BOSNIA AND HERZEGOVINA
COUNCIL OF MINISTERS

BUDGET OF THE STRATEGY TO RESPOND TO HIV/AIDS BOSNIA AND HERZEGOVINA 2011-2016

SARAJEVO, MARCH 2014

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List of terms and abbreviations used

AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral
BIH	Bosnia and Herzegovina
CCM	Country Coordinating Mechanism for GFATM
FMoH	Federation Ministry of Health
FPHI	Federation Public Health Institution
FZO RS	Health Insurance Fund of Republika Srpska
GDP	Gross Domestic Product
GF	Global Fund to Fight AIDS, Tuberculosis and Malaria
HCV	Hepatitis C Virus
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
IEC	Information, Education Campaigns
KM	Bosnia-Herzegovina Convertible Mark
MoCA	Ministry of Civil Affairs
NGO	Non-Governmental Organization
NHS	National HIV and AIDS Strategy, 2011-2016
OST	Opioid Substitution Therapy
PH	Partnership in Health - CSO
PLHIV	People Living With HIV
PSM	Procurement and Supply Management
RS MoH	Republic of Srpska Ministry of Health and Social Welfare
RS PHI	Republic of Srpska, Public Health Institute
TA	Technical Assistant
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
WB	World Bank
WHO	World Health Organization
ZZOiR FBIH	Health Insurance Fund of Federation BiH

Executive summary

This represents the process of developing the costing/budget of the Action Plan for Implementation of Strategy to Respond to HIV and AIDS in Bosnia and Herzegovina 2011–2016 (CNS).

Study Purpose

The basic purpose of this study is to inform main stakeholders and other reviewers about budget needed to accomplish the specific NHS goals and achieve specific impact. In addition, this study contains methodology, coordination and resources for monitoring and evaluation (M&E) of the Action Plan and costing/budget realization. Review and recommendations may be used by Global Fund and other donors to make decisions for future interventions. The audience for reports includes, in addition to Partnerships in Health, counterpart government agencies and institutions (state, entity, canton level, District Brcko), counterpart civil society organizations, major international supporters of BiH health sector development, including the Global Fund, UNDP, UNAIDS, other relevant ministries and institution identified in the Action Plan, as well as the public.

Study Background

Since 2003, Bosnia and Herzegovina has made the serious and organized efforts to respond to HIV. Project HOPE conducted HIV needs assessment of the region in 2002, in order to provide baseline data for further programming and strategies. Based on this assessment, Swedish SIDA funded a project implemented by Partnerships in Health on HIV for Western Balkans, which covered Bosnia and Herzegovina (Phase I 2003–2006; Phase II 2007–2010). Global Fund joined with two projects (R5 2007 –2011 and R9 Phase I 2011 – 2012). Currently the GFATM project R9 Phase II 2013 – 2015 is ongoing. UNDP BiH was the primary recipient of funds for R5 and is primary recipient of fund for R9 round. So far, upon the proposal of the National Advisory Board to Combat HIV and AIDS in Bosnia and Herzegovina, the Council of Ministers of Bosnia and Herzegovina have adopted the following documents:

- "Strategy of Bosnia and Herzegovina to prevent and combat HIV and AIDS 2004–2009", adopted in 2004.
- "Strategy to Respond to HIV and AIDS in Bosnia and Herzegovina 2011–2016", adopted in 2011.
- Action Plan for Implementation of Strategy to Respond to HIV and AIDS in Bosnia and Herzegovina 2011–2016, adopted in December 2012.

The response to HIV is heavy influenced by the constitutional structure of BiH. The country consists of two entities (Republika Srpska – RS and Federation of BiH – FBiH) and District Brcko. Each of the entities and District Brcko have their own health legislation, health system and health financing. Furthermore, FBiH consists of 10 cantons that have their own jurisdiction over the health affairs. On the state level, health issues are under the jurisdiction of the Ministry of Civil Affairs, which has a primarily coordination function, while the real decision making power is on the entities. This structure results in variations in priorities, strategies, budgets, salaries, etc. throughout different parts of the country. In spite of that, the response to HIV is well coordinated through the Global Fund Project.

Study Design, Methods and Limitations

The independent consultant carried out this study, and spent approximately four weeks in desk review and two weeks in fieldwork in January and February 2014, as the study was ending. The study process was designed to triangulate information, in order to independently and objectively validate findings and conclusions. It was based on two primary data sources:

I. DOCUMENTS

Relevant reports were available from a wide range of sources:

- The GFATM's project implementers progress reports;
- The technical assessments and reports of the expert consultants;
- Reviews and evaluations from other donors working in related areas (principally the UNDP, UNAIDS), and
- Documents and reports of the principal counterpart agencies (Ministry of Civil Affairs of BiH, Federation Ministry of Health, RS Ministry of Health and Social Welfare, Department of Health and Other Services of District Brcko of BiH, Institute for Public Health of FBiH, RS Public Health Institute, health insurance institutions in FBiH, RSrpska and District Brcko, health insurance institutions in 10 Cantons).

These separate sources enabled triangulation/validation within the document itself. The Consultant reviewed more than 500 pages from 66 different documents (Annex 2, Table 20).

II. INTERVIEWS WITH KEY INFORMANTS (KI):

Key informants were interviewed one-on-one or in groups within an institution. KIs were chosen from the principal agency counterparts, and included their chief executives. They also came from the Partnerships in Health Project, other CSOs, UNDP and other donors connected to health sector development. The consultant conducted numerous of separate KI field interviews, with their representative individuals (Annex 2, Table 19).

The information collected by the Consultant from these two principal sources and provisional findings, aligned with BIH HIV/AIDS Strategy, National guidelines and relevant local and international health policy documents, was developed and discussed with key informants.

Also, on this occasion it is necessary to emphasize the bottlenecks that hindered the service delivery in general:

1. Although this NHS replaced the Strategy to Prevent and Combat HIV/AIDS in BiH for the period 2004–2009, there were no available historical data on the budget spent for the implementation of the latter one;
2. The lack of historical data of expenditure led to dependence and limitation on data obtained from partners;
3. NHS contains no baseline information against which to measure progress;
4. There is no direct tracking of HIV infection as disease, what makes the precise definition of HIV expenditure difficult, because national financial institutions' budget plans have no funds related directly to the objective stated by the strategy;
5. Action plan for the implementation of existing strategies insufficiently elaborated on precise tasks within the specified actions to be executed in order to achieve the stated goals.

1. INTRODUCTION

The first case of the HIV infection in BiH was registered in 1986, and until the end of 2009, 163 HIV positive persons have been registered and AIDS developed in 102 cases. The key populations at higher risk of HIV infection are: persons injecting drugs, men who have sex with men, sex workers and their clients, cross-border migrants, migrant workers, internally displaced persons, refugees and convicts. Significant attention should be also paid to Roma population as a marginalized group, and youth in general, especially adolescents and elementary school pupils in rural areas.[1]

The infection in BiH, for the several last years, is being kept under control. The goals set referring to the HIV rate of less than 1% in general population, and less than 5% in any other key population at higher risk of HIV infection, are being met successfully, thanks to the National HIV and AIDS Program and the support of the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria.

Bosnia and Herzegovina for the time being can be regarded as a state with a low HIV/AIDS prevalence (less than 0.1%). However, many factors can lead to the outbreak and spread of epidemic at any moment.

The National HIV and AIDS Strategy 2011-2016

The National Advisory Board for Combating HIV/AIDS appointed the Working Group to develop the new National HIV and AIDS Strategy (NHS) to guide Bosnia and Herzegovina's response to the HIV epidemic over the period 2011–2016 in mid-2010. Strategy development was coordinated by the Ministry of Civil Affairs of BiH, together with the entity HIV coordinators and the representative of the Joint UN Team for HIV and AIDS in BiH. BiH Council of Ministers adopted and published the Strategy in 2011 as a separate document.

The NHS Implementation Framework

Action Plan for Implementation of Strategy to Respond to HIV and AIDS in Bosnia and Herzegovina 2011–2016, adopted in December 2012, is an accompanying document to the NHS that sets out the major activity areas needed to be implemented to achieve particular strategic objective. It provides directions to all partners/key implementers on how to operationalize the strategic objectives into Annual Activity Plans on their level.

1 "Strategy to Respond to HIV and AIDS in Bosnia and Herzegovina 2011-2016," BIH Council of Ministers

2. DEVELOPMENT OF BUDGET FOR THE NATIONAL HIV PREVENTION STRATEGY

Organizational structure of health care in BIH

BiH Constitution, an integral part of the Dayton Peace Agreement signed in 1995, defined a complex political and administrative structure of the state. It gives the mandate for organization, funding and provision of health services to two entities, Federation of BiH and Republika Srpska, and District Brcko of BiH. The health care system in Republika Srpska (RS) is centralized within the jurisdiction of the entity Ministry of Health and Social Protection. In the Federation of BiH (FBiH) the system is decentralized to the level of ten cantons. The Federation Ministry of Health has coordination role within this system. District Brcko has its own health care system where the Department of Health and other Services of District Brcko Government are in charge.

