts in improving the capacities of NGOs working in the area of HIV, and regular meetings are held aimed at networking organizations that provide services in relation to response to HIV, both from non-governmental and government sectors.

Voluntary counseling and testing services

A great effort has been made to promote and expand VCCT services. Since 2011, Ministry of Health financed all VCT services, including HIV tests, in all district IPHs, while some number of tests for HIV and hepatitis B and C were provided within GF HIV projects implemented by Ministry of Health. In 2013 a total number of 11,721 clients had been counseled and tested in 23 Public Health Institutions and other health facilities as well as out of health facilities during the IBBS surveys and in

drop in centers or mobile medical units in which services for the key most at risk populations were provided, while additionally 10,693 pregnant women had been counseled and tested (*IPHS, 2013, 2014).*

Prevention of mother-to-child transmission

A special attention was given to prevention of mother-to-child HIV transmission. Till the end of 2004 only a few pregnant women were tested on HIV in first trimester of wanted pregnancy by epidemiological indications. The new PMTCT strategy that endorses right of every pregnant women to get tested for HIV free of charge, has been developed and endorsed as a part of the National HIV strategy , 2005-2010, as well as in the current National HIV Strategy for the period 2011-2015. With support given by the Global Fund HIV Project and UNICEF the routinely voluntary counseling and HIV testing of pregnant women based on *"opt-out strategy"* was implemented as pilot project in 5 districts (in the 15 biggest Primary Health Care centers) in the period 2005-2006.
In 2013 a total of 10693 pregnant women were counseled and tested on HIV (around 16% of all pregnant women in Serbia) and 9172 in 2012 (15% of all pregnant women) versus 991 tested in 2003 and 1384 tested in 2004. Two of all tested pregnant women in period 2012-2013 had been newly diagnosed as HIV positive (two in 2013 and no one in 2012). In 2013 four HIV infected pregnant women decided to terminate the pregnancy.
At the other side, in period 2012-2013 a total of four HIV positive pregnant women, newly diagnosed or already known their HIV positive status, decided to have a baby. They were fully covered with HAART and with PMTCT protocol, including replacement of breastfeeding, so at this moment we notified that all children born by known/diagnosed HIV positive mothers were HIV negative.

Blood safety

All the blood units have been voluntary donated and mandatory screened for HIV since 1987 and the costs of testing as well as promotion of voluntary donations are fully covered by national budget. All donated blood units are screened using documented standard operating procedures in a high quality manner.

Key most-at-risk populations: preventive services

The coverage of IDUs, SWs, MSM and prisoners with preventive services in the area of VCT is still low, even though the outreach activities are scaled-up and very well developed. The development of new VCT sites in the framework of the Global Fund Round 6 HIV Project implemented by MoH, increased the accessibility of the service, but didn't change in a significant way the number of reported people tested on HIV among key MARPs. This is mainly the result of the fact that people do not recognized their risk or avoid to identify themselves as belonging to one of those MARPs or even are afraid to be additionally stigmatized if going to be tested especially in smaller cities.
Community outreach needle exchange program was initiated during 2003 in Belgrade, since January 2005 in Nis, since the end of 2005 in Novi Sad and since 2011 in Kragujevac within GF/MoH HIV Projects. Program data showed that in 2013 the total of 4285 unique IDUs had been reached with NEP versus 3831 unique IDUs in 2012. There is good cooperation and partnership between these NGOs and local IPHs in

providing VCT services for IDUs. Based on programmatic data for 2013, number of distributed needles has been higher then number of distributed syringes - 1,325,876. To calculate value for key EMCDDA indicator, we applied number of distributed syringes to estimated number of IDU aged 15 to 59 in Republic of Serbia for 2009 (the last national estimation) and the value for this indicator in 2013 was 16 syringes per IDU. But if we calculate indicator related to number of needles and syringes distributed per IDU per year by NEP on the same way as in 2012, using programmatic data on number of reached IDU by NEP (4285) and number of distributed syringes, the indicator value is much higher in 2013 compared to 2012 (115.3 vs 37.5).
Also, within the same MoH HIV project, opioid maintenance therapy is supported and at the end of 2013 OST was available at 29 public health care facilities in Serbia reaching in 2013 a total of 2460 DUs on OST versus 2010 in 2012. (*IPHS, 2013, 2014)*.
Results from the fourth round of IBBS surveys conducted in 2013 show that 69% of sampled SWs in Belgrade (65.5% in 2012 versus 32% in 2008), 14.5% of sampled IDUs in Belgrade (20% in 2012, 20% in 2010 and 21% in 2008), and 51% of sampled MSM in Belgrade (50% in 2012 versus 13% in 2008) have been reached by preventive activities (*Ministry of Health and IPHS, 2013*).

