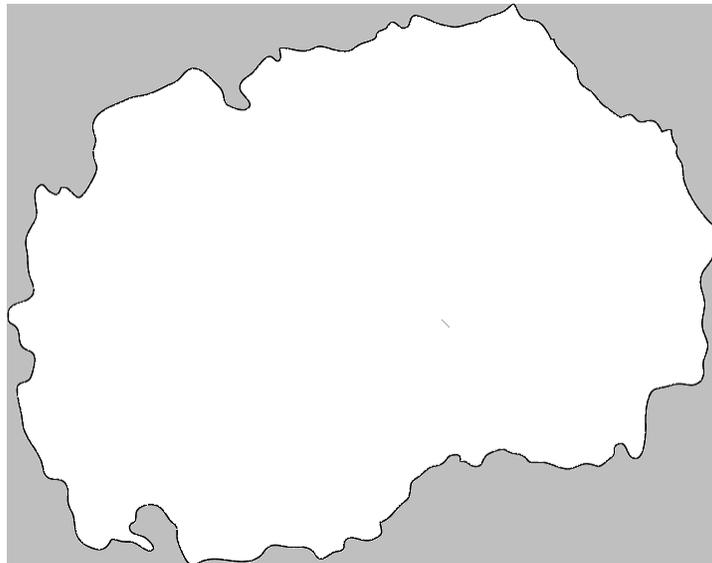




REPUBLIC OF MACEDONIA

UNGASS COUNTRY PROGRESS REPORT

Reporting period: January 2008-December 2009



31 March 2010

Address by the Minister of Health

The Republic of Macedonia is a country with a low prevalence of HIV. However, the fact that regional trends indicate continuous increase of HIV infection especially among most-at-risk-populations is rather worrying. For this reason, the national response of our country is focused on prevention of HIV infection with the aim to timely and efficiently prevent a possible HIV epidemic that always has broader health, social and economic impacts on the individual and community level. Regional and sub-regional aspects and conditions are always considered in our national activities.

As one of the countries that signed the UNGASS Declaration on Commitments for HIV/AIDS, Republic of Macedonia has undertaken the necessary steps in defining the strategic HIV/AIDS priorities, implementing concrete activities, building sustainable systems and mobilization of financial resources according to their availability. The HIV program supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria, enabled our country to successfully implement the aims and activities defined in the National AIDS Strategy 2007 – 2011. Moreover, this program contributed to the capacity building of the governmental and non-governmental sector for planning and implementation of activities targeting HIV/AIDS prevention.

The experience gained during the implementation of the National AIDS Strategy 2003-2006 and the National Strategy 2007-2011, as well as the priorities defined through the national consultation process on Universal Access to prevention, treatment, care and support, will be the basis for setting the future priorities in the National AIDS Strategy for 2012-2017.

This UNGASS Report for the period 2008-2009 demonstrates and summarizes the overall national efforts undertaken in development of relevant policies and progress in programme implementation and their contribution to the overall response to AIDS, as well as underlying further challenges that need to be addressed to halt the spread of HIV/AIDS in our country.

This report also reflects the challenges in securing sustainable funding for prevention, treatment, care and support of HIV/AIDS by the Government due to the influence of the economic crisis in 2009.