The public health care sector is following the same model: the RS Public Health Institute, with its five regional offices is in charge of this sector, in the FBiH, this sector consists the Public Health Institute of FBiH and ten cantonal public health institutes, while District Brcko has its own Public Health Subdivision.

The same principle refers to the health care systems' funding, which is also fragmented: RS has a single Health Fund, but FBiH has ten cantonal funds responsible for the funding of health services as well as a joint Federation Health Insurance and Reinsurance Fund. Similarly, District Brcko has its own Health Insurance Fund. Starting from 2003, to the BiH Ministry of Civil Affairs was given coordination role with regard to the health sector, as well as a mandate related to issues related to BiH international obligations, European integrations and international cooperation within the health sector. A Conference of Ministers of the Health Sector in BiH was established in 2007, aiming to provide better coordination within the health sector. Members of this Conference are health ministers in FBiH, RS health minister, District Brcko Government Health Department and the Minister of Civil Affairs of BiH.

Bosnia and Herzegovina is a member of the Council of Europe from 2002, and in June 2008 BiH signed the Stabilization and Association Agreement with the European Union (EU), thus becoming a potential candidate country for the EU accession. The European integrations process represents significant challenge for Bosnia and Herzegovina's health sector, especially in areas of common interest for all of the EU countries, such as public health, communicable diseases, safety of blood and blood products, drug use monitoring, safety of medications and medical products, etc.

The Bih Council of Ministers approved the development of the NHS Budget, as a consolidated plan, setting out the key activities to be undertaken by all partners for implementation of the NHS. For National Advisory Board for Combating HIV/AIDS the budget will form the basis for request submission for funding from the government, and the funding that will come from other donors.

To sum up, BiH has 12 ministries of health and health systems: one for Republika Srpska, one for the Federation level and ten cantonal ministries in the FBIH, plus Department of Health and other Services of Brcko District. It is very important to stress out that such comprehensive system has no direct tracking of HIV infection as a disease.[2]

2 Čavaljuga S., Džananović L., Leka A; "A practical approach to sustainable financing of the National HIV response in Bosnia and Herzegovina"

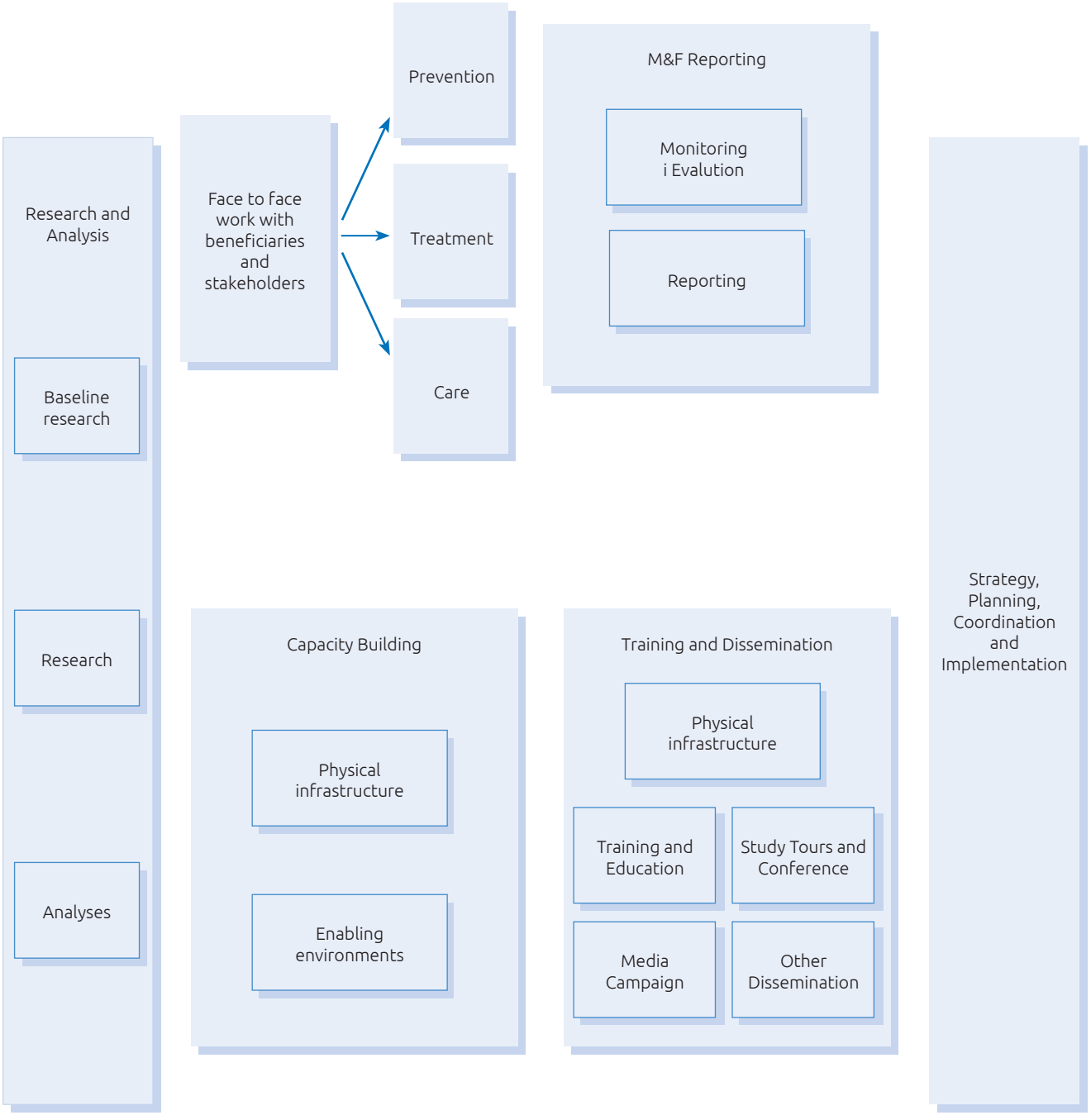
Process for developing an HIV budget

A broad approach is needed to effectively deal with the complex range of social and health issues posed by the HIV epidemic. The NHS and its Implementation Framework/Action Plan sets out the elements of BiH's comprehensive national response. It contains 6 Strategic goals (outcomes) and 27 targeted outputs. The listed targeted outputs are aggregated into following six Strategy Modules, created by the common unit costs:

1. Strategy Planning, Coordination & Management
2. Monitoring, Evaluation and Reporting
3. Prevention, Treatment and Care
4. Training and Dissemination
5. Capacity Building (physical infrastructure and enabling environment)
6. Research & Analysis

In contrary to activities based budgeting this approach slices different strategic goals into common units and enables cost comparison among the different strategies. Therefore, the expected value of this type of methodological study is twofold: to address program-specific information needed to program designer, implementers and funders, and to establish a basis for cost comparison among programs, interventions and activities.

Figure 1: Six Strategy Modules



There are approximately 65 major activities leading to the achievement of target outputs. Each activity was assigned to one of the 14 groups, as displayed in table 1. Costs and resource will be calculated for each of the activities.

Table 1. Activity Types of HIV/AIDS Programs

Group	Content Description
Baseline research	Develop instruments for and conduct censuses, surveys, focus groups, and baseline data gathering in other forms, to take the first measurement of the indicators to find out "Where are we today?"
Researches	Strategy design, technical planning and development, design and planning of training, and other event agendas
Analysis	Including identification of sites and partners for research, pilot TA, and study tours
Development of IEC materials	For media campaigning, face-to-face distribution, training
Training events	Financial, technical, and organizational support of Workshops, tutoring, roundtable discussions with a strong training element for regulators, technical experts, provider of services, community workers, in- country study tours and conferences etc; support of groups and individuals sent on study tours and internships; and support to attend conferences.
Media campaigning	Transmission of IEC materials, announcements, advertisements, and other forms of publicity through mass media
Dissemination	Dissemination of materials other than through media campaigning and education
Policy dialogue and development	Participation in task forces, committees, debriefings of, and other contacts with, the minister of health and other policymaking and executive institutions, community leaders, professional associations, employers, etc.
Institutional capacity building and support	Targeted at regulatory and executive agencies, communities, NGOs, health facilities, other CAs in TA forms other than training, and policy dialogue
Face-to-face work with beneficiaries: Prevention	Activities with predominantly preventive purposes directed at and involving a population with HIV risk (e.g., behavior change, condom distribution, blood screening, etc.)
Face-to-face work with beneficiaries: Care	Activities with the predominant purpose of providing care to people exposed to and living with HIV/AIDS (e.g., care-seeking counseling, home-care support)
Face-to-face work with beneficiaries: Treatment	Predominantly clinical interventions directed at and involving people living with HIV/AIDS e.g., purchasing condoms, pharmaceuticals, and home-care kits; equipment and renovation of premises for community work, etc.
Monitoring & Evaluation, Reporting	Developing instruments for and conducting censuses, surveys, focus groups, and evidence collection in other forms, predominantly with program monitoring and/or evaluation purposes, reviews, reports, SR debriefing in all forms
Strategy Coordination & Implementation	Including in-country and corporate contract management and general procurement; setting up offices, hiring staff, etc.

