HIV/AIDS in Southeastern Europe

Case Studies from Bulgaria, Croatia, and Romania

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# TABLE OF CONTENTS

Preface ................................................................................. v
Acknowledgments ................................................................. vii
Abbreviations and Acronyms ................................................... ix
Executive Summary ................................................................. 1
Chapter 1 Overview ............................................................. 5
Chapter 2 Romania ................................................................. 9
  Current State of the Epidemic ................................................ 9
  Special Populations ............................................................ 10
  Strategies and Interventions in Place ....................................... 11
  Current World Bank Activities and Possible HIV/AIDS Interventions ................................................... 13
Chapter 3 Croatia .............................................................. 15
  Current State of the Epidemic ................................................ 15
  Strategies and Interventions in Place ....................................... 16
  Current World Bank Activities and Possible HIV/AIDS Interventions ................................................... 18
Chapter 4 Bulgaria .............................................................. 21
  Current State of the Epidemic ................................................ 21
  Strategies and Interventions in Place ....................................... 22
  Current World Bank Activities and Possible HIV/AIDS Interventions ................................................... 25
Chapter 5 Main Conclusions and Recommendations .................. 27
  Lending Activities
  Non-Lending Activities
Appendices
  Appendix A. The South Eastern Europe Declaration on HIV/AIDS Prevention ........................................ 31
  Appendix B. Institutions and Persons visited in each country ................................................................. 35
References .............................................................................. 39
List of Tables
  Table 1 HIV and AIDS in Romania, Including Deaths and Living Cases, 2002 ........................................ 10
  Table 2 Testing for HIV According to Risk Group, Number Tested and Positive, Romania, 2002 .............. 10
  Table 3 HIV Testing in Croatia .................................................. 16
The purpose of this paper is to review the current status of the AIDS epidemics in ECC05 countries (Bulgaria, Croatia, and Romania), to evaluate the approaches and strategies currently being used in each country, and to make recommendations both for government strategies and for the Bank’s current and potential future involvement in relation to these strategies.

The paper is divided into three sections: 1) an overview of recent regional perspectives; 2) a situation analysis and evaluation for each country including current strategies and implementation arrangements, and 3) a discussion of potential actions by the Bank. The following approaches were used to complete the study:

(i) Collecting data and documents on the current state of the AIDS epidemic in the ECC05 countries (Bulgaria, Croatia and Romania). Information was obtained from UNAIDS, national AIDS committees and commissions (including UN Thematic Groups), and reviews of published literature. This report draws heavily on information produced in conjunction with Rapid Assessment Reports and the June 6–8, 2002, conference on HIV/AIDS in Southeastern Europe, held in Bucharest, Romania.

(ii) Reviewing each of the various government and UN-related strategies that are already in place to deal with the epidemics in terms of both prevention and treatment.

(iii) Assessing which national and international organizations (Non-governmental Organizations [NGOs], UN Organizations, European Union, etc.) are involved in which aspects of prevention, treatment, or advocacy related to HIV/AIDS, and the extent to which these activities are integrated into the national government strategies.

(iv) Visiting each of the countries twice to interview key informants, People With AIDS (PWAs), target group members, government officials, and UN agency field staff (April–June 2002).

(v) Highlighting those components and activities of current or previous World Bank projects related to HIV/AIDS and the relationship of this activity to the government strategies and unmet needs.

(vi) A peer review by individuals with particular knowledge of HIV/AIDS prevention and treatment programs from within the World Bank, the medical community, the donor community, NGOs, and country counterparts.

This study does not aim to duplicate any research, data collection, or analyses already completed, but rather to inventory information and to assess what pieces may be missing from current and future planning activities. Future directions as to where the World Bank may provide added value in the control of the nascent epidemics of HIV/AIDS in these countries are discussed.
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The authors alone are responsible for the conclusions and views in this document.

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Sector Director: Annette Dixon
Sector Manager: Armin Fidler
Task Team Leader: Dominic Haazen
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>APL</td>
<td>Adaptable Program Lending</td>
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<td>ARAS</td>
<td>Asociata Romana Anti-Sida</td>
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<td>ARV</td>
<td>Anti-Retroviral</td>
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<tr>
<td>CEE</td>
<td>Central and Eastern Europe</td>
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<td>Commonwealth of Independent States</td>
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<td>CIDA</td>
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<td>CSW</td>
<td>Commercial Sex Workers</td>
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<td>Department for International Development</td>
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<td>Europe And Central Asia</td>
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<td>ECC05</td>
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<td>ELISA</td>
<td>Enzyme-Linked Immunosorbent Assay</td>
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<td>GFATM</td>
<td>Global Fund To Fight AIDS, Tuberculosis, And Malaria</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HP</td>
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<td>International Harm Reduction Development</td>
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<td>International Organization On Migration</td>
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<td>MTCT</td>
<td>Mother-To-Child Transmission</td>
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<td>MOH</td>
<td>Ministry Of Health</td>
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<td>Médecins Sans Frontières</td>
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<td>MSM</td>
<td>Men Who Have Sex With Men</td>
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<td>NIPH</td>
<td>National Institute of Public Health</td>
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<td>Open Society Institute (The Soros Foundation)</td>
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<td>PWAAs</td>
<td>People With AIDS</td>
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<tr>
<td>SEE</td>
<td>Southeastern Europe</td>
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<tr>
<td>STD</td>
<td>Sexually Transmitted Disease</td>
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<td>Sexually Transmitted Infection</td>
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<td>Transnational AIDS/STD Prevention Among Migrant Prostitutes In Europe Project</td>
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<td>United States Agency for International Development</td>
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<tr>
<td>VCT</td>
<td>Voluntary Counseling and Testing</td>
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EXECUTIVE SUMMARY

In June, 2002, the countries of Southeastern Europe (SEE) re-committed themselves to scale up action on the prevention and treatment of Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) in the sub-region (Appendix A). Given the rapid increase in the rate of HIV infection in Eastern Europe in general and the generally similar risk conditions for low HIV prevalence SEE populations, this commitment is timely in terms of preventing a more widespread epidemic. It should also be recognized by the World Bank as a call to action to support these countries through the application of its comparative advantage in both lending and non-lending activities. The purpose of this paper is to review the current status of the AIDS epidemics in three countries of the Sub-region (Bulgaria, Croatia, and Romania—which constitute the ECC05 Country Department of the World Bank), to evaluate the approaches and strategies currently being used in each country, and to make recommendations both for government strategies and for the Bank’s current and potential future involvement in relation to these strategies.

The current low levels of HIV infection in SEE present a challenge in gaining recognition of the potential impact of HIV/AIDS on health systems, social structures, and individuals. Moreover, the approach to HIV/AIDS in SEE is complicated by relatively high levels of stigma against vulnerable groups (intravenous drug users [IDU], commercial sex workers [CSW], ethnic minorities such as the Roma, mobile populations, and men who have sex with men [MSM]).

There are numerous other agencies, donors, and interest groups with potential equity in HIV/AIDS in the sub-region, including the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), UNICEF, UNAIDS, UNDP, the International Organization on Migration (IOM), the Soros Foundation (Open Society Institute [OSI]), among others. Thus, it is important to consider a broad view of how the Bank might contribute to a systems approach to HIV/AIDS prevention and control. Ultimately, governments have a responsibility to address many parts of this systems approach—public education, health care, research, etc.

Potential interventions are organized according to four general groupings: 1) Epidemiology and Operational Research; 2) Health Care and Social Services; 3) Health Communications and
Promotion; and 4) Civil Society and Advocacy. Although the situation varies among the three countries, the following points summarize the key findings with respect to potential lending and non-lending activities applicable to them.

**Epidemiology and Operational Research**

- Adding specific project support for improvements in sentinel surveillance in high-risk, targeted groups, primary antiretroviral resistance surveillance, nosocomial infection surveillance in prisons and other settings, and surveillance for opportunistic infections.
- Including operational research in loan projects to assess efficacy and cost-effectiveness of HR and other prevention programs. Operational research that partners local experts with international institutions that have had success in destigmatization elsewhere may be supported. Further research into the largely heterosexual nature of the epidemic in these countries is warranted.

**Health Care and Social Support Systems**

- Adding specific training requirements for health providers to improve their sensitivity, recognition of HIV risk, and referral behavior for at-risk populations.
- Consider including advanced training for HIV/AIDS experts to assure that haphazard or harmful therapeutic approaches do not occur. These would contribute to drug resistance and increased costs of care.
- Improving training to reduce risk of transmission through inappropriate parenteral therapeutics or inappropriate needle usage. Expanding technological investments to increase availability of single-use needles.
- Adding specific project support for drug abuse treatment (detoxification) programs, as well as Methadone maintenance programs. These are in short supply throughout the region, and provide a critical access point for addressing an important epidemiological pump for the epidemic. Without specifically increasing treatment for IDUs’ demand for heroin and other injectable drugs, the HIV epidemic will not be effectively controlled.
- Adding specific project support for social support programs for PWAs and for re-socialization of risk groups (IDU, minorities, CSWs).
- Adding specific destigmatization training for health professionals who deal with HIV/AIDS patients or risk groups.

**Health Communications and Promotion**

- Include specific attention to HIV/AIDS public information as part of health promotion unit development and programming. Targeted activities to support VCT, condom social marketing, increased STI screening and treatment to highest risk groups should be focused.
- Expanding Health Promotion programs to specifically address reproductive health education, especially in school populations and other vulnerable populations.
- Adding specific de-stigmatization campaigns to existing HP programs geared both to the general public and to risk groups.