Minister of Health

Dr Bujar Osmani

Glossary

| | |
|-------------------|--|
| AIDS | Acquired Immune Deficiency Syndrome |
| ART | Antiretroviral therapy, |
| BBS | Bio-behavioural survey |
| BSS | Behaviour surveillance surveys |
| BCC | Behaviour Change and Communication |
| CCM | Country Coordination Mechanism |
| CID | Clinic for Infectious Diseases |
| CPH | Centres for Public Health |
| CRIS | Country Response Information System |
| EU | European Union |
| EPP | Estimation and Projection Package for Multiple Groups and Epidemics |
| GFATM | Global Fund for AIDS, Tuberculosis and Malaria |
| HAART | Highly Active Antiretroviral Therapy |
| HERA | Health Education and Research Association |
| HIV | Human Immunodeficiency Virus |
| IDU | Injection drug user(s) |
| ILD TB | Institute for lung diseases and TB |
| IPH | Institute for Public Health |
| IPPF | International Parenthood Planning Association |
| LSBE | Life-Skills Based Education |
| MDGs | Millennium Development Goals |
| M&E | Monitoring and Evaluation |
| MICS | MICS-Multiple Indicator Cluster Survey |
| MoH | Ministry of Health |
| MoE | Ministry of Education |
| MSM | Men who have sex with men |
| NAC | National AIDS Commission on HIV/AIDS |
| NCA | Norwegian Church Aid |
| NCPI | National Composite Policy Index |
| NGO | Non governmental organization(s) |
| PLWH | People living with HIV |
| PMTCT | Prevention of mother to child transmission of HIV |
| PPM | Public-private mix, public-private partnerships |
| (F) OSI | Open Society Institute Foundation |
| STI | Sexually transmitted infections |
| SW | Sex worker(s) |
| TB | Tuberculosis |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| UNGASS | United Nations Special Session on HIV/AIDS (June 2001) |
| UNGASS DoC | Declaration of Commitment adopted by UN member states at UNGASS |
| UNGASS Indicators | Indicators recommended by UNAIDS for global and national reporting on implementation of the UNGASS DoC |
| UNICEF | United Nations Children's Fund |
| UNFPA | United Nations Population Fund |
| VCT | Voluntary counselling and testing |
| WB | World Bank |
| WHO | World Health Organization |

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I. Status at a glance

The UNGASS Report 2010 was prepared by the members of the National AIDS Commission, with technical guidance from the Joint UN program on HIV/AIDS. The report incorporates the progress made in the national response to HIV/AIDS during the period 2008-2009 in addressing the priorities defined within the national consultation process on Universal Access to prevention, treatment care and support.

The work on this report was initiated in November 2009 with active participation of all relevant national stakeholders and international partners through initial discussions among the members of the National Monitoring and Evaluation working group on the report requirements and availability of national data.

In the process of identification, provision and verification of the available epidemiological, clinical, programmatic and other data relevant for reporting to the proposed UNGASS indicators, representatives from the Institute for Public Health, the Institute for blood transfusion, the Clinic for Infectious Diseases and the Ministry of Health have been included.

The National Composite Policy Index (NCPI) form was sent to the members of the National AIDS Commission, governmental institutions and representatives of the civil society sector active in the area of HIV/AIDS. Contributions to the National Composite Policy Index have been initially completed at two separate meetings. The first meeting was held on February 3, 2010, where Part A of the NCPI has been completed with inputs from representatives of 12 governmental institutions. At the second meeting held on February 4, 2010, Part B of the NCPI was completed with inputs from representatives of 4 UN agencies, 7 NGOs and the Ombudsman office. Once the NCPI form was completed, it was resent to all involved parties for further feedback and comments.

The current data on HIV-prevalence, knowledge and behaviours in this report were previously reported during the 2008 UNGASS reporting process. As they are the latest available data, they are also reflected in this report. This is due to unavailability of updated data reflecting the reporting period, caused by implementation delays of the

BBS funded through the R7 HIV Grant, originally scheduled for 2008, which has been postponed for 2010.

The first draft narrative report incorporating the findings and future challenges has been sent to more than 30 representatives of Government, NGOs, UN agencies and other technical experts. On March 19, 2010 the report and its findings have been presented on the meeting of the Country Coordination Mechanism (CCM)¹. Comments and inputs from both meetings are included in this final report, prior to its official submission on March 31, 2010.

During the whole process of the data gathering and report compilation, technical support has been provided by UNAIDS and the Joint UN Team on HIV/AIDS.

Republic of Macedonia remains low HIV prevalence country with total of 119 HIV/AIDS reported cases that represents the lowest reported number so far among the countries in the South Eastern European Region. However, country's specific socio-economic condition and the regional context of HIV/AIDS influence the vulnerability and the risk for rapid spread of HIV/AIDS epidemic, particularly among most-at-risk populations.

Although, from different aspects, it can be concluded that Macedonia is low HIV prevalence country, the specific trends in prevalence of HIV infection among most-at-risk population should be further explored. Furthermore, the results from the behavioural studies in 2005 and 2007 indicate that high risk behaviours are still present among most-at-risk populations such as Sex Workers (SW), Injecting Drug Users (IDU), Man who have Sex with Man (MSM) and Prisoners.

The most significant achievements of the country response in the period 2008-2009 include the following:

- Impressive work accomplished through the HIV program supported by the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), contributed to successful implementation of the key priorities and activities planned with the National AIDS

¹ CCM was established in 2003 for the GFATM program by joining the National AIDS and National TB Commission, reconstructed its membership and constituencies in November 2009 and consists of 32 members.