To develop a budget for the ministry's HIV implementation plan we followed the typical process in detail explained in Annex 1. After grouping the outputs in common strategic modules, we started defining the costs. The achievement of outputs grouped by different module causes different costs, whereby each modules has the same or similar costs. Therefore, the first step would be to identify the common costs defined as the cost that appear across more than one activity. Afterwards, we developed a unit cost table that contains standard costing for these common costs, i.e. standard prices for transportation, venue hire, poster printing, etc. As the strategy always takes more the one year, it is necessary to take into account the effect of inflation when developing a budget, so called an annual inflationary multiplier. When doing the calculations we have to consider that now is the year of 2014, and that we are developing the budget for period from 2011–2016. It means that prices we going to get for some goods and services already contain the effect of inflation. In this matter BiH is specific since we have currency board and officially very low inflation. Information about inflation is taken from the Vienna Institute for International Economic Studies and presented in Annex 3.

Table 2: Average inflation rate

Inflation Rate						
Year	2011	2012	2013	2014	2015	Average
Consumer prices, % p.a.	3.7	2.1	2.0	2.0	2.0	2.36

On the other hand, no all HIV interventions/activities are necessarily costly or require additional funding. These activities may cost the time to implement, but they have virtually no financial implications. Those actions can be put into practice on a zero-budget basis, therefore called zero-budget activities.

In accordance with previously defined strategy models we made grouping of activities from Action Plan for Implementation of Strategy to Respond to HIV and AIDS in Bosnia and Herzegovina 2011–2016, presented as follow:

Table 3: Grouped activity defined by strategy models

	Strategy Modules	Related activity from action plan
I	Strategy Planning, Coordination & Management	
	Strategy&Budget Development	
	Strategy Coordination & Implementation	
II	Monitoring, Evaluation and Reporting	
	Monitoring, Evaluation and Reporting	2.1.2.; 2.1.3; 2.1.4.; 2.1.5.;2.1.6.;
III	Prevention, Treatment and Care	
	Prevention	1.1.3.2.; 1.1.3.3.;
	Treatment	1.2.1.1.; 1.2.1.2.;1.2.1.5.; 1.2.1.3
	Care	1.2.2.1.; 1.3.1.4.
IV	Training and Dissemination	
	Training	1.1.2.1.; 1.2.2.1.; 1.1.2.2.; 1.3.1.1.;3.1.2.; 3.1.3.; 3.1.4.; 3.2.1.; 3.2.2.; 3.2.3.; 3.3.1.; 3.3.2.; 3.3.3.; 3.4.1.; 3.5.1.; 3.5.2.; 2.2.2.; 4.1.3.;4.1.4.;4.1.6.; 6.3.1.
	Dissemination	2.2.3.; 6.3.1.; 5.3.3.
V	Capacity Building	
	Physical Infrastructure	1.1.3.1; 1.2.1.4.; 4.1.5.; 4.2.1.; 5.3.1.;
	Enabling Environment	1.1.2.3.; 1.3.1.2.; 1.3.1.3; 1.3.1.5; 1.3.1.6.; 2.2.1.; 3.1.1.; 5.2.2.; 5.1.2.; 5.3.2.; 5.4.1.; 5.5.1; 6.2.1.; 5.2.1:
VI	Research&Analysis	
	Research	1.1.1.1.; 2.1.1.; 2.3.2.; 6.1.1.;
	Analysis	4.1.1.; 4.1.2.; 5.1.1.:

3. NHS BUDGET

3.1. Strategy Planning, Coordination & Management – Module I

The first step in the NHS budget creation is to determine the one-time cost of developing the Strategy, accompanying with Action plan and its budget creation, presented in the following table:

Table 4: Strategy planning & budget development costs

Strategy Planning &Budget Development	Description	Source of in-formation	EUR
Strategy to Respond to HIV and AIDS in Bosnia and Herze-govina 2011–2016	On the Strategy development worked 14 persons for 4 months. Costs calculated as 20% of their monthly gross salary.	MoCA	16,800
Action Plan for Implementati-on of Strategy to Respond to HIV and AIDS in Bosnia and Herzegovina 2011–2016	On the Action plan development worked 14 persons for 1 months. Costs calculated as 20% of their mon-thly gross salary.	MoCA	4,200
Budget Development	It includes costs of tender procedure, consultant fee, graphic design, and printing.	PH	8,000
		TOTAL :	**29,000**

Afterwards we should answer: "Who is responsible for Strategy coordination and implementation?" Due to the complicated organizational structure of BiH, the answer was not straightforward. There was no unit or structure dedicated only to implementation of the Strategy. In accordance with information received from the key stakeholders, we constructed the human resource costs caused by making the action plan operational.

Table 5: Strategy coordination & management costs

Strategy Coordination & Management	Description	Source of informati-on	EUR
Human Resources			
National Advisory Board (NAB)	The Board consists 9 participants from different institutions. They meet 4 times per year. Costs are calculated as one day of their gross monthly sa-lary.	MoCA	54,997
State level (Ministry of Civil Affairs BiH-Department of Health)	At the state level 2 persons are in charged for HIV/AIDS Strategy im-plementation. Cost are calculated as follows: monthly salary + 20% paid from UNDP.	MoCA	274,983
Entity level ministries of health	It refers to 2 HIV/AIDS Program Coor-dinators for two entities. Costs are calculated as 30% of their monthly gross salary.	FMoH/RS MoH	91,661
Entity level health insti-tutions (Resource In-formation Education Centers)	Those centers employed app. 10 per center. The costs are calculated as 20% of their monthly gross salary + additional funds received from UNDP	FPHI/RS PHI	1,094,838
Medical staff - BiH	The public health institutions provided the data about the medical staff in-volved in the prevention, treatment and care of HIV as well as their ave-rage monthly salaries. The estimation is that 10 %of their working time is spent on those activities.	FPHI/RS PHI	12,170,966
Technical and mana-gement assistance	Funds for potentially engaged exter-nal consultants.	FPHI/RS PHI	180,000
UNDP	In includes 1 HIV/AIDS Project mana-ger, 3 operations staff members (one procurement associate and two fi-nance associates)	UNDP	549,965
		TOTAL:	**14,417,409**

The total costs of the Module I for the period of 6 years amounts to **14,446,409 EUR.**

3.2. Monitoring, Evaluation and Reporting – Module II

Due to the information received, this activity should take place on different levels presented in the following table:

Table 6: Monitoring, evaluation and reporting

Monitoring and Evaluation	Description	Source of information	EUR
State level	At the state level, 2 persons are in charge for M&E of Strategy implementation. Cost calculated as fol-lows: monthly salary + 20% paid from UNDP.	MoCA	229,152
Entity level	At the entity level, there are 4 persons (2 in FBIH and 2 in RS) responsible for M&E activities. They are placed at entities health institutes, into resource centers so the cost of this unit set up are presented as a part of resource centers establishment.	FPHI/RS PHI	458,304
Municipality	It includes the costs of municipality M&E unit set up, their operational costs, and officers. To assess the required budget we take that the M&E unit will be set at 10% out of total municipality's number of 141, meaning 14 municipalities, with average cost of 500 EUR per municipality. The average operational costs per unit would be 300 EUR per month. The average salary per officer would be 900 EUR per month, and we take 2 officers per unit.	FPHI/RS PHI	2,252,691
UNDP	It includes 3 member staff: 1 M&E Expert, 1 M&E assistant and 1 M&E Data collection clerk	UNDP	412,474
M&E networking software deve-lopment & mainte-nance	The M&E System is an information system with the aim to support the data collecting process, which will meet the needs of the M&E unit of the HIV and AIDS Project. The system was developed as a web application, and users are able to access the M&E system using a web browser, regardless of location, time, or operating system (www.mesystem.ba). The average software cost is 10.000 EUR + the mon-thly maintenance cost of 500 EUR	UNDP + Report: "A practical ap-proach to susta-inable financing of the National HIV response in Bosnia and Her-zegovina")	82,192
Establish a register of people living with HIV	Per year per clinic	PH	45,000
M&A annual reviews	The annual review on state and entity levels, per review, per year 10.000 EUR.	FPHI/RS PHI	180,000
Exit Evaluation	It is necessary to conduct the exit evaluation on the end of the strategy implementation.		20,000
		TOTAL:	**3,679,814**

3.3. Prevention, Treatment and Care – Module III

When we are talking about prevention, it is necessary to calculate the funds needed for testing for HIV/AIDS. The distinction has to be made between persons who are tested particularly for HIV and the persons who voluntary donated blood. The costs of a test for the first group varies on the fact if the person is or not informed with the results. In addition, if the person is positive, it requires a further test. The baseline quantity was data from 2010 received from ZZOiR FBIH. We anticipated the increase of tested persons for 10 percent per year.