**Civil Society and Advocacy**

- Add outreach screening and mobile reproductive health facility procurements that might address uninsured or hard-to-reach populations such as Roma, CSWs, and IDUs.
- Add specific funding for HR programs overseen by the ministries of health but administered through existing NGOs, scaling up the now threatened individual projects to more national scope.
Non-Lending Activities

- Auditing the legislative frameworks in the Region regarding communicable disease control. This would help inform Bank dialogue with countries regarding public health reform. There seems to be several areas where legislation may impede HIV prevention and control. For example, tight regulations on providing Methadone maintenance will reduce the opportunity for HR for IDUs.
- Policy dialogue with the governments to consider optimum methods of institutionally supporting HR activities geared toward IDUs, Roma, and CSWs.
- Engaging specifically with ECA countries applying for GFATM to leverage World Bank projects as part of these collaborations.
- Cost-effectiveness analysis of expanded Methadone maintenance, needle exchange, and other IDU treatment programs geared toward reducing HIV, Hepatitis B, and Hepatitis C transmission.
- Working with other donors trans-nationally on destigmatization and public information about prevention needs in the sub-Region. A unified, vocal, and highly targeted approach would assist NGOs and government agencies in diverting attention from “risk groups” and a culture of blame, to global public responsibility and sensitivity. What has been happening as international dialogue has focused on high-prevalence countries; what is needed is a tailored approach to the prevention dialectic in low prevalence countries such as those in SEE.
- Engaging with multi-national drug enforcement agencies (UNDCP, INTERPOL) to approach drug use as an AIDS prevention issue.
- OSI has established an International Harm Reduction Network. The Bank may wish to consider officially joining this activity, mobilizing lending activities to specifically include these actions as part of country assistance strategies.
- Consider integration of key health promotion, information programs, and other activities into educational, labor, and other sectoral investments to take advantage of additional opportunities for prevention of HIV.
- Joining with governments in dialogue on human trafficking. This problem is expanding, with significant connections to poverty reduction efforts and increased vulnerability among trafficked women and children.
- Economic analysis of the potential future costs of the epidemic to countries and the Region.
- Acting as a co-convener for other donors and interested parties in addressing the potential for the growth of the HIV epidemic directly, and in building a coordinated response among partners such as bilateral donors, multinational organizations, and nongovernmental donors.
OVERVIEW

This review is particularly timely given that all three countries have signed the UN General Assembly Special Session (UNGASS) statement of commitment in June 2001, and given the establishment of the Southeastern European (SEE) AIDS Initiative and the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM). The Initiative aims to support and coordinate national efforts and to develop regional expertise in response to HIV/AIDS. It involves Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Serbia, The UN Administered Province of Kosovo, Former Yugoslav Republics of Macedonia and Montenegro, Moldova, Romania, and Slovenia. UN agencies, national governments, and other entities have already demonstrated significant coordination by lobbying for greater political commitment and supporting national responses. Several countries have already had successful applications to the GFATM. Various NGO networks provide expanded activities in areas where government support is lacking. National and regional strategies are under development, and rapid assessments of the epidemic have been or will soon be completed in each nation. At the completion of the June 6–8, 2002, Bucharest Conference, an additional statement of commitment was signed by participating countries (Appendix A). Three UN task forces relevant to HIV now are operative in the sub-region: Intravenous Drug Use, Young People’s Health Development and Protection, and Sexually Transmitted Infections.

The key challenge is that the three subject countries all have very low prevalence of HIV infection in the general population (UNICEF 2001), and thus it is difficult to achieve political recognition of the potential for rapid progression to higher prevalence levels. This may reflect partly the long AIDS incubation period, but also under-diagnosis and under-reporting in some cases (EuroHIV 2002). There are similar high risk groups in all three countries, including intravenous drug users (IDU); marginalized populations such as ethnic minority groups, men who have sex with men (MSM), and Commercial Sex Workers (CSW); mobile populations such as truckers and sailors; and youth, with a special problem of nosocomial infection among young people in Romania. Thus, the opportunity to prevent an anticipated epidemic explosion should be explored through improved collaboration and coordination of efforts among the various donors,
NGOs, and governments. The World Bank will have a comparative advantage in some areas, and it is timely to describe how this contribution may work within the context of existing or planned national strategies. It is also important to understand how the Bank’s comparative advantage might partner or leverage with other donor interests.

The three countries covered by this report share with others in the ECA Region several social conditions that have led to an alarming increase in HIV infection. These include increasing unemployment and poverty, rapid social changes, a decrease in the accessibility and quality of services and educational opportunities, psychological stress from post-conflict situations, increased substance abuse and sex work, and increased trafficking in women for sexual exploitation. Human trafficking has become the third largest criminal business worldwide, after illegal drugs and weapons (Limanowska 2002), and at least 175,000 women and girls were subject to this crime from CEE/CIS in 1997 alone. A particular gap is the lack of data on trafficked children (Stulhofer et al. 2002).

In fact, there has been an increase in in-country and cross-border mobility in general, and some groups are also more vulnerable due to lack of access to services as well as disruption of traditional cultural safeguards against high-risk behavior. It has also been concluded that the overall level of social disruption caused by the process of economic re-structuring in most of the countries of this region will increase the level of vulnerability to HIV/AIDS (UNAIDS/WHO 2000).

Conclusions regarding the future course of the HIV/AIDS epidemic have been provided by a recent UN Consultative Meeting (UN 2002) and by the proceedings of the June 2002, Bucharest Conference (UNAIDS 2002). Overall, the risk analysis shows that the countries in this region have high levels of risk for an expanded HIV/AIDS epidemic. The epidemic, driven initially by a nosocomial tragedy in Romania and also by the large numbers of youth who inject drugs throughout the Region, now risks spreading more widely as high levels of sexually transmitted infections (STIs) (at least in Romania), increases in sexual risk behavior, and low levels of knowledge about HIV/AIDS set the stage for crossover to those who do not inject drugs.

Two epidemics are therefore intertwined in these countries: a well-established IDU epidemic since 1995, and an incipient HIV epidemic. Young people are at the center of both, and UNICEF has now considered expanding its role in prevention among young people in the sub-Region (Burrows and Alexander 2001). In Russia, the IDU-driven epidemic is characterized by more rapid spread through this mode than others (an infected IDU who shares needles infects approximately two other individuals per year) (Ruhl et al. 2002) and in limited research studies (UNDCP 1998, UNAIDS 2002), lifetime sharing of needles and equipment is reported as 40–70 percent. This appears to vary among cities, depending on availability of Harm Reduction (HR) services; fewer IDUs surveyed report sharing when participating in HR (Methadone or needle exchange) programs. A particular concern is the increase in IDU among Roma populations (Grund 2000); marginalized populations such as these are at high risk, both for HIV/AIDS and IDU. It is clear that drug use in Eastern Europe and the former Soviet Union has grown rapidly (tenfold) in the past decade (Soros 2002), and thus the potential for this risk behavior to fuel the HIV epidemic is enormous.

Although data on mixing patterns among different vulnerable groups are scarce, the available data do suggest that there is sufficient overlap among groups that the spread from the core group of injecting drug users and their sexual partners to the wider population is possible, if not probable. The extent of this spread in the non-drug injecting population is unclear due to lack of sentinel and systematic surveillance systems in the sub-region, but the vast majority of cases in Eastern Europe and Central Asia (ECA) continue to be diagnosed among IDU (89 percent in 2001) (EuroHIV 2002). Although some countries established large scale screening programs for the general population during the pre-1990 era (Ministry of Health of the Republic of Bulgaria 2000), little data from particularly vulnerable groups are available through which accurate current assessments of the epidemic are possible. In fact, the actual numbers of reported cases of both HIV/AIDS and other STIs are likely underestimated (UNAIDS 2002).
Registration of HIV/AIDS cases in these countries involves recording of all test results at various testing centers using ELISA, the referral of positive results to an AIDS center for confirmation using the Western Blot technique, history taking, official registration, and treatment if indicated. Classification according to risk is based on a clinical interview, but many people are unwilling to report for testing (especially MSM) or to disclose a true history of risk behavior due to stigmatization (Grund 2000).

As described in the proceedings of the June, 2002, Bucharest Conference, three priorities emerging from a 1999 UNAIDS situation review were:

- The need to expand HIV prevention among IDUs.
- The need to address the epidemics of STIs.
- The need to develop comprehensive programs for young peoples’ health, development, and protection.

In addition, a subsequent strategic review (2000) included:

- The need to counteract stigmatization of PWAs through care and support for IDUs and PWA and to increase services for prevention of mother-to-child transmission (MTCT).
- The need to address IDU among CSWs.
- The need to address sexual transmission from IDUs.
- The need to direct attention to prisoners, armed forces, and ethnic minorities as loci of infection.
- The need to address mobile populations in general and trafficking of women for sexual exploitation in particular.

Common to all countries in the Region are rather high levels of stigmatization, discrimination, and marginalization of people with AIDS and for most of the vulnerable groups. This may in part be traced to the historical large scale screening programs in some countries (for example, Bulgaria), where new cases of HIV positive status were associated with socially unacceptable behavior, even though some cases were due to blood transfusion and heterosexual spread. IDUs have not been targeted for prevention programs but rather for arrest and repression. In addition, it appears as though the sensitivity and skills of the general health provider community are lacking in terms of identification, counseling, social support, and understanding of current risks of transmission. Health systems are complex and hierarchical, and thus lack flexibility in addressing socially complex problems such as HIV/AIDS. There is considerable gender inequality and power imbalance in SEE that may increase vulnerability of women to HIV infection. The sexual mode of transmission is now the most common path for HIV, regardless of IDU status, but the behavior and serological status of IDUs is not well understood. Of major concern is the overlap between IDU populations and CSW which could become the main link in the epidemiologic spread of HIV infection to the general population in SEE (Dehne et al 1999).

Also common to all the countries are health systems that through law or policy guarantee access to medical treatment of HIV infection and opportunistic infections. However, this guarantee is operative in a rather low level epidemic. With an explosive epidemic possibility, the under-funded health systems in all three countries may not be able to cope with the future demands on treatment or social services (Ruhl et al. 2002), and the economies will suffer from reduced human capital and investment. For the most part, blood supplies are safe, and policies are in place to assure that this mode of transmission of HIV is no longer a major threat. A clear deficiency in most of the health systems is the lack of response to the need for more extensive drug abuse treatment facilities. In Croatia, GPs and specialists may prescribe Methadone, but in Bulgaria, Methadone treatment is limited to the Narcology Center, and even there with limited numbers of authorized patients.

NGOs have dozens of project-oriented activities in the three countries that serve high-risk and marginalized populations. In several cases, these are funded by the Open Society Institute (OSI).
(Soros 2002), which has a limited time commitment policy that encourages assimilation by national or local institutions. Thus, there is considerable need to institutionalize the activities of NGOs as part of larger national strategies and funding mechanisms that may rely on decentralized sources. It is clear that HR programs are a key element in addressing marginalized and stigmatized activities such as IDU and CSWs (Des Jarlais 1995; Hurley 1997; TAMPEP 2001). HR is a response that recognizes that drug treatment programs rarely attain conditions of total abstinence and that CSW will expand in the face of economic deprivation in SEE (Drucker 1995; OSI 2001). It is likely that HR programs for IDU are cost effective; in Belarus, the cost of an infection averted was estimated at $240–442 (UNAIDS 2002).

OSI established the International Harm Reduction Development Network (IHRD) in 2000 to fund NGOs in 12 countries in ECA. This effort reaches CSWs with information, education, counseling, referrals, and follow-up services. Other groups also support various HR in the region, including the Red Cross (needle exchange), TAMPEP (CSW outreach and networks), International Organization on Migration (IOM) (CSWs and IDUs), Médicins Sans Frontières (clinical and HR services), among others.