Strategy 2007-2011 and resulted in overall increase in coverage of clients reached and types of services provided.

- The GFATM Round 3 and Round 7 HIV programs have also contributed to improved collaboration and coordination between the governmental and non-governmental organizations, as essential precondition for implementation of services especially among hard to reach populations.
- Valuable political support has been provided for implementation of the National AIDS Strategy 2007-2011 and in successful implementation of specific HIV prevention programs. For example, the established Harm Reduction programs through needle exchange services and substitution treatment are considered as best practices not only at national, but also at regional level.
- And finally, the political support was crucial in formulation of the country future roadmap through identification of priorities within the national consultation process on Universal Access.

Data reported for the UNGASS indicators (Table 1) are coming from the Clinical records, Surveillance studies on HIV prevalence and risk behaviours among most-at-risk-populations, conducted in 2006 and 2007 and MICS-Multiple Indicator Cluster Survey 2005-2006. In almost all cases, unless otherwise indicated, data are disaggregated by gender and age group.

Data is not available for 4 indicators (Number 3, 11, 16 and 17) and these indicators are not reported at all. Data for indicators Number 16 and 17 are available only for women age 15-24, thus not entered in CRIS database but reported in the narrative part. Indicators Number: 6, 7 and 9 are partially filled out due to lack of data or estimates for the denominator. Indicators Number: 10, 12 & 22 are not reported at all as they are not relevant for a low prevalence country.

Table 1. Overview of UNGASS indicators data

| National Commitment and Action | | |
|---|---|--|
| Indicators | Status | Source of Data |
| 1. Domestic and international AIDS spending by categories and financing sources | Data for 2008: 157.947.178 MK denars (\$3.659.064) | 1) National AIDS spending assessment, 2010. Ministry of Health 2) Reports from all donors in the country |
| 2. National Composite Policy Index (Areas covered: gender, workplace programmes, stigma and discrimination, prevention, care and support, human rights, civil society involvement, and monitoring and evaluation) | NCPI document (UNGASS online data base: http://ungass2010.unaids.org) | Results from two meetings for NCPI and final report consultation meeting |
| National Programmes | | |
| Indicators | Status: 2008-2009 | Source of Data |
| 3. Percentage of donated blood units screened for HIV in a quality assured manner | No data available | |
| 4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy | Indicator: 5,53% Numerator: 23 (2008) Denominator: 416 (2008) Indicator: 5,43% Numerator: 24 (2009) Denominator: 442 (2009) | Clinical records from the Clinic for Infectious Diseases in Skopje HIV Estimations and projections using EPP & Spectrum |
| 5. Percentage of HIV-positive pregnant women who receive antiretroviral to reduce the risk of mother-to-child transmission | Indicator: 0% (2008) Numerator: 0 (2008) Denominator: 3 (2008) Indicator: 0% (2009) Numerator: 0 (2009) Denominator: 3 (2009) (no HIV-positive pregnant women in 2008 and 2009) | Clinical records from the Clinic for Infectious Diseases in Skopje HIV Estimations and projections using EPP & Spectrum |
| 6. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV | Partially reported indicator Numerator: 0 (2009) Denominator: estimates not available | Clinical records from the Clinic for Infectious Diseases in Skopje Estimates: Global TB |

| | | |
|--|---|---|
| | | control report 2009, WHO |
| 7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know the results | Partially reported indicator Male: No data available Female: 2.92% | MICS-Multiple Indicator Cluster Survey 2005-2006, Republic of Macedonia. State Statistical Office |
| 8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results | SW: 47.25% Males: 86.67% Females: 39.47% MSM: 55.90% IDUs: 43.73% Males: 42.31% Females: 52.83% | Surveillance studies on HIV prevalence and risk behaviours among most-at-risk-populations, 2007. RIHP |
| 9. Percentage of most-at-risk populations reached with HIV prevention programmes | Partially reported indicator Data available only for question "Know where to receive HIV test" (SW- 78.75%; MSM - 96.14%; IDUs - 90.98%) | Surveillance studies on HIV prevalence and risk behaviours among most-at-risk-populations, 2006. RIHP |
| 10. Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child | Not relevant | |
| 11. Percentage of schools that provided life skills-based HIV education within the last academic year | No data available | |
| Knowledge and Behaviour | | |
| Indicators | Status: 2006-2007 | Source of Data |
| 12. Current school attendance among orphans and among non-orphans aged 10-14* | Not relevant | |
| 13. Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission* | All: 21.55% Male: 17.87% Female: 24.87% | Surveillance studies on HIV prevalence and risk behaviours among most-at-risk-populations, 2007. RIHP |
| 14. Percentage of most-at-risk populations who both correctly identify ways of preventing the | SW: 46.67% Males: 66.67% | Surveillance studies on HIV prevalence and risk behaviours among |