The voucher system was planned as one-time activity. Vouchers were printed in the quantity of 5,000, and distributed through CSOs during the lifetime of the strategy.

Table 7: Prevention costs

Prevention	Description	Source of information	EUR
Prevention	Overview of the HIV cost of counseling and testing	FZO RS/ZZOiR FBIH	1,892,921
	Overview of the HIV cost of testing of blood donations	FZO RS/ZZOiR FBIH	7,862,006
	Introduced a system of vouchers for testing at VCT centers	MoCA; PH	10,000
		TOTAL:	**9,764.927**

To determine the costs of ARV therapy, we should project the trend of number of infected persons. We had available data for the years of 2009.[3] and 2011.[4] Those numbers indicated an increase of HIV infected for app. 10 per cent per year and AIDS infected for app. 7 per cent per year.

Tabela 8: Prognoza kretanja broja osoba zaraženih HIV/AIDS-om

YEAR	2009	2010	2011	2012	2013	2014	2015	2016
HIV	163	179	197	217	239	263	289	318
AIDS	102	109	117	125	134	143	153	164

3 "Strategy to Respond to HIV and AIDS in Bosnia and Herzegovina 2011–2016"

4 "A report on the epidemiological surveillance of HIV/AIDS for 2011."

The average cost of ARV therapy per person was calculated by using the data on total consumption of ARV drugs in the year of 2013 in FBIH. It amounted to 287,613 KM or 147,054 EUR for 57 patients.

Table 9: Treatment Cost

Treatment	Description	Source of information	EUR
Treatment	ARV therapy costs	ZZOiR FBIH	4,176,277
	Revising the list of ARV drugs	FMoH	1,200
	Revising the list of ARV drugs with pediatric dosage forms	FMoH	1,200
	PEP therapy costs	UNDP	6,300
		TOTAL:	**4.184.977**

Table 10: Care Costs

Care	Description	Source of information	EUR
Care	Case management directed towards the needs of people	MoCA	0
	Strengthening the capacity of home care (includes the pro-curement of equipment, edu-cation and operational costs for three medicine center per year)	none	238,700
		TOTAL	**238,700**

3.4. Training and Dissemination - Module IV

When estimating the cost for education we found very useful the data provided in UNDP training plan, which contains the information on organizer, name of training, topic and purpose, cost of venue, number of participants and days, cost of supplies and materials and cost of instructors for previous years. This helped us to determine the unit cost table per training, as well as to determine the average number of trainings held for different beneficiaries in accordance with Strategy Action Plan.

Table 11: Training unit costs

Unit Cost Table	**EUR**
Number of trainings	123
Total costs	303,668
Average cost per training	2,469
Additional data	
Number of participants	2,426
Number of days	254
Per diem cost	9
Venue hire	546
Supplies and materials	125
Instructors	210
Other costs	1097

Allocation of Education Costs by different beneficiaries:

Table 12: Education Costs

Education	**Description**	**Source of informati-on**	**EUR**
Education	Costs of education in educational institutions and CSOs to carry out prevention programs	UNDP	471,451
	Costs of education for key populations at high risk	UNDP	628,601
	Costs of staff training in the centers for social welfare and mental health	UNDP	157,150
	Costs of training health workers to conduct VCT	UNDP	78,575
	Costs of training to strengthen the capacity of primary and secondary health care	UNDP	471,451
	Costs of training to strengthen the capacity of other actors outside the health system	UNDP	314,301
	Costs of training for combat against stigma and discrimi-nation	UNDP	78,575
		TOTAL :	**2,200,105**

In accordance with the Action Plan, the dissemination will include the following tasks:

- Informing the public about the HIV testing, testing procedure, institutions that perform testing and the rights of citizens during the testing should be realized through out two major activities:
- Media campaign (TV, radio, press, bill-boards, social networks),
- Development and distribution of informational-educational material;
- Improving approach to combat stigma and discrimination among all participants in the process via guidelines for education on HIV stigma and discrimination;
- Campaign among girls and women about the need for regular gynecological examination and testing, which will be realized via organization of, so called, school for pregnant women and developed and distributed accompanying guidelines.

Table 13: Dissemination costs

Dissemination	Description	Source of informa-tion	EUR
Informing the public about the HIV testing procedures	Media campaign	Media plan/UNDP	300,000
	Development of IEC materi-als	Media plan/UNDP	300,000
Improve approach to com-bat stigma and discriminati-on	Guidelines for education on HIV stigma and discriminati-on	Media plan/UNDP	210,000
Campaign among girls and women	School for pregnant women	PH	74,066
	Development of IEC materi-als	PH	90,000
Condom distribution	Promotional-prevention activity	UNDP	280,000
The expenditure for preven-tion and promotion activities aimed for fight against HIV/ AIDS (5%)	1% of total expenditure in the health sector	World Bank/ FPHI	17,371,645
		TOTAL:	**18,625,711**

3.5. Capacity Building (physical infrastructure and enabling environment) – Module V

3.5.1. Physical infrastructure

To strengthen the physical capacity for early detection of HIV infection, the Strategy anticipated to open at least 4 new VCT centers. We will project the opening of one per each year. Presently operates 22 of them, although in 2011 there were 17 VCT centers. The establishment of one VCT center is app. 3,000 EUR and the operational costs per VCT center amounts to 3,500 EUR, yearly.

Establishment of one laboratory for the resistance determination includes the start-up cost consisting of: purchase of Abbot set in amount of 250,000 EUR, and operational costs per year 10,000 EUR. It also requires study visits abroad, one time per year, for app. 10 persons that causes costs of app 10,000 EUR.

To establish of 3 reference centers for the diagnosis and treatment of HIV infection, we anticipated that each center will have one "Western Blot" machine, whose acquisition costs are 30,000 EUR per machine, requiring yearly operational costs per center in amount of 6,000 EUR.

Establishment cost of 2 resource centers (RCs), one in FBiH, the other in RS, costs 38,000.00 EUR. Each center needs to have one software for addiction diseases of approximately 12,000.00 EUR and web-page designing and hosting in amount of 20.000 EUR. For activities that support the work of the RCs, as printing educational materials, buying literature for libraries of RCs, subscriptions for professional journals, and other activities, including overheads, is 75,000.00 EUR. Additionally it is necessary to plan funds for travelling, meetings, per diems and accommodation costs for both centers in amount of 45,000 EUR per year.

Establishment of drop-in centers (care for girls and women drug addict injecting) causes following costs: rental, utilities, staff, medical assistance, social assistance in amount of app. 12,000 EUR per center yearly. We anticipate the opening of 2 centers per year.

Table 14: Physical Infrastructure

Capacity Building	Description	Source of information	EUR
Physical Infrastructure	Establishment of 6 new VCTs (including the start-up and operational costs)	MOH	427,500
	Establishment of 1 laboratory for the resistance determination (including the start-up, operati-onal costs, study visits)	PH/UNDP/ "Diamedic" d.o.o.	310,000
	Establishment of 3 reference centers for the diagnosis and treatment of HIV infection (3 "Western Blot" machine + operational costs)	UNDP	162,000
	Establishment of 2 resource / informative / educational centers	RS PHI/ FPHI	790,000
	Establishment of drop-in centers (to care for girls and women injecting drug addict)	UNDP	144,000
		TOTAL:	1,833,500

3.5.2. Enabling environment

Creation and implementation of preventive programs for all key populations, based on previously verified facts and assessed existing programs and good practices, may consider the establishment of new stationary centers, education, etc. that costs 12,000 EUR per year. Establish and ensure the functioning of multidisciplinary teams for patient care, which include physician-infectious disease specialist, a psychologist, social worker, nurse, etc. who will spend part of their work time to participate in those teams. We already calculated those costs under the Model 1. This activities requires only drafting regulations for FBiH, RS and District Brcko. This one-time activity costs 3,000 EUR. To build-up a confidential system that connects institutions for health and social care at all levels, aimed at people living with HIV, it is necessary to organize trainings to introduce the Law on Patients' Rights and the Law on Information. That activity needs funds in amount of 5.000 EUR per year.

To develop programs of social and economic support to people living with HIV assumes the distribution of funds, aimed for economic and social assistance, in amount of 50.000 EUR annually. Additionally, included is funds for staff and other costs to implement this activity that would amount to 25,000 EUR per year.

To strengthen the network of organizations that provide support to people living with HIV include different networking activities (trainings, annual meetings, exchange of best practices, etc.) costing 30,000 EUR. We should stress out the importance of providing CSO Annual conference.

The activity of development and support of the institutional system for testing and counseling means to develop a system of quality assurance and supervision in the consultation process, and to improvement the system of quality assurance in laboratories for HIV testing, applying the prescribed standards. This cause following costs: accreditation, training, study trip, etc. The accreditation process per VCT is 2,500 EUR. Currently we have 22 VCTs. The education and study trips would be 16,000 EUR annually.