The strategic directions provided by the countries attending the June 2002 conference in Bucharest included the following:

- Development and implementation of sentinel and STI surveillance that can support strategic plans;
- Support for expansion of HIV prevention programs targeted to IDUs;
- Support for drug treatment, harm reduction, and demand reduction for IDUs;
- Support for centralized procurement of needles, syringes, substitution drugs, and condoms for the entire sub-region;
- Scaling up responses to STIs that address both the health problem itself as well as the increased risk for HIV spread (focus on CSWs);
- Strengthening services for prevention and care of STIs focusing on highly vulnerable groups;
- Addressing directly the needs and risks of mobile populations to help prevent spread of HIV/AIDS;
- Reducing stigmatization and marginalization for infected and vulnerable populations;
- Improving skill-based and peer education programs for young people;
- Focusing on trafficking as a separate risk-related social problem.
CHAPTER 2

ROMANIA

Current State of the Epidemic

Of the three subject countries, Romania has the largest number of cumulative reported HIV infections (including AIDS cases alive and dead, 12,559 in mid-2002 [Table 1]). Of these, 2699 are deceased, and 110 are unknown. Of adult HIV/AIDS cases with reported risks, most (48-57 percent) were transmitted through heterosexual contact, but most (n = 9936) of the national total HIV/AIDS cases are found among children. The vast majority of these (greater than 70 percent) acquired HIV through blood transfusions or nosocomial infection (Hersh et al. 1991). However, there is no official estimate of the true number of HIV-infected persons in Romania; the actual number may be 5 to 10 times that of the registered cases (UNAIDS 1999).

It seems clear from the number of new adult cases reported per year over the last few years (average 113) and the sex ratio (1:1) that heterosexually transmitted AIDS now dominates the epidemiology of the epidemic, unlike most of Western Europe. Both prostitution and IDU are expanding in Romania, and several tens of thousands of Romanian women (primarily) work abroad as CSW. Mobility among these populations as well as Roma communities and other persons who work abroad and return to Romania periodically might permit increased transmission of HIV into Romania. Subtype F is the dominant strain of HIV, fairly unique to Romania.

Although still experiencing slow growth, there appears to be two arms for the epidemic: 1) the nosocomially infected children from 1988–1991 (who will soon become sexually active), and 2) adult risk groups including IDUs, CSW, mobile populations, and marginalized groups. Nosocomial infection has likely been nearly eliminated as a major source of infection, and thus the epidemic will be concentrated in group 2, some of which may be fed by group 1 cases over the short term. Vertical transmission is very low (less than 5 percent of cases) in contrast to other European countries, but testing is offered to all pregnant women in Romania. A significant concern is the large number of cases among orphans (n=600) in institutions, who will be released from the institutions at age 18. In addition, syphilis incidence has increased from 7.1 per 100,000 population in 1986 to 55 per 100,000 population in 2001, indicating significant increase in risky
T able 1: HIV and AIDS in Romania, including deaths and living cases, 2002

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</tbody>
</table>


A significant percentage of reported cases (38 percent) is recorded as unknown as to the method of transmission, indicating weaknesses in the surveillance system and public health outreach work in Romania. In addition, 74 percent of deaths are recorded within 5 months after diagnosis, suggesting inefficient surveillance and detection, lack of clinical skills among providers for diagnosis, and lack of access among infected persons to medical services. In terms of trends, the number of adult cases is increasing geometrically, and especially among IDUs, where prevalence is still low and where harm reduction strategies might be effective.

Testing rates among high risk groups are low (Table 2), and thus sentinel surveillance is probably insufficient to fully assess the spread of HIV or current status of the epidemic. In addition to HIV testing among IDUs, 40 percent of 152 were positive for Hepatitis C, and 20 percent for Hepatitis B, suggesting a high rate of needle sharing and high infection potential (Ministry of Health and Family 2002).

Special Populations

A dramatic example of the impact of poverty and missing protective bonds between children and significant adults can be seen among Roma children in Romania. There are at least 400,000 Roma (registered) and perhaps as many as 1.5 million more unregistered Roma in the country. Socio-economic and cultural traditions that guide life decisions have made many Roma children highly vulnerable to HIV infection, no matter where they live. Most of the 2000-5000 children working or living on the street, where they are exposed to sexual abuse, exploitative work and violence, are Roma children. For them, key relationships tend to be with other children who use drugs and engage in commercial sex, both of which increase their risk for HIV infection. There is a high rate of information asymmetry among the Roma due to poor socio-economic status and a distinct cultural background. Low levels of access to education and information are noted, and increased risky sexual behavior may be common due to misconceptions about STIs and risks of oral and anal sex (Luca and Buhuceanu 1999).

In another example, the mobile CSW population appears to be expanding. Though theoretically illegal in Romania, increased child prostitution, brothels, and prostitution along border crossings has been noted (Bocai 1999). Several tens of

Table 2: Testing for HIV according to risk group, number tested and positive, Romania, 2002

<table>
<thead>
<tr>
<th>Sub-population Groups</th>
<th>Number of Tested</th>
<th>Number of HIV+</th>
<th>Rate (per 1000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>IDUs</td>
<td>152</td>
<td>4</td>
<td>26.3</td>
</tr>
<tr>
<td>CSW</td>
<td>28</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>STI patients</td>
<td>8216</td>
<td>46</td>
<td>55.9</td>
</tr>
<tr>
<td>Pregnant women</td>
<td>26064</td>
<td>15</td>
<td>5.75</td>
</tr>
<tr>
<td>Blood donors</td>
<td>369076</td>
<td>32</td>
<td>0.86</td>
</tr>
<tr>
<td>Prisoners</td>
<td>916</td>
<td>12</td>
<td>13.1</td>
</tr>
<tr>
<td>Voluntary tested</td>
<td>71579</td>
<td>1113</td>
<td>155.5</td>
</tr>
<tr>
<td>Others TB</td>
<td>10578</td>
<td>37</td>
<td>34.9</td>
</tr>
</tbody>
</table>

thousands of Romanian sex workers are abroad in countries including Turkey, Greece, Cyprus, former Yugoslavia, and Western Europe. Romania is a chief source country for these (primarily) women, and also a chief transit country from Moldova, Ukraine, and other former soviet republics (Liemanowska 2002). As shown in Table 2 above, there are no good estimates about seropositivity among trafficked persons or about their risk reduction behavior.

Little is known about the prevalence of IDUs in Romania, but it has been estimated that from 800 registered IDUs in 1998, there may be as many as 10,000 now using injectable drugs. Romania has moved from being a transit country to a destination for 10–20 percent of the drugs entering from abroad.

Homosexuals were regarded as criminals until 1996. Owing to a high degree of discrimination against MSM, the approximate 5 percent of HIV infections sourced to them is likely an underestimate (note high rate of seropositivity among VCT group in Table 2 above). Thus, little behavioral or sentinel surveillance data are available for this vulnerable group.

There are several critical points to make regarding the Romanian epidemic:

- Not enough is known about the behavior and seroprevalence of high risk groups, especially IDU, CSWs, and Roma populations. There is no clear testing policy to assure adequate surveillance.
- The IDU population is in critical need of expanded harm reduction activities, including additional treatment programs and expanded needle exchange. In fact, many current NGO programs will need to be incorporated at a local or regional level with oversight from the central Government if they are to survive.
- There is a critical need for operational research on the efficacy and cost-effectiveness of such programs in order to direct evidence-based policy decisions.
- Outreach for STI treatment, VCT, and reproductive health education is needed for CSWs, mobile groups, and sexual contacts of HIV-infected persons.
- Stigma reduction is needed to assure openness, participation, accountability, effectiveness, and coherence of any health system based activities. Policy dialogue with government agencies, the media, donors, and other possible partners is needed to resolve this issue.
- A clear and specifically organized program to address the children infected through nosocomial transmission of HIV in the late 80s and early 90s is probably indicated. This could have an adverse effect of public identification of these unfortunate people as infected, but nevertheless, they are now reaching sexual maturity and they and their partners must at least be educated as to the risk of transmission inherent in unprotected intercourse. Ultimately, those additionally infected will depend on the State for care and treatment, and thus organized and targeted, but rights-sensitive, interventions seem to be needed.

**Strategies and Interventions in Place**

- The Government recently codified the Multisectoral AIDS committee, which had its first meeting on April 12, 2002. Various ministries, NGOs, and others comprise this commission, which will revise the existing AIDS strategy for the government for 2003–2005. John Snow International will apparently provide some support (USAID funds) to the committee secretariat. A recent EC grant ($1 million) will also assist in building infrastructure and capacity.
- Extensive USAID project activities involve reproductive health services and education, caring for children with AIDS, peer education for safer sex and healthcare seeking behavior, family planning training, and condom social marketing.
- The UN Thematic Group supports the Multisectoral AIDS committee and will try to expand membership to ILO and UNESCO to cover worker issues and educational approaches within schools.
AIDS treatment is one of four programs specifically covered in the Public Health Law, and 4410 of current cases are under treatment at this time. However, due to procurement irregularities, there have been significant interruptions in drug treatment, and pricing policies related to taxation and negotiations with pharmaceuticals are yet to be worked out. It appears as if all those who seek treatment will be covered for now, but 95 percent of program funds ($21 million) now go for treatment, with subsequent lack of prevention and education resources. This is a significant barrier in the prevention of further cases. In addition, at least 1000 more cases should probably be under ARV treatment. The government has succeeded in negotiating reduced prices for ARV directly with drug companies.

The linkage to governmental social service assistance for cases is irregular at best. NGOs assist patients with social services, but these have to be negotiated within existing systems. Because of stigma, illiteracy, and other disadvantages, such support appears to be quite tenuous. Only one hospice unit serves HIV infected persons. UNOPA is an association composed primarily of parents of infected children and AIDS victims; it advocates for social inclusion and community development for PWAs. ARAS is an NGO with a broad mandate in harm reduction, education, health promotion, and policy development through leadership on the Multisectoral AIDS committee. It also supports several harm reduction activities.

Nine Regional Centers test for HIV infection. Public Health departments, however, are understaffed and cannot thoroughly investigate new cases. There is a database of cases for reporting purposes (anonymous), but insufficient voluntary contact tracing for counseling and testing. Testing is offered to all pregnant women, with 5,000 (20 percent) tested so far (12 found positive for HIV). Drug treatment center clients are offered testing (with only three cases so far identified in this population). Sentinel surveillance among high risk groups is lacking, however, and thus the true progress of the epidemic is difficult to trace. In addition, there is scant information on the behavioral surveillance necessary to track risk behavior in target populations.