Testing rate in the past 12 months and condom use among key MARPs

Stigma to which SWs are exposed and the illegal status of prostitution result in a very low access to preventive services (that are now becoming more client-friendly) and a high under-reporting rate as members of the population often failing to declare their belonging to this population group.
Results from fourth round of IBBS surveys conducted in 2013 showed that 49% of surveyed SWs in Belgrade reported that have been tested in the past 12 months and knows the result of testing (65.5% in 2012, 59% in 2010 and 45% in 2008) while only 19% of sampled IDUs in Belgrade (25% in 2012, 33% in 2010 and 32% in 2008) and 36% of surveyed MSM in Belgrade (44% in 2012, 34% in 2010 and 31% in 2008) reported having been tested in the past 12 months and knowing the result of testing (*Ministry of Health and IPHS, 2013*).
Also, results from fourth round of IBBS surveys conducted in 2013 showed that 91% of sampled SWs in Belgrade were reported using condom with their most recent client (90.5% in 2012, 87% in 2010 and 91% in 2008), while only 32% of sampled IDUs in Belgrade reported using condom the last time they have sex (31% in 2012, 32% in 2010 and 29% in 2008)) and 62% of surveyed MSM in Belgrade reported using condom the last time they had anal sex with a male partner (58% in 2012, 64% in 2010 and 67% in 2008) (*Ministry of Health and IPHS, 2013*).

HIV treatment: antiretroviral combination therapy

Till the beginning of 2008 the ART was available only in Belgrade at Clinic for Infectious Diseases in Clinical Centre of Serbia for all PLHIV in need. Since 2008
HIV/AIDS treatment is available through a well-organized system, with out-patient and inpatient services available at Clinical Centers in Belgrade, Novi Sad, and Nis and since 2009 at Clinical Centre in Kragujevac. The need for referral obtained by general practitioners in primary health facilities, and the need for clearance from the Local Health Insurance Fund branch in locations outside of the Belgrade, Novi Sad, Nis and Kragujevac are barriers for some PLHIV to access treatment. Establishment of the

new treatment sites is accompanied with comprehensive mapping of the medical and social professionals that will be part of the system for provision of comprehensive medical and psycho-social care and support. The stigma that is significantly present in general population is present at some level in the health sector, too. A HIV infected people who need to come for check-ups undergoes through a demanding administrative procedures that are handling referral papers with the full name and diagnosis of the patient. This in some cases compromises confidentiality and privacy and causes stigmatization and discrimination in the community.
Government of Serbia ensures universal access to HAART and all other drugs for prophylaxis and treatment of opportunistic infections for all people living with HIV eligible for it. The qualifying criteria are given in National Guidelines for Clinical management and treatment of HIV infection in adults which is adopted by NAC in March 2011. The Treatment guideline is developed and revised in line with recommendations given by European AIDS Clinical Society (EACS).
The entire cost of the ARV treatment is covered by Republican Health Insurance Fund (*around 7 million US$ in 2012, and more than 8 million US$ in 2013, Source: Republican Health Insurance Fund*). In the period 2003-2011 a significant increase in the number of people on HAART was observed (1165 at the end of December 2013 versus 300 in 2003). The estimated ART costs per patient was around 7000 US$ in 2013). Also, around 60% of the total HIV/AIDS spending money from all financial sources in 2012 as well as more than 60% in 2013 was related to PLHIV outpatient and inpatient treatment and care.
Estimated number of PLHIV with advanced HIV infection in need for ART is overestimated using EPP and Spectrum model developed by UNAIDS for countries with low level of HIV epidemic and with lack of continuous and comprehensive screening data for some key population group such as IDU, patients with STIs, pregnant women, TB patients etc. It is important to procure and sustain diagnostic tests as well as tests for monitoring and evaluation of success or failure of ARV treatment and to implement palliative care and home based care for those PLHIV in need.

Major challenges faced and actions needed to achieve the goals/targets

Development of a budgeted action plan for implementation of the new National HIV Strategy in the period 2014-2015, as well as, necessary revision and continuous improvement of the overall National M&E framework that will assure better collection of good quality data from different stakeholders and proper triangulation and improvement of data analysis and use for better planning and acting in the future is one of the major challenges. The UN TG on HIV/AIDS / UNAIDS has supported defining and implementation of the National M&E System since November 2004.

Introduction of the Second generation of HIV/AIDS surveillance had been a special challenge that the country was faced with in order to provide more comprehensive picture and to monitor trend of HIV and other STIs prevalence in defined most at risk population groups, as well as, to monitor key behavioral data that will offer a better insight in the status of the epidemic or potential negative course. Also, triangulation of good quality data obtained through repeated surveys and adequate program data will enable comprehensive and sector wide approach in monitoring and evaluation of

national response to HIV epidemic and better planning of resources and preventive activities especially among defined key hard to reach MARPs throughout the country.