To strengthen cooperation at all levels, involvement of various institutions, organizations and departments in activities aimed at combating the HIV epidemic, mechanisms of intersectoral communication and cooperation, and involvement of representatives of the population living with HIV, in developing programs implies multiple meetings per year, involving key stakeholders, i.e. ministers, CCM, etc. The planned funds supposed to be 55,000 EUR annually. This also includes strengthening of their capacities, with special emphasis on methadone centers (6 OSTs) and therapeutic communities/campuses (11). It foresees funds for methadone centers staff, as well as provision of products needed for HIV/AIDS population (e.g. HIV tests, HCV tests, condoms, lubricants, needles, methadone, Hep B vaccines, hygienic packs, etc.).

Provision of legal assistance to high risk population by the CSOs would costs 5,000 EUR per year.

To adopt amendments or adopt new regulations was necessary for the purpose of absolute respect of the human rights of people living with HIV or among key populations at higher risk. It is zero-cost activity due to the fact that this activity is already included in existing laws. This information was provided by the key informants.

Strengthening capacity of the CSOs to treat, care and support for people who sell sex, annually is 50.000 EUR in total. Development of by-laws regulations for strict application of the Decision on the basic package of health rights in the Bosnia and Herzegovina is zero-cost activity. Advocating for effective policies and strategies that are evidence-based and economically feasible requires working groups meetings, which includes representatives of CSOs and medical experts. Results of those meeting should be in the form of documents proposals (amounts to 30,000 EUR). Motivation and encouragement of decision makers in order to support the implementation activities is directed toward interreligious communities (app. 45,000 EUR per year). Ongoing work with all sectors in order to ensure respect for human rights is anticipated to be zero-budget activity.

Table 15: Enabling Environment

Capacity Buil-ding	Description	Source of in-formation	EUR
Enabling Envi-ronment	Creation and implementation of preventive programs for all key populations	MoH	72,000
	Establish and ensure the functioning of multidi-sciplinary teams for patient care	MoH	3,000
	Build-up a confidential system that connects institutions for health and social care at all le-vels	PH	30,000
	Develop programs of social and economic support to people living with HIV	PH	450,000
	Strengthen the network of organizations that provide support to people living with HIV (e.g. Annual CSOs conference)	UNDP	180,000
	Develop and improve the quality assurance system (in the consultation process, in labora-tories)	PH	151,000
	Strengthen cooperation and capacity of all le-vels (especially OSTs, campuses)	MoCA, UNDP, MoH	7,410,000
	Provision of legal assistance to high risk popula-tion by the CSOs	MoH	30,000
	Adopt amendments or adopt new regulations where necessary for the purpose of absolute respect of the human rights of people living with HIV or among key populations at higher risk		0
	Strengthen the capacity of the CSOs to treat, care and support for people who sell sex.	UNDP/ UG PROI/ MARGINA	250,000
	Development of by-laws regulations for the strict application of the Decision on the basic package of health rights in the BiH		0
	Advocating for effective policies and strategies that are evidence-based and economically fea-sible	MoH	180,000
	Motivation and encouragement of decision makers in order to support the implementation of activities is directed toward interreligious communities	MoH	270,000
	Ongoing work with all sectors in order to ensu-re respect for human rights		0
		TOTAL:	**9,026,000**

3.6. Research & Analysis – Module VI

3.6.1. Research

The Action plan foresees the research within following fields:

- Periodic surveys to monitor the epidemic and to ensure valid data for creating and customizing intervention programs;
- Periodic serological surveys and studies of behavior among key populations;
- Periodic anonymous surveys on prevalence of HIV in the general population;
- Researches in the field of stigma and discrimination in order to improve prevention programs.

During the budget development we learned the number and costs of researches already conducted, and we used them to plan the funds for those above mentioned tasks.

Table 16: Research

Research	Description	Source of information	EUR
Research	Periodic surveys to monitor the epi-demic and to ensure valid data for creating and customizing intervention programs	PH/RS PHI/FPHI	1,200,000
	Periodic serological surveys and studi-es of behavior among key populations	RS PHI/FPHI	1,200,000
	Periodic anonymous survey on preva-lence of HIV in the general population	RS PHI/FPHI	300,000
	Researches in the field of stigma and discrimination	RS PHI/FPHI	360,000
		TOTAL:	**3,060,000**

3.6.2. Analysis

The strategy implementation includes conducting three analyzes (Analysis of the existing capacity of the government sector, Analysis of the existing capacity of civil society organizations, Analysis of the existing legislation in the field of education, health care, social sector, employment, housing, police and judiciary), and publicly presentation of their results with clear conclusions and recommendations for improvement.

Table 17: Analysis

Analysis	Description	Source of information	EUR
Analysis	Analysis of the existing capacity of the government sector	UNDP/MoCA	200,000
	Analysis of the existing capacity of civil society organizations	UNDP/MoCA	200,000
	Analysis of the existing legislation in the field of education, health care, social sector, employment, housing, police and judiciary	UNDP/MoCA	200,000
		TOTAL:	**600,000**

4. ALLOCATION OF STRATEGY COSTS BY IDENTIFIED STRATEGIC GOALS FOR 2011-2016

Table 18: Allocation of Strategy Costs by Strategy Module/Implementation Area

Strategy		YEAR						Total
MODUL		2011	2012	2013	2014	2015	2016	
I	Strategy Planning, Coordination & Manage-ment	2,295,709	2,319,495	2,373,527	2,428,835	2,485,447	2,543,396	14,446,409
	Strategy & Budget Development	29,000						29,000
	Strategy Coordination & Implementation	2,266,709	2,319,495	2,373,527	2,428,835	2,485,447	2,543,396	14,417,409
II	Monitoring, Evaluation and Reporting	620,100	581,646	594,488	607,633	621,088	654,860	3,679,814
	Monitoring, Evaluation and Reporting	620,100	581,646	594,488	607,633	621,088	654,860	3,679,814
III	Prevention, Treatment and Care	2,008,099	2,153,553	2,273,627	2,415,792	2,593,996	2,743,536	14,188,604
	Prevention	1,472,724	1,541,800	1,588,389	1,648,358	1,734,058	1,779,597	9,764,927
	Treatment	497,875	573,368	645,947	727,216	818,771	921,800	4,184,977
	Care	37,500	38,385	39,291	40,218	41,167	42,139	238,700
IV	Training and Dissemination	3,267,083	3,339,647	3,423,923	3,509,952	3,597,776	3,687,436	20,825,816
	Training	345,638	353,795	362,145	370,692	379,440	388,395	2,200,105
	Dissemination	2,921,445	2,985,851	3,061,778	3,139,260	3,218,336	3,299,041	18,625,711
V	Capacity Building	1,811,000	1,721,500	1,761,000	2,004,500	1,794,000	1,767,500	10,859,500
	Physical Infrastructure	312,500	216,000	255,500	499,000	288,500	262,000	1,833,500
	Enabling Environment	1,498,500	1,505,500	1,505,500	1,505,500	1,505,500	1,505,500	9,026,000
VI	Research & Analysis	460,000	460,000	460,000	1,060,000	460,000	760,000	3,660,000
	Research	460,000	460,000	460,000	460,000	460,000	760,000	3,060,000
	Analysis	0	0	0	600,000	0	0	600,000
							TOTAL:	67,660,143

5. MONITORING AND EVALUATION

If you want to get to the correct destination, it is best to begin by finding out what directions to head. In that sense we started with constructing a theory of change or also known as logical framework. It can be viewed as a representation of how strategy is expected to achieve results, as an identification of the underlying assumption referring to the events or conditions that may affect whether this strategy will obtain the desired outcomes (read as potential risk or contextual environment).