NGOs have been active in eight harm reduction and preventive interventions in limited risk group populations. Reports on pilot interventions for CSWs, MSM, Roma, and IDUs show success in improvement of knowledge, attitudes, and behavior to reduce risk. Additional work among TB hospitals, prisons, truckers, sailors, and others working abroad is targeted. The Government has a strategy for Roma populations although the absorptive capacity through community nurses is limited. OSI, TAMPEP, and UNDP have all been involved as source agencies for harm reduction (HR) activities. OSI will not be funding new proposals for harm reduction, but will continue to fund ARAS up to the four-year grant limit for these activities. The programs focus on CSWs, Roma, IDUs, and include health education, referrals, condoms, needle exchange, outside of the register-based health care system. A need was expressed to improve and scale up such activities using mobile services as opposed to stationary services (where waiting lists, payment problems, pimp discouragement, and lack of registration are barriers). A network has been established for such clients (n = 250), but the need is greater than current resources support. There has been no real outcome research as to the effectiveness and cost-effectiveness of such programs. These programs are not linked to sentinel surveillance, and there is an expressed need to institutionalize funding support and local level support for such programs. Respondents felt that small grants, in fact, would be more effective than larger administrative programs. After OSI reduces support, CIDA, DFID, and the GFATM are targeted. Additional operational research may be necessary, and eight regional programs are needed to scale up from the small HR activities now supported.

The Health Promotion Center is supported in part by a World Bank loan project to develop media campaigns on high burden diseases, including HIV/AIDS. There are 42 local public health agencies that are poorly linked to both health promotion activities and to the surveillance and disease control network. Public information is not a national program. It is unclear as to how the Ministry of Education can expand life-skills training and sex educa-
tion within the school system. This appears to be an area where expanded efforts among children could be engaged.

- The Ministry of Interior deals with drug abuse issues, but to date, no information campaign for IDUs has been mounted. NGOs have active needle exchange and education programs, especially involving CSW populations who also use drugs. However, these are limited in scope and there is no national HR program. Legislation initially interfered with such programs, but through training, study tours, and informal relationships, these problems with Ministry of Interior officials have been reduced. Treatment for IDU is through the Narcology Institute, but limited Methadone treatment is available. Trainings have been implemented for prison officials, but there is no formal program on HR in prisons.

**Current World Bank Activities and Possible HIV/AIDS Interventions**

HIV/STD control is currently supported by an Adjustable Program Lending instrument (APL) within a broader reproductive health program of the MOH. This project aims to develop political support, raise awareness, integrate best practices within government programs, and improve health service models of prevention and treatment. Education of health professionals, community leaders, teachers, and others as to prevention is one focus. Other aims include public information over five years in conjunction with the reproductive health program, improvement of behavioral surveillance through surveys, and improvement of laboratory diagnostic facilities and service delivery for STDs. Ten million (US$) was programmed to tobacco control, mental health, tuberculosis, and STI/HIV, as well as strategy development and capacity building in public health.

Given the current state of the epidemic, intervention strategies, and existing donor activities, the World Bank might consider the following elements for support as lending activities:

**Epidemiology and Operational Research**

- Improve STI surveillance systems. These overlap with HIV/AIDS risk groups and are a source of referral for VCT.
- Develop a sustainable behavioral surveillance system to monitor public attitudes (especially those associated with stigma), behaviors among vulnerable and high risk populations (especially Roma and IDUS), and knowledge among school children.
- Develop further the local public health department capacities to conduct sentinel surveillance for HIV infection among targeted high risk groups, as well as sentinel surveillance among mobile populations who travel outside Romania. Included in this would be a rights-sensitive voluntary contact tracing, testing, and counseling program using peers and/or community outreach workers through existing NGO networks.
- Support operational research on cost effectiveness of various targeted interventions, including testing of pregnant women, needle exchange, condom social marketing campaigns, and other harm reduction activities.

**Health Care and Social Support Systems**

- Support a more extensive HIV drug treatment procurement system through policy change, legislative change, or other avenues to assure unbroken supply of medications and effective tendering for efficient pricing.
- Expand drug abuse treatment (detoxification) programs and Methadone maintenance systems. Expand testing facilities where IDUs may be identified, including through Ministry of Interior and in prison system. Expand needle exchange programs through existing NGO networks.
- Expand social service integration with the medical system, including hospice care for AIDS victims and linkage for newly diagnosed cases with housing, food, and other support services. Specifically address infected orphan populations.
• Institutionalize CSW harm reduction interventions at a national level; fund and support mobile clinics to facilitate appropriate utilization, screening, health education, counseling and testing.
• Conduct specific de-stigmatization training for health providers who may work with HIV/AIDS patients and high risk groups.

Health Communications and Promotion

• Develop targeted public information and prevention campaigns on a national level that reach and measurably impact high-risk groups, using models already proved by pilot activities in Romania. Improve infrastructure for health promotion to expand VCT, condom social marketing, STI screening and treatment, with regional capabilities included in these efforts. Key to this is sufficient funding for specific evaluations of behavior and knowledge improvement among the high risk groups.

Civil Society and Advocacy

• Develop a destigmatization campaign emphasizing social inclusion of PWAs.
• Expand voluntary testing and counseling directed to mobile and street populations through mobile outreach facilities administered through NGOs.
CHAPTER 3

CROATIA

Current State of the Epidemic
Croatia has 341 reported cases of HIV and AIDS as of end 2001, up from 315 in the previous year. Approximately 25–35 new cases are reported each year. The sex ratio is 3.3:1 in favor of males, with 39.2 percent heterosexual transmission and 33.7 percent homosexual transmission, and with the rate of growth favoring heterosexual transmission. The proportion of IDU in the infected population is low (13.1 percent), and only 2.3 percent were due to vertical transmission. Only about 7 percent are unknown as to mode of transmission, indicating fairly good surveillance and investigation of positive cases. There have been 106 deaths registered due to AIDS since the beginning of the epidemic. Currently, approximately 145 patients are under treatment at the only treatment facility, the Fran Mihalovic University Hospital for Infectious Diseases in Zagreb (Begovac 2002).

Testing is performed at drug treatment centers (including needle exchange programs), hospitals, HIV testing centers (usually institutes of public health laboratories), and transfusion centers (Table 3). The total number of HIV tests performed, excluding testing of blood donations, is approximately 5 per 1000 inhabitants in 2001. Testing is available free as part of health benefits through GP referral to testing centers, but it may also be accomplished for a fee (about $10) without referral or identity disclosure, either at blood banks or at testing centers. GP referral is not needed for testing at the Fran Mihalovic Infectious Disease Hospital and at the Institute of Public Health in Rijeka free of charge with proof of insurance. This is a passive testing program; there is no national testing or sentinel surveillance policy per se.

Therefore, little is known about the prevalence of HIV among IDUs, homosexuals and mobile populations such as migrants, sailors, guest workers, Roma, and prostitutes. Very little is known about the health risk behavior among these groups. The Rapid Assessment (Kuzman et al 2002) indicated a constant increase of IDU among young people but a leveling of sharing behavior possibly related to HR programs. Perception of risk for HIV among young people is lacking, with condom use mainly associated with birth control. A significant percentage of new heterosexual cases (37 percent) was found among merchant marines in 2001. Approximately one-third of all new
cases are among MSM, but none of these were thought to be imported. Thus, indigenous spread in this risk group has been established. Only a small proportion of known IDUs have been tested for HIV, and thus, as elsewhere, sentinel surveillance of high risk populations is sketchy at best.

Several background risk conditions are worthy of note:

- Croatia has observed decreases in the absolute numbers of cases of gonorrhea and syphilis over the last 10 years, indicating relatively good access to services and public information about STIs. However, increases in Chlamydia and Human Papilloma Virus infections have been noted.
- Drug and alcohol use have increased, especially among vulnerable young people, over the last ten years. Indicative data from treatment centers for IDUs show increased demand for treatment services, greater than 70 percent positive history of sharing paraphernalia, and relatively low knowledge among IDUs regarding risks of HIV from unsafe sexual behavior. There are an estimated 10-20,000 IDUs in Croatia.
- Tourist destinations, prostitution associated with tourism, and the large number of merchant mariners traveling back and forth to Croatian coastal areas permit the spread of sexually transmitted diseases, including HIV.
- Condoms are available but relatively expensive; they are sub-optimally used by at-risk young persons. Lack of sufficient condom machines has been noted as a possible barrier to access.
- Sex education in the school system appears inadequate, but alternative lifestyles are highly stigmatized.

### Strategies and Interventions in Place

- Treatment has basically been covered for HIV infected persons since 1998, with all cases referred to the Fran Mihalavic Infectious Disease Hospital in Zagreb. Some outpatient treatment for opportunistic infections is conducted in a few other cities. Testing is available in Zagreb, Rijeka, and Split, as well as (for a fee) at transfusion centers. Thus, the medical aspects of the AIDS epidemic are so far fairly well covered.
- Reporting of HIV and AIDS cases is mandatory under the Public Health Law. Blood products have been screened since 1987. However, HIV testing remains rather sporadic outside large population centers; contact tracing with voluntary testing and counseling is not done. A lack of field epidemiology follow up as well as unreliable identification of possible cases by GPs is noted.
- Social services for PWAs is disjointed and not sufficiently linked to the treatment facilities. Patients are referred to existing social services, but in part because of stigma, these are relatively inadequate. In addition, stigma has negatively impacted the few pediatric cases in Croatia: HIV-positive children have been refused admittance to day care centers, and there appears to be persistent misinformation about risks of transmission in day-to-day settings.
- NGOs are very active, not only in Zagreb, but in coastal areas such as Split and Rijeka, and in the border area of Osijek. For example, HUHIV supports PWAs through social service referrals. However, space is needed, preferably in proximity to the infectious disease center, to consolidate and increase access to social service support and ancillary health services (such as dentistry). There is an Organization of Youth Against AIDS, mostly concentrating on reproductive health services, with donor funding.
- Methadone maintenance treatment is delivered through GP prescriptions after referral to the Drug Treatment Centers. The HIV testing Centers and not the drug treatment centers,

### Table 3: HIV Testing in Croatia

<table>
<thead>
<tr>
<th>Category Tested</th>
<th>No. Tested</th>
<th>Positives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Donors</td>
<td>156513</td>
<td>2 (0.001%)</td>
</tr>
<tr>
<td>IDU</td>
<td>724</td>
<td>5 (0.7%)</td>
</tr>
<tr>
<td>Other settings</td>
<td>23767</td>
<td>49 (0.2%)</td>
</tr>
</tbody>
</table>

Note: Duplicate tests from the same individual are not excluded.