The period 2012–2013 is characterized by significant progress made in the area of prevention of HIV and reduction of the HIV impact, as well as, reduction the level of stigma and discrimination in the whole society in Serbia. The strong partnership between governmental sector and civil society sector acting to implement the Strategy has been successfully implemented. Major prevention interventions have been expanded to national level with scaled-up access to services and programs for key populations most at risk for HIV. Also, there is need for further strengthening the health system, as well as, to raise the level of comprehensive knowledge in different populations and professionals.

Although the civil sector is present and noticeable in responding to HIV, a need has been recognized for its additional strengthening in the area of monitoring the national response, or in the system's response to HIV prevention, treatment and care, promotion of systematic and social changes which would decrease new HIV cases, and protection of the rights of the most disadvantaged groups. Coordination and better networking of organizations which deal with HIV directly, and those working on the reduction of risk, and prevention of behaviors which increase the risk of infection, would increase the representative ness of the civil sector in the relevant national and local structures and have an enhanced impact. Further building and strengthening of civil society organizations, especially in areas less well represented and among the young in particular, would be a significant contribution to the prevention efforts.

An important role has been played by the significant Global Fund contribution to the Strategy implementation, almost exclusively for prevention interventions and the important national contribution dedicated to prevention, treatment, care and social support of PLHIV.

The main challenges for new National HIV Strategy implementation in the forthcoming period will be to maintain and scaled-up already developed prevention activities and to make sustainable the universal access to good quality treatment, care and support of PLHIV and those affected by HIV through improvement of planning and management of drugs and routine tests for monitoring progress of HIV infection procurement (CD4, PCR tests etc.); development and implementation in the large scale of HIV testing strategy for TB patients and other patients initiated by health services providers; improvement of TB infection control in HIV treatment centers; sustainability of CD4, PCR and testing on HIV drugs resistance in accordance with national recommendations/guidelines. These will require an increased contribution from the national budget. Despite the progress made, the programs targeting high vulnerable groups are far from reaching enough to make a significant impact.

Alternative strategies and innovative approaches based on best practices should be implemented together with a revision of current legislation with objective to encourage programs where it is necessary. Also, sector wide approach is needed meaning that HIV specific issues need to be integrated in different national plans and programs and to raise involvement of local community and private sector in response to HIV epidemic.

Also, challenges are funding some of the key activities, such as testing on Hepatitis B and C, as well as provision of free of charge HIV testing for greater number of pregnant woman and continuation of procurement of monitoring test for PLHIV for all treatment centers; conducting the cost effective analysis of PLHIV treatment; standardization of OST service at all levels of health care. Also, we are planning to

develop wider gender approach and to integrate gender policy in activities of different stakeholders.

Support required from country's development partners

UN TG for HIV/AIDS members also contributed to the national efforts for better implementation of the priorities highlighted in the National HIV Strategy:

- Support in formulation of national policies and standards for youth friendly health, social and education services (formal and non-formal), and assessment of the community and health services provided to especially vulnerable young people, including adolescents (UNICEF)
- Efforts to strengthen HIV/AIDS/STI surveillance and support the surveillance capacity building (UN TG, WHO)
- Assessment and response of the PLHIV on the current available healthcare, and social services (UN TG, UNDP)
- Raising funds for the medium to longer term programs and projects (bilateral and multilateral agencies).

EU influence is increasing while the UN agencies influence on funding key programs/ activities in the area of HIV/AIDS is decreasing but at EU agenda HIV is not put as remarkable issue for potential funding in Serbia.

Monitoring and evaluation environment

In 2006, the National HIV/AIDS Office was established as an operational body of the NAC. The Office has been established within the IPH of Serbia, with support from UNDP and UNAIDS. The Office is continued to be funded by domestic sources since 2007/2008. The main functions of the National HIV/AIDS Office are: assistance to the NAC in overseeing implementation of the National HIV/AIDS Strategy; development and implementation of broad capacity building strategy based on continuous needs and resource assessment; development of M&E plan, and establishment of reporting procedures and data flows within the program, as well as, to provide regular reports based on collected and analyzed different data, to establish and maintain database on program resources, provided services and financial resources, to enable further strategic planning of activities and to ensure transparency of the program implementation, by establishing information exchange channels and networks, and dissemination of all relevant information to wide audiences, trainings of journalists and health care workers, capacity building of all relevant stakeholders regarding 2nd generation surveillance and M&E and budgetary-based programming and planning.

It is planned in the next period to establish fully operational Department for HIV/AIDS, STI, viral hepatitis and tuberculosis in the Institute of Public Health of Serbia with aim to improve and to integrate coordination of activities in the area of prevention and control of these infectious diseases as well as to improve the M&E system and dissemination of information and periodic reports to different partners.