Figure 2: Change theory

CHANGE THEORY			
INPUTS	ACTIVITIES	**OUTPUTS**	**OUTCOMES**
Strategy as action plan developed as adopted by the Council of Ministers of Bosnia and Herzegovina Donors as local funds available for strategy implementation Adequate quality and quantity of medical staff employed in the prevention and treatment of HIV Experience in implementing such type of strategy Good coordination among two entities and relevant sub-strategy implementers Monitoring and evaluation system Infrastructure	Scaling-up age-appropriate behaviour change interventions focused on messages targeting early sex, cross generational sex, transactional sex and multiple partnerships Expanding the coverage and uptake of services, especially provider initiated counselling and testing in health facilities and communities Ensuring steady supply of test kits and lab reagents, coordination of strategies, providing policies and guidelines (such as Home-Based-Care and law counsellors), fostering synergy and collaboration among stakeholders and advocating for adoption of practice that will streamline counselling and testing, including the use of law counsellors and focusing on testing literacy Ensuring that every health facility providing antenatal care service test pregnant women for HIV Condoms will be widely availed from various outlets, including pharmacies, clinic, bars and hotels Advocating for condom use with key stakeholders, including religious and community leaders Expanding capacity building as related procurement for universal precautions for prevention of medical transmission of HIV including expanding training, needle stick surveillance, PEP and personal protective wear for health workers Engaging private sector, professional associations and other civil society groups in HIV prevention Strengthen the school system to ensure promotion of positive value and norms in learners All stakeholders will be mobilized to advocate for actions that ensure government budgets allocate funds for women, girls, gender equality and HIV Support the development of the national program and campaign for elimination of stigma and discrimination	Improved coverage and quality of prevention mother –too-child transmission of HIV, HIV Counselling and Testing, ART (Anti-retroviral Therapy), blood transfusion safety Improved logistics and supply management of HIV prevention commodities (condoms) Increased HIV/AIDS spending as % of the total annual national budgets Increased number of individuals reached with the HIV prevention program, by target group Improved coordination and leadership for HIV prevention Legal norms changed to protective HIV-related behaviour and attitudes	Ensuring universal access to prevention, treatment, care, social welfare and social support Strengthening surveillance of HIV risk factors Strengthening intersectoral and multisectoral cooperation Strengthening capacities of all stakeholders in the HIV and AIDS response Strengthening legal framework to promote, respect and protect human rights Reducing stigma and discrimination

CHANGE THEORY			
INPUTS	ACTIVITIES	**OUTPUTS**	**OUTCOMES**
	Promote the rights of PLHIV Strengthen the legal framework for protecting individuals and groups living with and affected by HIV/AIDS Work with the local governments, MoHs and other relevant ministries to ensure all work plans and budgets align with this HIV prevention strategy All relevant ministries will be required to develop and issue guidelines aligning with the strategy to implement programs in the sectors Implementing Ministry will be supported to provide technical assistance to other sectors Undertake regular meetings for joint planning, review of progress and sharing of experiences among sectors, civil society and PLHIV networks Advocacy for increased domestic funding for HIV Regular triangulation of data from various sources to obtain estimates and trends of new infections Production and dissemination of annual HIV surveillance reports Building technical capacities at relevant ministries and institutions to strengthen HIV/AIDS surveillance system		

RISKS			
1. Poor socio-economic status	2. Insufficient level of education among the population	3. Population migrations	4. Inadequate HIV/AIDS monitoring system
5. Stigmatization and discrimination rela-ted to HIV/AIDS	6. Budget availability	7. Political stability	8. Complicated coun-try organizational structure

IMPACT
Gradual reduction in the number of persons newly infected with HIV Creating an environment that will ensure that all of those persons living with HIV live long quality and healthy lives

The measurement of progress (or lack of it) toward outcome begins with the description and measurement of initial condition. Collecting baseline data essentially means taking the first measurements of the indicators to found out "Where are we today?" In the developed Strategy Action plan there are no information on baseline data. Existed or not, we have to anticipate the funds for the activity in the budget.

From the available documents we were not able to assess the applied system for monitoring and evaluation but, in any case, our recommendation is always to build so-called results-based monitoring and evaluation (M&E) system (Annex 4) that can be extremely useful as a management and motivation tool that helps track progress and demonstrate the impact of the strategy. It can help policy makers, decision makers and other stakeholder answer the fundamental questions of whether promises were kept and outcomes achieved.

Results-based information can come from two complementary sources: a monitoring system and an evaluation system (Annex 5). Both systems are essential for effective performance management.

To understand why we recommend this system, a distinction between traditional and results-based M&E needs to be drawn:

- **Traditional M&E** focuses on the monitoring and evaluation of inputs, activities and outputs (strategy implementation);
- **Results-based M&E** combines the traditional approach of monitoring implementation with the assessment of outcomes and impacts, or more generally of results.

This linkage of progress implementation with progress in achieving the desired objectives or results of government strategy makes results-based M&E useful as a public management tool.

The strategy implementers need to determine the evaluation questions, prepare terms of reference and choose the independent evaluation team. The Performance Evaluation will deliver to strategy implementers a thorough and objective assessment of the achievements of the strategy, how it has been implemented, how it is perceived by counterparts and indirect beneficiaries, and whether its expected results are occurring. This summative evaluation will enable the implementers to objectively establish accountability for and gain learning from this Strategy implementation process. The proposal of work plan for the performance evaluation is contained in the following table. The timing for each task assumes that the engagement begins three months prior to the strategy completion and take for 30-40 days. There is some overlap/simultaneity in timing of tasks.

Table 19: Evaluation Work Plan Overview & Timeline

Major Task	Sub-Task / Description
1. Document review & Eval-uation Plan preparation	• Gather and review all project documents and existing data • Conduct related research • Prepare and submit detailed Evaluation Plan
2. Conduct self-assessment	• Finalize self-assessment instrument; deliver to strategy implementers; receive their completed self-assessment
3. Finalize interview instru-ments and questionnaires	• Complete direct interview and questionnaire formats • Compile and distribute list of Key Individual Interviewees (KIIs) and questionnaire recipients
4. Conduct field interviews and gather completed ques-tionnaires	• Implement field visits and telephone conferences to conduct and complete KII interviews • Follow up with questionnaire recipients to obtain sufficient responses • Carry out follow-up interviews/queries for clarification where needed • Hold Exit Briefing with strategy implementers
5. Analyze data	• Compile self-assessment, interview, and questionnaire information into organized format • Outline principal findings
6. Prepare Evaluation Report	• Prepare draft evaluation report and submit to strategy implementers/ main client
	• Receive strategy implementers comments on draft report • Revise, finalize, and submit Evaluation Report

The evaluation should utilize sound social science methods and describe the procedures to obtain high quality data and credible evidence corresponding to the questions asked.

Potential data sources should be:

1) Key informant interviews: Key informants will be identified in collaboration with the strategy implementers in order to identify the most appropriate persons to provide in depth information related to specific questions.

2) Site visits: Site visits to the relevant ministries, public health institutions, donors, sub-recipients and other counterpart offices. The objectives of the site visits will be to:
   a) independently validate reported information;
   b) observe evidence of implementation of systems and procedures.

3) Interviews with a sample of managers and staff: These interviews will be for a sample of participants in capacity building activities in order to validate participation, to collect information on familiarity with key items related to the training, and to collect information on changes in personal or institutional practices relevant to improved adherence to international standards.

4) Review of documents and website postings: In terms of data collection and analysis methods we propose the following:

a) Structured interview guides will be developed for Key Informant Interviews (KII). Separate interview guides will be developed, tailored to the group of individuals being interviewed and the topic of the interview. The objective of the guides is to ensure that similar issues are addressed with all KII relevant to a particular question, so that commonalities and differences can be identified;

b) Site visits: Site visits to a sample of clinics (if relevant) and counterpart offices will be made with the sites selected using stratified systematic sampling. The sites will be stratified by counterpart organization, as FBiH/RS location. The sample size will not be sufficient for statistical comparisons by levels of stratification due to time limitations, however, it will be sufficient to provide overall percentages for identified result with a reasonable level of precision (number and level of precision TBD). Structured interview forms and checklists will be developed to collect information on site activities and evidence of implementation of systems and regulations.

c) Structured interview questionnaires will be developed for interviews with a sample of participants in capacity building activities. These will consist of closed questions and a few open questions to identify familiarity with key information from the capacity building activities. The questions will be structured so that percentages for each response can be calculated. Among the variety of capacity building methods and topics of focus, the interviews will prioritize those that address issues most critical for moving toward compliance with defined impacts. The interviewees will be selected by type/topic of capacity building they participated in. Stratified systematic sampling methods will be used, with stratification by institutional affiliation, level of trainee (management/implementer), and FBiH/RS location. The sample size will not be sufficient for statistical comparisons by levels of stratification due to time limitations. However, it will be sufficient to provide overall percentages for identified result with a reasonable level of precision (number and level of precision TBD).

Analysis

1. Notes from KII will be transcribed so that they are available to all Evaluation Team members. Information from the KII will be collated and commonalities identified. Feedback from the KII will also be used to identify successful strategies for achieving results, and identification of intractable issues that need to be addressed to achieve the defined strategy vision.
2. Tables will be developed to provide the following information:
   - PMP indicators, the targets, and the reported results;
   - Results (percentages) for selected information from the participants interviews in capacity building;
   - Expected institutional changes in practices, current reported status, project activities expected to result in these changes;
   - Laws/regulations/policies relevant to this Evaluation and required to meet strategy goals and the current status for these in the legislative and institutionalization of their implementation/enforcement;
3. Information from site visits and from interviews of participants in capacity building activities will be collated to provide findings by percentages, stratified by gender, institution, and geographic entity (FBiH/RS) where relevant. The analysis will focus on evidence of validity of reports of activities and quality of the capacity building activities as measured by familiarity with key content (e.g., new rules/regulations).

Obstacles and strategies to address the obstacles shoule be assessed in the context of achievements and KII feedback. The objective is to determine if project was proactive in addressing obstacles, and whether the process and strategies used to identify and address obstacles were based on a reasonable expectation that they would result in improved outcomes.