Source: Begovac 2002.
however, provide most screening for HIV among IDUs. IDUs are served by several local facilities, funded through a combination of OSI to local NGOs and through local municipalities. For example, in Rijeka, Terra (an NGO) cares for 400 IDU with needle exchange, 200 additional with counseling, and 168 receiving Methadone maintenance. The municipality provides a facility, and the NGO pays rent. Uniquely among the three countries studied, Croatia also has an office of support for NGOs, and this particular NGO received a small amount of funding assistance. Testing on the individuals served in Rijeka is performed through the regional public health institute, and only Hepatitis C and B have been discovered thus far. In Split, Soros initially funded HELP, an NGO, to conduct similar larger scale harm reduction activities, particularly among cross-over IDU/prostitute populations, but now funding for this activity has been assumed entirely by the local municipality. Split has the most registered drug users, but Rijeka may, according to local staff, have the steepest rate of increase. Both Split and Rijeka are port towns where previously there were facilities for STI treatment of CSWs and clients. Outreach activities are needed for such individuals, but resources are at present insufficient. Limited drug abuse treatment centers affiliated with local hospitals are available, but overdoses are managed as emergencies, with mandatory reporting to police. Health Insurance Fund payments are not now available to the NGO facilities, and few of the clients have a legal right to health care. The government does not financially support HR per se, but Methadone and the medical costs for treatment at Drug Treatment Centers and GP offices are fully covered for all insured individuals. There is also a prevention program through school doctors with no real evaluation performed on this program as yet.

- HR programs are functional in several other arenas. The Red Cross supports needle exchange in Zagreb and other sites. The IOM works with sailors, prostitutes, and drug users to encourage safe sex and reduce harm through needle exchange. It assists with rapid assessments and national action plans on HIV/AIDS. Trafficking (research and advocacy) is a major concern, and IOM works with the police and Ministry of Interior on policy and shelters for trafficked women. Funds from USAID support this organization. A USAID contractor (Population Service International) works to improve STI services, reduce drug use, and prevent trafficking; they have recently conducted a social market assessment. However, OSI funding for HR through Novi Sad (NGO in Split) and Terra may cease in two years. Trafficking in women and children for sexual exploitation may be more serious than is evident at present. Data are quite scarce, but illegal immigration has been increasing over the last five years, and there appears to be a need for a change in government policy approaches to this vulnerable population (Stulhofer et al. 2002).

- Health promotion on HIV/AIDS has been very minimal. Previously, modest public information on HIV risk has been provided, but little of this is targeted to the highest risk groups. According to the Rapid Assessment, there is fair knowledge about high risk behavior, but earlier sexual initiation and multiple partners without regular condom use seem to be prevalent behaviors among young people (RAR 2002). Human sexuality education in the school system is lacking. It appears as though the political commitment in general to public information and school health education is modest. Coupled with the lack of behavioral surveillance, not enough is known about the effectiveness of formal information campaigns, particularly among marginalized populations. Again, stigma seems to dominate public opinion.

- Although a lack of field epidemiological resources is noted, additional laboratory diagnostic support was also suggested; sub-typing is not at present possible.

- The Soros Foundation/OSI education project conducted workshops for teachers in health education, covering sexuality, AIDS, drugs, tobacco, nutrition in 1992-95. USAID supports healthy cities projects (including Split NGOs), HUHV, and IOM for women's shelter and trafficking issues. Reproductive health education for CSWs, vulnerable young people, CSW clients, and the general public seems to be needed.
- The AIDS committee includes the prison system, Ministry of Sport, Ministry of Education, NGOs, Red Cross, and children (but not the military), but in the view of some, not enough cross-sectoral support has been established. A committee has been established to develop a GFATM proposal.

- An adolescent medicine department attached to the Children’s Hospital in Zagreb essentially works as an NGO, providing advocacy as well as youth friendly services for STI, peer education, counseling, and HIV prevention. Funds from the private sector, UNICEF, the government, and others support this activity. Training for MDs has been conducted as well as research in adolescent behavior.

- A revised AIDS strategy draft has been developed (Begovac 2001), but it does not as yet include enough focus on prevention through health promotion. It does focus on six essential mission areas: surveillance, program service delivery, evaluation, research, technical assistance, and policy development. It notes the need for capacity building, surveillance, and program evaluation in particular. Additional areas of focus now include reduction of transmission in high risk populations, increasing voluntary testing, counseling and referral, improving care for persons infected with HIV, and implementing standard precautions for the handling of blood, tissues, and organs. Evidence-based interventions are stressed, and thus the need to conduct appropriate operational research and to collect data on behavior, special populations, and outcomes is also cited.

- Expanded voluntary counseling and testing may be needed in areas outside of the main population centers, including rapid testing technologies and outreach activities, especially to high risk groups, TB patients, STI clients, and others. Currently, companies employing sailors pay for screening, but without pre- and post-test counseling. If positive, these are referred to the infectious disease hospital for treatment. There is a lack of public health personnel at the regional level. The Red Cross in Zagreb functions as a testing site, and many may have become blood donors to check their status.

- Treatment is currently covered at the National Infectious Disease Hospital, but it may need to be regionalized for PWAs, and this would include disability and social assistance services. In addition, smoother drug registration processes may be needed to secure drug therapy as new drugs appear.

**Current World Bank Activities and Possible HIV/AIDS Interventions**

- The Government of Republic of Croatia has secured a Loan from the International Bank for Reconstruction and Development (IBRD) to help finance the development of its health sector. The Health System Project (HSP) is the second in a planned series of operations in support of the Government’s health sector reform and development program. Its objective is to support Croatia’s capacity to achieve a more effective, efficient, and financially sustainable health system through: (a) strengthening institutional capacity within the health sector; (b) introducing pilot delivery system improvements and a national heart disease program; (c) strengthening public health activities; (d) developing policy options that will increase the sector’s financial sustainability; (e) improving and expanding the health information system; and, (f) disposing of outdated and unusable pharmaceuticals.

- Development of Health Promotion (HP) capacity in the Government was started in the first Bank-financed Health project, with an HP unit established and partially equipped in the NIPH. Studies conducted as part of the first Health project, as well as other research, represent early pilot efforts to enhance the capacity of NIPH and the Andrija Stampar School of Public Health staff in public health monitoring and health promotion. These have provided some basic information on health status and health related behaviors among the Croatian population. HP materials intended for public media campaigns have been developed and tested, including those for HIV/AIDS, but the main thrust of the current
project supports a national cardiovascular disease reduction program with a pilot for second-
ary prevention and primary care development in Koprivnica.

- A systematic process for periodic collection, analysis, and dissemination of health-related
  behavioral information is lacking. More in-depth information, for example, at regional levels
  and for population subgroups is needed for priority setting, for health care planning and
  resource allocation, and for program evaluation. Dissemination of epidemiological data also
  needs to be improved to be more accessible to stakeholders and to be more “user-friendly”
  for decision-makers.

- Currently, the project supports consultants to develop health risk behavioral surveys, HP
  infrastructure, and health promotion material development. National intersectoral seminars
  on health behavioral data are planned. In addition, it will permit training of GPs in seminars
  on health promotion.

Given the above project activities and the review of the Croatian system, the following activi-
ties might be considered by the World Bank:

**Epidemiology**

- Develop current and new outreach testing and counseling units to not only identify positive
  carriers among high risk groups but to teach prevention techniques and to anonymously
  monitor the status of the epidemic among such groups in Croatia.

**Health Care and Social Support Systems**

- Establish a model social and psychological service support and health promotion unit to be
  affiliated with the Infectious Disease Hospital. This could provide valuable assistance in
  contact tracing and voluntary testing, assuring social support services through NGOs and
  existing MOH facilities, and better monitoring of individual PWAs.

- Institutionalize harm reduction programs (IDU and CSW) through government support for
  expanded NGO clinical and outreach activities.

- Expand teaching program for primary care practitioners so that the recognition of risk be-
  havior, testing opportunities, and symptoms suggestive of HIV/AIDS is more reliable.

- Finance limited laboratory development to identify subtypes and resistance to anti-retriviral
  treatment, and to expand laboratory-related surveillance capabilities (rapid testing).

**Health Communications and Promotion**

- Develop more specific, targeted health promotion activities geared toward high risk groups
  throughout the country, but in particular in the coastal resort and maritime communities in
  partnership with NGOs.

- Develop a national stigma-reducing health promotion campaign, with careful monitoring
  through expanded health behavioral surveillance that includes HIV infection risk information.

- Support expanded sexuality education within the school system, working with Ministry of
  Education.

- Support a condom social marketing program to tourists and other mobile populations as a
  public service activity of MOH.

**Civil Society and Advocacy**

- Expand cross-sectoral support for merchant marine, prisoners, military based HIV/AIDS
  prevention work, through official agencies or NGOs.

- Consider policy work to reduce the price of condoms (through elimination of taxes, sub-
  sidies, etc.)
Current State of the Epidemic

The present incidence of HIV/AIDS is relatively low, with 366 reported HIV positives recorded since 1987. However, the rate of increase accelerated from three new reported cases in 1990 to 30 new reported cases in 2000. STIs are increasing, with syphilis at 2509 new reported cases in 1999 (Varleva 2002). Bulgaria had instituted an inefficient, large scale testing program in the late 1980s, which may have stigmatized vulnerable groups (Ministry of Health 2000). Now, testing is confidential and available in limited facilities. 260,000 tests per year are reported, with 40 positives last year and eight as of June, 2002. Currently half of new HIV positives are below 25 years of age, and 71 percent are below age 40. Ninety-one percent of transmission is sexual, the vast majority of which (88 percent) is heterosexual. One percent of cases results from vertical transmission, and of the 8 percent of blood-borne cases, only one-fifth of these are from IDU. This may suggest inadequacy of sentinel surveillance in this high risk group and perhaps over-testing among non-risk group persons.

Surveys of IDUs are conducted through the National Drug Addictions Centre. CIDA supports needle testing for HIV, but no positives have been found using this technique. Testing is anonymous and unlinked to names in this study, but it is unclear as to the value of such testing (Nikolov et al. 2000). Bulgaria experienced its first real epidemic of heroin use in the early 1990s, but given the high rates of hepatitis C (50 percent) and B (20 percent) antibodies among the IDU population tested, it is clear that a substantial risk for HIV spread through needle sharing exists in Bulgaria. Although there are few reliable data on the number of IDUs in Bulgaria (one estimate is 45–46,000 heroin users, but this is contested by some), there is no question about an IDU epidemic. IDUs can obtain treatment (using Methadone) mainly in psychiatric institutions. However, treatment opportunities are limited, and the current health reform program does not provide for such treatment within the existing health financing system. Ethnographic studies and surveys confirm high rates of paraphernalia sharing and low knowledge about the risks of injecting and prevention.
The Roma population (estimated numbers of this minority group range from 300,000 to 800,000) in Bulgaria presents some special risks for HIV/AIDS, due to lack of access to health care services, cultural barriers, and lower educational attainment due to poverty, migratory patterns, and differing values. Lower educational opportunities and lack of marketable skills make it difficult for Roma youth to later enter and succeed in the job market. Many other Roma children work on the streets. Thus, integrated social services and outreach are insufficient, and the protective patriarchal system may be deteriorating in this community, adding to the future risk for HIV spread.