Coverage indicators are defined to incorporate all three levels of coverage within particular service delivery areas. To ensure full participation of implementing agencies, and collection of good quality data, implementers are fully trained on M&E.

Strengthening of national M&E capacity, as well as providing training in 2nd generation HIV/AIDS Surveillance was the key activity in Serbia over the last four years period. Local trainings have been made available for selected number of national stakeholders and sub recipients of GF HIV programs. The national workshops served as consultation forums where all relevant stakeholders participated in revision and harmonization of existing and defining new indictors and designing of functional M&E system on national level. With support of UN TG for HIV/AIDS, UA targets for 2010 related to prevention, treatment, care and support have been set and endorsed by NAC.

The Plan for monitoring and evaluation of the strategic response to HIV and AIDS in Serbia in the period 2011-2015 has been adopted by NAC in March 2011. Multi-agency M&E Toolkit was among few resource documents that was used for its development. The plan provided sufficient basis for monitoring key indicators. The National HIV/AIDS Office settled the M&E Unit which is operative body for collecting and verifying data.

Within GFATM HIV Projects implemented by Ministry of Health national outcome and impact indicators is planned to be measured through periodic repeated bio-behavioral surveillance surveys among defined most at risk populations, as recommended for low and concentrated epidemics. Baseline surveys for collection of these indicators have been done in 2008, second cycle of surveys in 2010, third in 2012 while the last cycle was conducted in the period October-December 2013.

In addition, the PIU of MoH for GFATM HIV Project organize regular monitoring visits to implementation sites/organizations, ensuring data verification and advising implementing partners on required improvements in data quality for the purpose of reporting. Since July 2009 introduction of a **Universal Identification Code - UIC** for every client reported in program and development of project's **web-oriented data base** has enabled crosscheck of data during and after regular monitoring activities. Also, minimum package of services was defined and applied from July 2011 in the framework of HIV prevention activities for defined MARPs which allows us to properly measure and evaluate quality of different types of services.

Surveillance system for HIV and AIDS and M&E system have been substantially developed from the 6th Round of the GFATM and further strengthened through implemented MESS activities and by attending relevant courses on 2nd generation surveillance and other topics in the area of HIV/AIDS at the School of Public Health "Dr Andrija Stampar" in Croatia and other courses or conferences in country and abroad.

Surveillance surveys in six populations most at risk for HIV and among PLHIV are planned to be implemented biannually with objective to provide the set of core national impact and outcome indicators. Third and fourth rounds of MoH/GFATM integrated Bio-behavioral or only behavioral surveys in 2012 and in 2013 were conducted by the Institute of Public Health of Serbia "Dr Milan Jovanović – Batut" in partnership with all relevant governmental institutions, regional institutes of public health/VCT centers and NGOs, as well as with treatment departments in clinical centers.

Strengthening the strategic planning of the national response to the HIV epidemic will be based on monitoring and evaluation of the national response through the analysis of impact and outcome indicators, coverage and other relevant program data. The Ministry of Health of the Republic of Serbia as well as Principal Recipients planned

to strengthen the National HIV M&E system, which would meet the requirements of the Global Fund in regard to performance-based funding.

Moreover, the revision of previous ones and provision of new size estimates of IDU, MSM, and SW population at local and at the national level based on available 2010 survey and relevant program data by consensus of key stakeholders followed by the final report on MARPs Prevalence in Republic of Serbia with recommendations has been done with assistance provided by external consultant in the period May-July 2011. Moreover, the VCT web oriented data base at national level, as well as, on GF HIV projects level has been developed and implemented since January 2014, in order to improve collecting data system and dissemination of final reports for different audiences.

The key activity in the next period will be finalization and implementation of new data flow system through web oriented data base for M&E of HIV response on national level for all stakeholders; supervision and quality control of data and reporting system, as well as of implemented activities. The major challenge is to oblige CSOs to report standardized data to national level through unique data base for data collecting and reporting.

Other challenge in the next period will be collecting data on AIDS spending on national level using NASA or other recommended methodology and improvement in the area of monitoring treatment.

Annex 1: Consultation/preparation process for this national report

The report was prepared by the National Multisectorial HIV/AIDS and TB Commission and Ministry of Health of Serbia in close collaboration with the Institute for Public Health of Serbia/National HIV/AIDS Office, civil society organizations, PLHIV and UN TG on HIV/AIDS based on the current policy, strategic approach and latest results of targeted surveillance surveys among populations most at risk for HIV and among PLHIV, as well as, on available program data.
WHO policy questions and ECDC supplement questionnaires were broadly discussed and fulfilled at the consultation meeting of key stakeholders from governmental and civil society sector on March 31, 2014.
Also, the draft report was discussed and adopted by key national and international stakeholders on March 31st, 2014.