Findings from reports and documents should be triangulated with findings from site visits, results from manager and implementer interviews, and commonalities from key informant interviews to provide validation for reported activities and results and to provide a more complete context for the Evaluation conclusions and recommendations.

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7. ANNEXES

Annex 1: Process for developing an HIV budget

Step 1: Assemble a team of persons who will be involved in the budgeting process.

Step 2: Obtain a copy of the ministry's HIV strategic and implementation plans, and provide each member of the team with a copy of these documents. Ask team members to study the documents.

Step 3: Develop a budget matrix (usually a spreadsheet, using the appropriate software) that defines, for every objective listed in the HIV policy, the specific activities that will be implemented, as well as the timeline for these activities. The list of activities for this matrix may be obtained from an existing HIV implementation plan. Define activities that support the specific program.

Step 4: For every activity in the program and for every year of implementation, identify the cost elements. Describe the costs in detail, for example: "In year 1, four two-day workshops of 30 participants each".

Step 5: Identify whether there are any costs that are common, i.e. costs that appear across more than one activity. For example, there may be a need for workshops to be undertaken in more than one activity. Then develop (a) a UNIT COST TABLE that contains a standard costing for these common costs, and (b) standard prices for road transport, venue hire, poster printing, etc.

Step 6: Based on the estimates that the team developed Step 4 and Step 5, should be develop a detailed budget for the entire lifespan of the HIV implementation plan. For each budget item, list the potential funding source for that budget item (this could be government or other external funding sources, such as development agencies).

Annex 2: Sources of Information

Table 20: Key Informant Interviews

No	Date	Organization	Individual	Position
1	01 2014	FMoH	A. M. Magazinović	Head of Financial Department
2	01 2014	FMoH	Dr. Cardaklija	HIV Federation Coordinator
3	01 2014	PH	A. Paripovic,	CSO
4	01 2014	FZZOiR	Z. Ademaj	Head of Department
5	01 2014	MCA	Dr. Godinjak	Head of Department
6	01 2014	UNDP	Dr. Seremet	HIV Project Manager
7	01 2014	UNDP	A. Drinic	Project Staff
8	02 2014	FMoH	Dr. Cardaklija	HIV Federation Coordinator
9	02 2014	PH	A. Paripovic, Damir…	CSO
10	02 2014	FZZJZ	A. Malicbegovic	Head of Finance Department
11	02 2014	FZZJZ	Dr. Vucina	Project Coordinator
12	02 2014	UNDP	Dz. Babic	UNDP Staff
13	02 2014	FZZJZ	Dr. Ravlija	Federation Epidemiologist
14	02 2014	CSO	UG Proi, Victoria	…..
15	02 2014	Media Plan, Metacenter		
16	02 2014	UNDP	Stakeholders	Group Meeting, consultations
17	02 2014	UNDP	S. Brankovic-Merdzo, I. Stojadinovic	Project Staff
18	03 2014	UNDP	Dz. Babic	Project Staff
19	03 2014	FZZJZ	Dr. Vucina	Project Coordinator
20	03 2014	FZZJZ	A. Malicbegovic	Head of Finance Department
21	03 2014	PH	A. Paripovic	CSO

Most of the listed interviewers were contacted several times, personally, by the telephone or exchanging e-mails.

Table 21: Documents Reviewed

	Documents Reviewed
1	Health Insurance Fund RS - Information on the costs of treating patients with HIV in 2011
2	Health Insurance and re-insurance fund FBiH- Program of voluntary, anonymous and free counseling and testing for HIV / AIDS (VCT) and drugs for the treatment of AIDS patients
3	Institute for alcoholism and other toxicomania Canton Sarajevo
4	Institute for Transfusion Medicine RS - Costs of medical supplies, equipment, salaries, ma-intenance
5	Institute for Transfusion Medicine FBiH- Costs of tests for transmissible diseases
6	FMOH essential list of medicines
7	80 years of Institutional public health in BiH
8	Prevention percentage
9	Report PHI HR
10	Health insurance amount in 2011
11	IDU Therapeutic Community Campus Report
12	Canton Sarajevo Budget Campus
13	Expenses 2010 line 1261, 1235, 1275
14	Canton Sarajevo Budget lines 1790, 1793, 1797
15	BUDZET ZDK
16	Tuzla Canton budget
17	City of Mostar budget
18	NGO Viktorija
19	Health Insurance Fund RS- HIV Prevention, diagnostic and treatment costs 2010-2012
20	Clinical Hospital Mostar
21	Banja Luka City participation 2011
22	FBiH Ministry of labor and social policy budget
23	Joint UN Team – response to HIV
24	UNICEF -report
25	EMCD ANNUAL REPORT BIH
26	Papua New Guineas - Implementation Framework, Mid Term Review of PNGHIV Strategy, National HIV Strategy_ 2011-2015, NHS_M&E framework, Progress Report, Scope of Servi-ces PNG HIV Implementation
27	ME Monitoring Evaluation Toolkit
28	The Global Fund to Fight AIDS, Tuberculosis and Malaria
29	National HIV prevention strategy-Uganda
30	How to Make a Budget for a Social Program- http://www.ehow.com
31	Communication costs
32	ProDoc 2 faza_001

	Documents Reviewed
33	ProDoc- Implementation of GF-BiH
34	Project Document R9 HIV - Final
35	Project Document R9 HIV 080411
36	Addiction Diseases Institute ZE DO Canton
37	Public Health Institute HR RS - HIV and prevention - gross salaries paid in 2010,2011,2012
38	HIV and HEPATITIS 2009 2010 2011
39	HIV and HEPATITIS - jun 2012
40	Suboxone UKC Tuzla 2010 2012
41	Supporting letter for Hepatitis and HIV
42	Health Insurance Fund FBiH 2010 2012
43	IDU Therapeutic Community Campus Report
44	Canton Sarajevo Budget Kampus
45	Project Document R9 HIV
46	BiH-910-G03-H_Phase 2 GA_Countersigned_19Jul2013 (1)
47	UNDP STC
48	PSM plan BiH R9 phase 2 April 30 2013
49	PSM Plan Annex
50	UNDP HIV AIDS UGOVOR O GRANTU ZA REALIZACIJU PROGRAMA
51	Performance Framework
52	Budget translation
53	UNDP STC- Final_17092013
54	Document II Results, conclusions and recommendations BCS
55	Data indicators-BiH Country
56	Required Charts B&H – GDP, Indicators
57	DATA B&H
58	Costing the implications of HIV in education
59	HIV UNDP Strategy
60	MEStrategy031020-global fund
61	National HIV prevention strategy-matrix
62	Nigeria_2010-15
63	PNG_NHS Implementation Framework
64	A Step-by-step Methodological Guide for Costing HIV/AIDS Activities
65	Strategija HIV 5.1
66	WPP_What is it likely to cost