There is a significant population of guest workers (returnees), merchant marines, and mobile prostitutes that may provide an increased risk for HIV spread within the national population. Ten to twelve percent of this population is of ethnic minority status with subsequent difficult social access issues. Unwanted pregnancies and abortions are more common than in surrounding countries. In addition, Bulgarian peacekeeping troops working under UN operations in high-prevalence countries (Rwanda, etc) may present a risk for the spread of HIV (Cuban troops returning from endemic areas were found to have been a major amplifier of the epidemic in Cuba).

Considerable stigma exists, and in reality, testing of high risk groups is very scarce; counseling is modest at best. Little to no information is collected for behavioral surveillance (knowledge, attitudes, and practices) among risk groups. However, there appears to be genuine political support, and press coverage for concerted efforts to prevent the spread of HIV/AIDS is evident.

Strategies and Interventions in Place

- A well developed, albeit ambitious, national strategy for 2001-2007 is in place, with a substantial cross-sectoral focus (Ministry of Healthcare 2001). Developed with UNAIDS assistance over two years, this insightful plan has been officially accepted as a guiding document by the Government—a significant accomplishment. Ministries allocate implementation funds from within their own budgets under coordination of an inter-ministerial national expert committee. Most high-risk group activities are decentralized and conducted by NGOs, but the government is responsible for providing ARV treatment, investigation, and testing of registered citizens. All care is provided in Sofia to the estimated 350 patients with HIV or AIDS. However, of the $4.1 million budget required for the total national program, government and donor sources now only cover about half. Prevention, surveillance, social care, and treatment all are under-funded. Thus, harm reduction and social service programs need additional resources in particular. Youth-friendly programs are in need of expansion. The plan focuses on behavior change (individual and group), changing community attitudes, changing health care services, creating supporting environments, and building political commitment.

- The AIDS Coalition was established in 2000 with 44 member organizations. Its aim is to support the national policy on AIDS and to implement prevention practices. Main activities include organizing anti-AIDS campaigns, developing information and education activities, and joint projects. The Coalition will participate in the National Committee on AIDS/STIs Prevention.

- The National Confirmatory Laboratory has been the only referral laboratory since 1987. Subtype testing is available, but there is no ability as yet to test for drug resistance. Testing had been compulsory for sailors and other risk groups, but this has been reduced, and additional epidemiological skill development is also needed.

- The UN Thematic Group, with leadership by UNAIDS, channels small grants with funding from CIDA through the regional UNICEF office for Romania, Bulgaria, and Moldova. The grants support several NGOs working with high risk groups. In March 2002, these included: a project dealing with children in orphanages, a counseling facility on HIV/AIDS, a project to educate Bulgarian peacekeeping forces working abroad (and their families), a proposal
addressing young people in Dobrich, a school-based peer educator program, a program to involve parents in HIV/AIDS education, and a project in Sofia addressing young people including Roma. Additional funds were allocated to external project evaluation.

- UNFPA supports a main focus on youth, assisting such organizations as the Bulgarian Family Planning Association. The agency worked to gain approval of the national strategy with the Council of Ministers.
- UNDP focuses on strategic planning and change, especially at the national level (with the RAR). Funds support training civic organizations to develop local plans, conduct rapid assessments, and implement plans of action using national funding as well as municipal budgets and small grants to five municipalities.
- Innovative work with IDUs, prostitutes, and other risk groups is carried out by several local and international NGOs (UNDCP/UNAIDS 2000). Through these, OSI and UNDP/UNAIDS funding has reached more than 4000 IDUs since 1998, with additional work conducted in the CSW community. OSI has addressed the Roma community since 1999. A common barrier is the lack of referral resources (IDU treatment, STI treatment, etc.) for the marginalized populations addressed in these various programs. The only evaluation conducted so far has not reported outcomes but it has reported a substantial positive change in acceptance and functionality of several HR programs (Kojuharova 2002). UNDCP/UNAIDS reports reduced sharing behavior, increased knowledge of risks, and reduced resistance and improved cooperation with local legal authorities.
- OSI in Bulgaria is working to improve capacity in public health surveillance through the establishment of a School of Public Health. This will target managers and policy makers in the 28 regional public health centers, municipalities and health insurance funds to receive training that will improve the public health infrastructure.
- The Bulgarian Family Planning Association has had specific service activities in support of Roma and youth populations, and it has worked to improve sexual health through education, advocacy, and improved services. Joint Roma/non-Roma teams, with careful attention to cultural sensitivity, implemented these programs (Turnev 2002).
- MSF supports one sexual health clinic in Sofia and in another rural area. It acts as a referral and testing center, as well as an educational and clinical center for reproductive health services, using WHO syndromic treatment protocols as well. Other outreach NGOs refer clients to this clinic. The clinic will test but is not authorized to report results to clients; they must obtain their results from the authorized official agencies. The psychosocial needs of the patients are in need of additional attention.
- The Health and Social Development Foundation conducts mobile outreach work with needle exchange, education, referral for drug and medical treatment, and referral for testing and counseling for HIV. A pilot project in six communities (including two Roma) worked with other service providers, Ministries, the Bulgarian police force, and community members using OSI support to reduce sharing of needles, increase knowledge of risk reduction techniques, reduce unsafe sexual practices, and increase use of condoms by IDUs, prostitutes, and Roma. Tens of thousands of needles were exchanged in this project. This NGO is a member of TAMPEP, a European consortium dealing with prostitution and risk behaviors. Regulation of prostitution as an EU ascension issue was cited as a possible expansion of activities.
- The Initiative for Health Foundation conducts extensive needle exchanges and mobile outreach among CSWs, Roma, and IDUs in eight different sites. It facilitates access to IDUs for Caritas, which does field HIV testing and counseling through referral. Research in conjunction with the National Development Research Institute of Beth Israel Hospital in New York on needle exchange, risk behavior, and sero-prevalence is planned for September 2002. This organization has developed exemplary relationships with local police to assure that clients and workers are not obstructed in this activity. Teams sent to field sites are a
combination of professional staff and volunteers, and the existing four teams need about $25-30,000 per year for support. An additional two teams would be ideal.

- The Law on Drugs of 1999 regulates the licensing of needle exchange programs, providing a sound legal basis for their existence. These are currently all conducted by NGOs. In addition, needles were collected to test blood residues for HIV (these have so far all been negative, but this testing mechanism warrants additional evaluation). Re-socialization of IDUs is lacking, and thus a cohesive structure for drug treatment, screening for HIV, and social support is needed. There are 60-70 police contacts with IDUs per month in Sofia alone. Health insurance does not cover Methadone; instead it is specifically provided as part of the narcology center's budget. The government is considering a national drug abuse strategy, which could provide linkage to HIV/AIDS prevention efforts.

- The Gemini organization, with funding from a Dutch foundation, conducts media campaigns to raise awareness, including some electronic media, leaflets, condoms, and educational programs through gay bars, discos, etc. The seven-member board is made of up gay and lesbian persons. Issues noted on condom social marketing include price and access as barriers. Low-cost or free testing, with assured anonymity is lacking (currently, official test sites require personal information, a barrier to VCT). There is no hot line but rather a counseling line staffed by volunteers.

- OSI is conducting several comparative legislative analyses regarding patient's rights, healthcare institutions, and drug use and services for drug users.

- There are four organizations of PWAs (for example, Kaspar Hauser and Plus-Minus Foundation) as well as an organization of mothers of IDUs. OSI has funded coalition development for HIV/AIDS. Legislation is not adequate to protect the rights of PWAs, and although NGOs have good relationships with the government, not enough response in terms of services, destigmatization, and public education is noted. Funds to support human rights activities and reduce discrimination have been sought from the EU. Protection for pensions and disability status is lacking.

- The National Centre for Addictions receives 2000 new referrals per year through GPS and voluntary referral. Only one center is in Sofia, and it provides VCT, with psychological services available after results are known. However, there is a gap between testing and the social support needed for seropositive individuals. The various NGOs refer to and work closely with the Centre. Only 600 addicts can be treated with methadone at present, but this will increase to 1000 shortly. There is a demand for many more treatment resources.

- HIV testing before marriage is being considered. Legalizing prostitution was considered in the past but rejected by lawmakers.

- The National Center of Public Health has the Secretariat for the National Committee on HIV/AIDS. It is supported by the UN and government, and the HIV/AIDS/STI Prevention Program conducts national reproductive health programs, evaluation and monitoring, strategy development for NGOs, and some interviews with focus groups and surveys, especially among gay men and other risk groups. There is no formal program of contact tracing, and NGOs seem to perform this key function.

- The National AIDS Coordinator oversees the MOH program components including prevention among vulnerable populations, epidemiology and testing, social and medical support to PWAs, and treatment. She estimates an approximate 5 million Leu shortfall per year. The National Strategy was implemented in ten pilot sites by the end of 2002. Gaps cited include counseling and testing outreach, dialogue with appropriate subspecialty professionals to understand and treat HIV better, facilities for consultation in Sofia, contact tracing and testing, social support linked to the medical treatment system, school curricula for sex education, and active inter-sectoral collaboration.
Current World Bank Activities and Possible HIV/AIDS Interventions

- Bulgaria has had two health projects, with the first (on health system restructuring) closing in 2001. It included activities on rationalizing blood transfusion facilities (with assurance now that the blood supply is safe), amounting to 32 percent of project costs. Twenty-eight regional processing centers were reduced to five, and there is now little in the way of black market activities involving blood products. Primary health care development amounted to an additional 26 percent of project funding, and policy analysis and management were assigned 6 percent of project funds.
- The second health project is moving slowly with a recent change in government. Health promotion is a part of this project. It also involves extensive financing for health insurance development.
- The Bank participates in the UN Thematic Group on AIDS.

Based on the above assessment of activities and interviews with key individuals, the Bank may consider the following possible interventions:

**Epidemiology and Operational Research**

- Improve behavioral surveillance, especially among vulnerable populations. This would involve consistent, targeted surveys, outreach work and qualitative data collection, including among young people in and out of school.
- Conduct operational research in prisons for high risk individuals and behaviors, assessing the cost benefit and efficacy of such risk group interventions.
- There is need for rigorous evaluation of intervention programs. The network of public health institutions (n = 28) needs to be developed to conduct sentinel surveillance and prevention activities. These institutions lack methodology and organizational structure for modern public health practice. Technical assistance is needed for surveillance system design, with a focus on high risk groups. The global benefit for such development lies in the fact that Bulgaria is a crossroads for trafficking, drug transshipment, mobile populations, and tourism.
- Improve epidemiologic mapping, data reporting, and sentinel surveillance among high risk populations. Improve program evaluation and standard setting capacity for treatment and prevention across risk populations.

**Health Care and Social Support Systems**

- Institutionalize harm reduction programs (with the possible impending reduction in support from OSI), including needle exchange, condom distribution, and drug treatment within government programs or through more extensive government funding of NGOs. Developing a government structure to provide grants to NGOs would be one option.
- Decentralizing the National Drug Treatment Center is another. Clarity is needed in the legislation regarding drug use and possession so that the legal system does not provide a barrier to the health system in dealing with this particular risk group. Clearly, HIV strategies and drug control strategies need to be mutually supportive.
- Develop specific training for GPs, medical students, and dental students to recognize and refer for HIV/AIDS services. Improve training and behavior of specialists to reduce stigma through improving their attitudes and behavior.
- Expand drug treatment facilities to reduce harm and also reduce criminality. In addition, consideration should be given to expanding the range of treatment providers beyond just the psychiatric facilities.
- Invest in specific social service support projects for PWAs and also for those leaving institutions for children, broken homes, Roma, and street children. A system to support
unregistered, mobile, and other marginalized populations would support the Governments larger HIV/AIDS strategy in reducing risk to the general population.
- Modernizing equipment at the referral laboratory.

**Health Communications and Promotion**
- Engage Ministry of Education and Science, Ministry of Interior, and other ministries in dialogue to improve ministerial approaches including the legal framework to deal with risk groups and to focus on primary prevention through media, the schools, and other venues.
- Expand health promotion among young people and other vulnerable groups by implementing reproductive health education in schools.
- Establish improved condom and lubricant distribution and marketing systems.

**Civil Society and Advocacy**
- Support additional mobile outreach screening, harm reduction, and educational teams, especially for CSWs and other marginalized groups. A mobile gynecologic screening and treatment unit is being considered by one NGO.
- Increase funding to national program to support wider application of national strategy at local levels, including services integrated with testing programs.
- Develop training programs for journalists to reduce stigma and improve public information about HIV/AIDS.
Several clear conclusions can be drawn about the future course of the HIV/AIDS epidemic for this sub-region based on this review and analyses.

First, for the ECA region as a whole, the current estimated prevalence in adults (15–49) is 0.7 percent. Even if transmission were to be concentrated among IDU and their sexual partners, the regional adult prevalence rate most likely will exceed 1 percent in a several years' time. It is likely that Croatia, Romania, and Bulgaria will not reach these levels as fast as other countries in the entire region. However, this situation may change given the high risk profile in each of the countries.

Second, over the course of the epidemic, heterosexual spread has become more important, both in terms of a source of spread within injecting drug users, but also to the wider population, particularly as there is interaction due to mobility and trafficking. In addition, minority groups, with their insularity and cultural barriers, may be especially at risk for epidemic spread. Thus, there is a substantial probability of a more generalized epidemic in the sub-region. Lessons from Estonia, Russia, and Ukraine may be appreciated.

Third, there is variation among the three countries in levels of vulnerability. Countries differ in rates of STIs, levels of unsafe sex, and in the number of people who inject. Romania has a specific vulnerable population of infected children who are now reaching the age of sexual maturity.

Fourth, the impact of the epidemic is only now beginning to be felt in the region. Without effective preventive efforts, morbidity and mortality caused by HIV/AIDS may grow significantly in the next 5 to 10 years. This may place large demands on the health care systems of all the countries.

Fifth, much of the specific preventive activities in each of these countries is limited in scope and conducted with international funding support. These need to be institutionalized through government programs and expanded budgetary allocation.

The World Bank has a comparative advantage in providing input through lending and non-lending activities that support government programs. It is also a co-convener within country Thematic Groups, donor groups, and multilateral programs such as the GFATM. There is sub-
substantial interest in HIV/AIDS prevention through HR and reproductive health activities by countries and donors such as IOM and OSI, but many of these are project-oriented, time limited activities, and not focused on institutionalization of the interventions. The World Bank can and should consider scaling up these activities as part of the substantial health reform project activities at national levels, with appropriate attention to decentralization as seen in the Croatian HR projects. Approaches that may be used include reprogramming funds at the request of Governments, planning new loan projects with specific activities as described below, modifying existing Terms of Reference to specifically address HIV/AIDS within the scope of existing subcomponents, and working directly with other donors and multilateral groups to help bridge policy gaps. These approaches all require significant dialogue with country counterpart health professionals and this dialogue should include the relevant public health experts in the country as well as Bank team leaders who can mobilize procedures permitting such actions.

Lending Activities
Although the situation varies among the countries, specific lending activities that should be considered throughout these countries include:

**Epidemiology and Operational Research**
- Adding specific project support for improvements in sentinel surveillance in high-risk, targeted groups, primary antiretroviral resistance surveillance, nosocomial infection surveillance in prisons and other settings, and syndromic surveillance for opportunistic infections.
- Including operational research in loan projects to assess efficacy and cost-effectiveness of HR and other prevention programs. Operational research that partners local experts with international institutions that have had success in destigmatization elsewhere may be supported. Further research into the largely heterosexual nature of the epidemic in these countries is warranted.

**Health Care and Social Support Systems**
- Adding specific training requirements for health providers to improve their sensitivity, recognition of HIV risk, and referral behavior for at-risk populations.
- Consider including advanced training for HIV/AIDS experts to assure that haphazard or harmful therapeutic approaches do not occur. These would contribute to drug resistance and increased costs of care.
- Improving training to reduce risk of transmission through inappropriate parental therapeutics or inappropriate needle usage. Expanding technological investments to increase availability of single-use needles.
- Adding specific project support for drug abuse treatment (detoxification) programs, as well as methadone maintenance programs. These are in short supply throughout the region, and provide a critical access point for addressing an important epidemiological pump for the epidemic. Without specifically increasing treatment for IDUs’ demand for heroin and other injectable drugs, the HIV epidemic will not be effectively controlled.
- Adding specific project support for social support programs for People living with AIDS and for re-socialization of risk groups (IDU, minorities, CSWs).
- Adding specific destigmatization training for health professionals who deal with HIV/AIDS patients or risk groups.

**Health Communications and Promotion**
- Include specific attention to HIV/AIDS public information as part of health promotion unit development and programming. Targeted activities to support VCT, condom social marketing, increased STI screening and treatment to highest risk groups should be focused.
• Expanding Health Promotion programs to specifically address reproductive health education, especially in school populations and other vulnerable populations.
• Adding specific de-stigmatization campaigns to existing HP programs geared both to the general public and to risk groups.

**Civil Society and Advocacy**

• Add outreach screening and mobile reproductive health facility procurements that might address uninsured or hard-to-reach populations such as Roma, CSWs, and IDUs.
• Add specific funding for HR programs overseen by the ministries of health but administered through existing NGOs, scaling up the now threatened individual projects to more national scope.

**Non-Lending Activities**

Non-lending activities that should be considered throughout these countries include:

• Auditing the legislative frameworks in the Region regarding communicable disease control. This would help inform Bank dialogue with countries regarding public health reform. There seems to be several areas where legislation may impede HIV prevention and control. For example, tight regulations on providing Methadone maintenance will reduce the opportunity for HR for IDUs.
• Policy dialogue with the governments to consider optimum methods of institutionally supporting HR activities geared toward IDUs, Roma, and CSWs.
• Engaging specifically with ECA countries applying for GFATM to leverage World Bank projects as part of these collaborations.
• Cost-effectiveness analysis of expanded Methadone maintenance, needle exchange, and other IDU treatment programs geared toward reducing HIV, Hepatitis B, and Hepatitis C transmission.
• Working with other donors trans-nationally on destigmatization and public information about prevention needs in the sub-Region. A unified, vocal, and highly targeted approach would assist NGOs and government agencies in diverting attention from “risk groups” and a culture of blame, to global public responsibility and sensitivity. What has been happening as international dialogue has focused on high-prevalence countries; what is needed is a tailo red approach to the prevention dialectic in low prevalence countries such as those in SEE.
• Engaging with multi-national drug enforcement agencies (UN Drug Control Program, INTERPOL) to approach drug use as an AIDS prevention issue.
• OSI has established an International Harm Reduction Network. The Bank may wish to consider officially joining this activity, mobilizing lending activities to specifically include these actions as part of country assistance strategies.
• Consider integration of key health promotion, information programs, and other activities into educational, labor, and other sectoral investments to take advantage of additional opportunities for prevention of HIV.
• Joining with governments in dialogue on human trafficking. This problem is expanding, with significant connections to poverty reduction efforts and increased vulnerability among trafficked women and children.
• Economic analysis of the potential future costs of the epidemic to countries and the Region.
• Acting as a co-convener for other donors and interested parties in addressing the potential for the growth of the HIV epidemic directly, and in building a coordinated response among partners such as bilateral donors, multinational organizations, and nongovernmental donors.

Clearly, the World Bank has a key role to play in specifically addressing prevention of HIV/AIDS in ECA. It is rare in public health to have such an opportunity. The lessons learned, both
within the ECA region, and from other more extensively infected regions, are that with even limited efforts in prevention, huge disease and economic burdens placed on health systems and governments through high rates of HIV infection can be averted. In Thailand, harm reduction within the CSW community has reduced heterosexual transmission of HIV; in Uganda, government policy has been strengthened to acknowledge risks and to speak openly to the population about reducing risks; in New York, harm reduction has reduced the rate of infection among IDUs.
Preventing the spread of HIV/AIDS in South Eastern Europe

At the end of last year an estimated 40 million people were living with HIV/AIDS worldwide. At a global level, political leadership and commitment to address this challenge has gained momentum. This was demonstrated by the UN General Assembly Special Session on HIV/AIDS, June 25–27, 2001, which produced the Declaration of Commitment on HIV/AIDS, to intensify and coordinate efforts to combat HIV/AIDS in a comprehensive manner.

In 2001, Central and Eastern Europe witnessed the fastest global growth of the HIV epidemic, with some countries in the region reaching a prevalence rate of over 1 percent. This exceptionally rapid increase has been caused by a dramatic rise in risk behavior, predominantly injecting drug use (IDU), which is itself related to the social and economic shifts which many countries in the region are experiencing. While the prevalence of IDU and HIV/AIDS in South Eastern Europe cannot be compared, many of the conditions and rates of prevalence in Southeastern Europe today, mirror the situation in Central and Eastern Europe seven years ago.

Although much more information is needed to understand the dynamics of the spread of HIV and to be able to respond more effectively, young people are often clearly the most at risk, and they should be at the center of our response to HIV. Risky and unsafe sexual behavior and injecting drug use are the often the means by which HIV enters the wider population, therefore strategies, programs and activities should address those factors that make individuals vulnerable. These should address the gender dimension, specify action taken to address vulnerability and set targets for achievement.

At the “South Eastern Europe Conference on HIV/AIDS” held in Bucharest, Romania, from the 6th to 8th of June 2002, representatives of the governments of Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Federal Republic of Yugoslavia (including the UN Administered Province of Kosovo), Former Yugoslav Republic of Macedonia, Moldova, and Romania declared the following commitments: to scale up national responses to HIV/AIDS.
We declare our commitment to scale up national responses to HIV/AIDS to prevent a widespread HIV epidemic in South Eastern Europe. In support of our commitment to the Declaration of Commitment on HIV/AIDS we agree to the following priorities of action:

**Leadership**

Strong leadership at all levels of society is essential for an effective response to the epidemic. Leadership by Governments in combating HIV/AIDS is essential and their efforts should be complemented by the full and active participation of civil society, the business community and the private sector.