Annex 3: Bosnia and Herzegovina: Selected Economic Indicators

	2008	2009	2010	2011	2012	2013	2014	2015
						Forecast		
Population, th pers., mid-year	3842.3	3843.0	3843.1	3839.7	3843.0	3842	3842	3842
Gross domestic product, BAM mn, nom. 2)	24898	24202	24773	25666	26000	26700	27800	29200
annual change in % (real) 2)	5.6	-2.8	0.7	1.0	-0.7	0.8	2.0	3.0
GDP/capita (EUR at exchange rate)	3300	3200	3300	3400	3500	3500	3700	3900
GDP/capita (EUR at PPP)	6500	6200	6400	6600	6600	.	.	.
GDP by expend. approach, BAM mn, nom. 2)	26783	26378	26410	27240	.	.	.	.
annual change in % (real) 2)	4.9	-4.2	-0.6	2.0	.	.	.	.
Consumption of households, BAM mn, nom. 2)	21752	20927	21338	21918	21900	.	.	.
annual change in % (real) 2)	5.5	-4.6	0.1	-0.3	-2.0	1.0	1.0	2.0
Gross fixed capital form., BAM mn, nom. 2)	6744	5380	4779	5241	5400	.	.	
annual change in % (real) 2)	15.9	-19.4	-11.8	7.0	0.0	6.0	5.0	5.0
Gross industrial production								
annual change in % (real)	7.3	1.5	3.7	6.4	-5.2	5.0	7.0	5.0
Gross agricultural production								
annual change in % (real)	9.1	3.9	-7.1	2.0	.	.	.	.
Construction output total 3)								
annual change in % (real)	16.9	-7.2	-12.4	-5.1	.	.	.	.
Employed persons, LFS, th, April	890.2	859.2	842.8	816.0	813.7	810	812	820
annual change in %	4.8	-3.5	-1.9	-3.2	-0.3	-0.5	0.2	1.0
Employees total, reg., th, average	705.6	697.6	695.7	691.2	688.0	692	692	699
annual change in %	2.9	-1.1	-0.3	-0.6	-0.5	0.5	0.0	1.0
Unemployed persons, LFS, th, April	272.0	272.3	315.1	310.9	316.6	313	312	311
Unemployment rate, LFS, in %, April	23.4	24.1	27.2	27.6	28.0	28.0	28.0	27.0
Unemployment rate, reg., in %, end of peri-od	40.6	42.4	42.7	43.8	44.0	44.0	44.0	43.0
Average gross monthly wages, BAM	1113	1204	1217	1273	1290	1310	1350	1400
annual change in % (real, net)	8.4	5.6	-1.1	-1.4	-0.9	.	.	.
Consumer prices, % p.a.	7.5	-0.4	2.1	3.7	2.1	2.0	2.0	2.0
Producer prices in industry, % p.a. 4)	8.6	-3.2	0.9	3.7	1.5	2.0	2.0	2.0
General governm. budget, nat.def., % of GDP								
Revenues	44.0	43.0	43.8	44.2	43.5	43.5	44.0	44.0
Expenditures	46.2	47.5	46.3	45.5	46.5	46.0	46.5	46.0
Deficit (-) / surplus (+)	-2.2	-4.4	-2.5	-1.3	-3.0	-2.5	-2.5	-2.0
Public debt, nat.def., % of GDP 5)	30.8	36.2	39.6	40.7	43.1	43.0	44.0	45.0
Central bank policy rate, % p.a., end of peri-od 6)	.	.	.	.	.	.	.	.
Current account, EUR mn 7)	-1771.3	-777.7	-719.3	-1141.9	-1200.0	-1300	-1400	-1500
Current account, % of GDP	-13.9	-6.3	-5.7	-8.7	-9.0	-9.5	-9.9	-10.1
Exports of goods, BOP, EUR mn 7)	3522.0	2920.2	3761.9	4347.2	2560.0	2700	3000	3300
annual growth rate in %	13.9	-17.1	28.8	15.6	-2.5	7.0	10.0	10.0
Imports of goods, BOP, EUR mn 7)	8344.6	6330.1	6994.1	7976.0	6720.0	7100	7600	8100
annual growth rate in %	15.4	-24.1	10.5	14.0	-2.5	5.0	7.0	7.0
Exports of services, BOP, EUR mn 7)	1131.9	1024.9	974.5	922.3	1520.0	1580	1640	1710
annual growth rate in %	6.6	-9.5	-4.9	-5.4	3.0	4.0	4.0	4.0
Imports of services, BOP, EUR mn 7)	467.7	461.7	407.4	378.6	410.0	420	440	460
annual growth rate in %	10.8	-1.3	-11.8	-7.1	-0.5	3.0	5.0	5.0
FDI inflow, EUR mn 7)	683.8	180.5	173.6	313.0	400.0	500	500	800
FDI outflow, EUR mn 7)	11.2	4.3	31.7	14.2	30.0	0	0	0
Gross reserves of NB excl. gold, EUR mn 8)	3218.9	3143.8	3267.6	3207.0	3150.0	3200	3200	3300
Gross external public debt, EUR mn	2168.0	2676.2	3215.4	3405.3	3700.0	4000	4000	4100
Gross external debt, % of GDP	17.0	21.6	25.4	25.9	27.8	29.4	28.2	27.5
Exchange rate BAM/EUR, average	1.9558	1.9558	1.9558	1.9558	1.9558	1.96	1.96	1.96
Purchasing power parity BAM/EUR	0.9982	1.0137	1.0071	1.0186	1.0227	.	.	.

1) Preliminary and wiiw estimates. - 2) According to ESA'95 (including non-observed economy, real growth rates based on previous year prices). - 3) According to gross value added. - 4) Domestic output prices. - 5) Based on IMF data. - 6) Bosnia and Herzegovina has a currency board. There is no policy rate and even no money market rate available. - 7) Converted from national currency with the average exchange rate. From 2012 BOP 6th edition, 5th edition before. - 8) Including investment in foreign securities.

Source: wiiw Database incorporating national statistics and IMF. Forecasts by wiiw.

Annex 4: Ten Steps to Building a Results-Based Monitoring and Evaluation System

Building a quality results-based M&E system involves 10 steps (figure 111):

1. Conducting a readiness assessment;
2. Agreeing on outcomes to monitor and evaluate;
3. Selecting key indicators to monitor outcomes;
4. Gathering baseline data on indicators;
5. Planning for improvement - setting realistic targets;
6. Monitoring for results;
7. Using evaluation information;
8. Reporting findings;
9. Using findings:
10. Sustaining the M&E system within the organization.

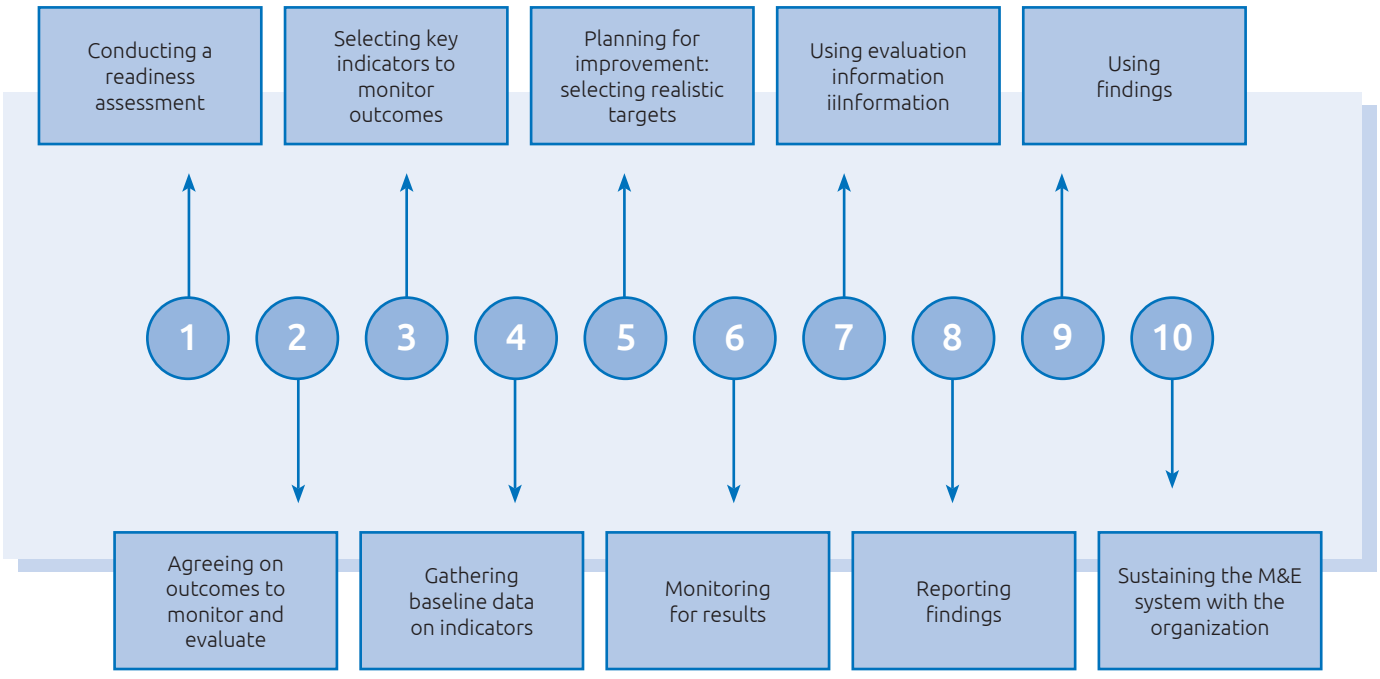

Figure 3: Ten steps of results-based M&E system

Annex 5: Difference between Results-Based Monitoring and Results-Based Evaluation

Results-based monitoring is the continuous process of collecting and analyzing information on key indicators and comparing actual results with expected results in order to measure how well a project, program, or policy is being implemented. It is a continuous process of measuring progress toward explicit short, intermediate, and long-term results by tracking evidence of movement toward the achievement of specific, predetermined **targets** by the use of **indicators**. Results-based monitoring can provide feedback on progress (or the lack thereof) to staff and decision makers, who can use the information in various ways to improve performance.

Results-based evaluation is an assessment of a planned, ongoing or completed intervention to determine its relevance, efficiency, effectiveness, **impact**, and sustainability. The intention is to provide information that is credible and useful, enabling lessons learned to be incorporated into the decision-making process of recipients. Evaluation takes a broader view of an intervention, asking if progress toward the target or explicit result is caused by the intervention or if there is some other explanation for the changes picked up by the monitoring system. Evaluation questions can include the following:

- Are the targets and outcomes relevant?
- How effectively and efficiently are they being achieved?
- What unanticipated effects have been caused by the intervention?
- Does the intervention represent the most cost-effective and sustainable strategy for addressing a particular set of needs?

BUDGET OF THE STRATEGY TO RESPOND TO HIV/AIDS BOSNIA AND HERZEGOVINA 2011-2016

SARAJEVO, MARCH 2014