We recognize that effective leadership is needed to build a coherent response to the epidemic. We will strive for strong political and social commitment at all levels to address the priorities of action through the implementation of national strategic plans on HIV/AIDS. We will ensure the development and implementation of multi sector national strategies and financing plans for combating HIV/AIDS.

We will take action to increase and prioritize national budgetary allocations for HIV/AIDS, and to ensure that existing resources and structures contribute optimally, and that all ministries and other relevant stakeholders make appropriate allocations. We will take steps to integrate HIV/AIDS prevention, care, treatment, support and impact mitigation priorities into the mainstream of development planning, including poverty eradication strategies, gender equality strategies, national budget allocations, sector development plans and legislative reviews.

We will ensure effective and operational coordination and collaboration mechanisms to enable the involvement of all sectors of society, both public and private. In this regard, we actively encourage and support the participation of non-governmental organizations, young people, Roma and people living with HIV/AIDS.

**Prevention**

Prevention must be the mainstay of our response. By 2003 we will establish national prevention targets as a part of the national planning process. We recognize the urgency to expand HIV prevention among especially vulnerable groups of young people including injecting drug users, sex workers, and men having sex with men and other marginalized groups, in order to prevent the transmission of HIV. Effective prevention programs, which reach a majority of these people, complemented by life skill programs for the wider youth population, will prevent the further spread of HIV. Such programs should include expanded access to information, condoms, life skills education, voluntary counseling and testing, drug treatment, withdrawal programs, access to clean needles, substitution therapy and other youth friendly services. They must also include services for pregnant women to prevent mother to child transmission.

We will actively support the expansion of such programs and, where appropriate, strengthen cross-border collaboration, exchange of best practices and technical capacity in the region.

We recognize the urgent need to respond to the increase of sexually transmitted infections (STIs) both as risk factors in relation to HIV, as well as major public health problems in their own right. Early diagnosis and treatment of STIs is cost effective, and greatly reduces vulnerability to HIV infection. We will take action to strengthen primary prevention and effective case management, with special attention to young people and highly vulnerable groups such as injecting drug users, sex workers, men who have sex with men, and trafficked women.

**Care, Support and Treatment**

Care, support and treatment are fundamental elements of an effective response. We support strategies to strengthen health care systems and address factors affecting the provision of HIV related drugs. We support efforts to provide progressively and in a sustainable manner, the highest attainable standard of treatment for HIV/AIDS.
To further support and develop a comprehensive care strategy to strengthen community and family based care, both by the informal sector and health care systems, to provide and monitor care, support and treatment for people living with HIV/AIDS.

We will ensure the availability and accessibility of medical and preventative services based on the principles of strict confidentiality.

**HIV/AIDS and Human Rights**

Realization of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS. Respect for the rights of people living with HIV/AIDS drives an effective response. All our HIV/AIDS efforts will be based on an approach that promotes and protects the fundamental rights and freedom of all individuals and groups. No individual or group should suffer discrimination or stigmatization in relation to HIV/AIDS. We will take action to enact, strengthen, and enforce legislation and measures to eliminate all forms of discrimination. This includes people living with HIV/AIDS, young people, sex workers, victims of trafficking, Roma, and members of other vulnerable groups. We will address any existing legal barriers to effective HIV/AIDS prevention.

**Reducing Vulnerability**

The vulnerable must be given priority in the response. Empowering women and girls is essential for reducing vulnerability. We will support the development and expansion of health and life skills promotion programs, particularly focusing on the most vulnerable. We will support the inclusion of health and life skills education, including HIV-related issues, in the national curricula for adolescents. We will support the provision of good quality, youth friendly information and sexual education as well as counseling services, based on the principles of strict confidentiality. We further support efforts to expand and strengthen gender appropriate, youth-friendly reproductive and sexual health programs. We support the development and increased access to peer education and outreach programs to promote healthy lifestyles, particularly on sexual health, gender relationships and prevention of drug abuse.

Particular attention will given to the needs of the most vulnerable, including IDUs, sex workers, victims of trafficking, Roma, and mobile populations.

**Research and Development**

With no cure for HIV/AIDS yet found, further research and development is crucial. We support increased research and data collection on epidemiology and behavior, as knowledge and comprehension of the actual HIV related situation are preconditions for the development of effective strategic plans. With gender disaggregation where appropriate, this data will help to shape more effective national and regional responses.

**HIV/AIDS in Conflict and Disaster Affected Areas**

Conflicts and disasters contribute to the spread of HIV/AIDS. We will support the incorporation of HIV/AIDS awareness and prevention, care and treatment elements into programs among conflict affected populations. Also attention will be given to uniformed services.

We call upon UN agencies, regional and international organizations and non-government organizations, to incorporate as a matter of urgency HIV/AIDS awareness, prevention and gender training for their staff.

**Partnerships and Alliances at the National and Sub-Regional Level**

We support collaboration and networking among the South Eastern European Countries, and we recognize that sub regional activities can make a major contribution to halting the spread of HIV and AIDS. We recognize that each country has expertise and technical capacity in specific areas, which can benefit others, through exchange of information, lessons learnt and best practices.
We will therefore encourage collaboration between government and non-governmental partners throughout the sub-region, and support cross-border initiatives on areas, which can best be addressed through joint efforts.

We support placing HIV/AIDS and health related public concerns as appropriate on the agenda of regional meetings at all levels.

We urge international organizations and agencies to play an active role in supporting our efforts through increased international assistance and to participate in the implementation of the national strategic plans on HIV/AIDS.

We again declare our commitment to the Declaration of Commitment on HIV/AIDS of the United Nations General Assembly Special Session on HIV/AIDS, and agree to implement the goals and time bound targets that it expressed.

*Bucharest*
*June 2002*
APPENDIX B.
INSTITUTIONS AND PERSONS VISITED IN EACH COUNTRY

Romania
World Bank Resident Mission
Matei Bals Institute

Ministry of Health and Family
Asociatia Roman Anti-SIDA (ARAS)
UNOPA (People with AIDS)
UN Thematic Group for HIV/AIDS

MSD
Open Society Institute
USAID
UNAIDS-Vienna

Silviu Radulescu, Dominic Haazen
Dr. Adrian Steinu Cercel, President of Anti-AIDS Commission
Dr. Alexandru Rafila, Director General
Maria Georgescu, Executive Director
Cristiana Vlad, Executive Director
Eduard Petrescu, UNAIDS Advisor
Dan Dionisie, UNDP Governance
Karin Hulshof, UNICEF (Chair)
Elin Ranneberg-Nielsen, UNFPA
Victor Olsawachi, WHO
Tania Goldner, UNICEF
Doina Bolga, UNFPA
Gabriel Ghitescu, Business Unit Manager
Adrian Caretu, Country Manager
Cristian Vladescu
Susan Monaghan
Jean-Paul Grund
### Croatia

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<tr>
<th>Organization</th>
<th>Coordinator/Position</th>
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<tbody>
<tr>
<td>Andrija Stampar School of Public Health</td>
<td>Dr. Stipe Oreskovic, Director</td>
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<tr>
<td>Children’s Hospital Zagreb</td>
<td>Dr. Vlasta Hirsl-Hecej</td>
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<tr>
<td>HUHIV (NGO-PWAs)</td>
<td>Iva Jovovic, Social Worker</td>
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<tr>
<td>Institute for Public Health</td>
<td>Tomislav Vurusic, President</td>
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<tr>
<td>Institute of Sociology</td>
<td>Dr. Ira Gjenero Margan</td>
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<td>International Organization for Migration</td>
<td>Aleksandar Stulhofer</td>
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<td>Klinika “Fran Mihaljevic”</td>
<td>Gregoire Goodstein, Chief of Mission</td>
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<tr>
<td>Ministry of Health</td>
<td>Dr. Josip Begovac, National AIDS Coordinator</td>
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<td>Municipality of Rijeka</td>
<td>Dr. Dunja Skoko-Poljak, AIDS Coordinator</td>
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<td>Soros Foundation</td>
<td>Dr. Karla Muskovic</td>
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<td>TERRA Association, Rijeka</td>
<td>Dr. Dulija Malatestinic</td>
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<td>World Bank Resident Mission</td>
<td>Darko Tot, Educational Programs</td>
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<td></td>
<td>Natasha Janev-holcera</td>
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<td>UNDP</td>
<td>Dr. Ilinka Serdarevic, Program Coordinator</td>
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<tr>
<td>USAID</td>
<td>Cornelis Klein, Resident Representative</td>
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<td></td>
<td>Jadranka Mimica (TG Secretariat)</td>
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<td></td>
<td>Chuck Howell, Director, Office for Democracy and Social Transition</td>
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<td></td>
<td>Vladimira Dukic, Project Specialist</td>
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<td>Indira Konjhodizic, Country Manager</td>
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### Bulgaria

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<tr>
<td>BGO Gemini Organization</td>
<td>Anina Asenova, Program Coordinator</td>
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<tr>
<td></td>
<td>Mr. Genko Gengov</td>
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<tr>
<td>Federation of Dutch Associations for the Integration of Homosexuality</td>
<td>Reka Incze, Consultant</td>
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<td>Ministry of Health</td>
<td>Dr. Tonka Varleva</td>
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<td>National AIDS Coordinator</td>
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<td>Ministry of Justice</td>
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<td>Detective</td>
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<td>National Centre for Addictions</td>
<td>Dr. Nikolay Tomov, Head Blood Infections</td>
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HIV/AIDS in Southeastern Europe: Case Studies from Bulgaria, Croatia, and Romania is part of the World Bank Working Paper series. These papers are published to communicate the results of the Bank’s ongoing research and to stimulate public discussion.

The countries of Southeastern Europe (Bulgaria, Croatia, and Romania) have re-committed themselves to scale up action on the prevention and treatment of Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) in the sub-region. These three countries share several social conditions that have led to an alarming increase in HIV infection. These conditions include increasing unemployment and poverty, rapid social changes, a decrease in the accessibility and quality of services and educational opportunities, psychological stress from post-conflict situations, increased substance abuse and sex work, and increased trafficking in women for sexual exploitation.

This paper reviews the current status of the AIDS epidemics in the three countries, evaluates the approaches and strategies currently being used in each country, and makes recommendation both for government strategies and for the World Bank’s current and potential future involvement in relation to these strategies. Potential interventions are organized according to four general groupings: 1) Epidemiology and Operational Research; 2) Health Care and Social Services; 3) Health Communications and Promotion; and 4) Civil Society and Advocacy.

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