| | | |
|---|---|---|
| sexual transmission of HIV and who reject major misconceptions about HIV transmission | <p>Females 42.67%</p> <p>MSM: 41.03%</p> <p>IDUs: 34.46%</p> <p>Males: 32.43%</p> <p>Females 47.17%</p> | most-at-risk-populations, 2007. RIHP |
| 15. Percentage of young women and men who have had sexual intercourse before the age of 15 | <p>All: 4.65%</p> <p>Male: 8.50%</p> <p>Female: 1.15%</p> | Surveillance studies on HIV prevalence and risk behaviours among most-at-risk-populations, 2007. RIHP |
| 16. Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months | No data available ² | |
| 17. Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse | No data available ³ | |
| 18. Percentage of female and male sex workers reporting the use of a condom with their most recent client | <p>All: 77.91%</p> <p>Males: 92.86%</p> <p>Females: 75.00%</p> | Surveillance studies on HIV prevalence and risk behaviours among most-at-risk-populations, 2007. RIHP |
| 19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner | All: 56.48% | Surveillance studies on HIV prevalence and risk behaviours among most-at-risk-populations, 2007. RIHP |
| 20. Percentage of injecting drug users who report the use of a condom at last sexual intercourse | <p>All: 50.76%</p> <p>Males: 50.68%</p> <p>Females: 51.16%</p> | Surveillance studies on HIV prevalence and risk behaviours among most-at-risk-populations, 2007. RIHP |
| 21. Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected | <p>All: 72.73%</p> <p>Males: 73.37%</p> <p>Females: 68.63%</p> | Surveillance studies on HIV prevalence and risk behaviours among most-at-risk-populations, 2007. RIHP |

² Data available from MICS study 2005-2006 only for women age 15-24 that had sex with more than one partner in last 12 months and is 0.05%

³ Data available from MICS study 2005-2006 only for women age 15-24 who used condom at last sex with non-marital, non-cohabiting partner and is 69.8%. (MDG indicator 19a)

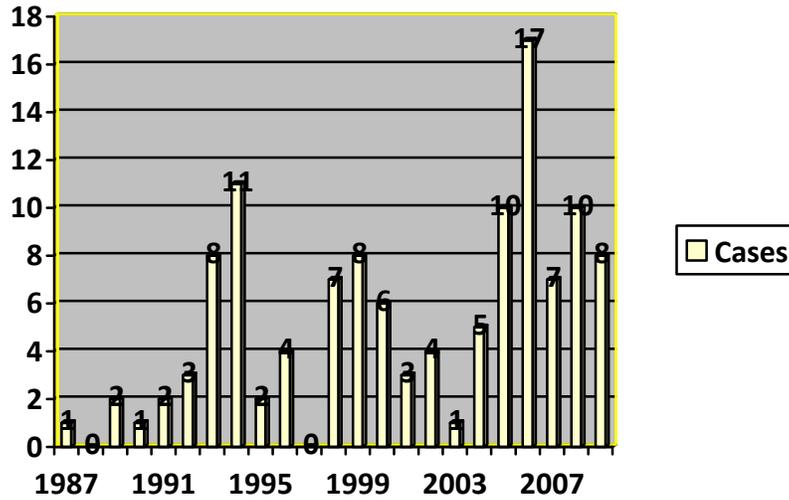
| Impact | | |
|---|--|---|
| Indicators | Status | Source of Data |
| 22. Percentage of young women and men aged 15–24 who are HIV infected | Not relevant | |
| 23. Percentage of most-at-risk populations who are HIV infected | SW: 0.00% MSM: 2.78% IDUs: 0.75% | Surveillance studies on HIV prevalence and risk behaviours among most-at-risk-populations, 2006. RIHP |
| 24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of ARV therapy | All: 77.78% Males: 71.43% Females: 100.00% Adults: 77.78% Children: 0.00% | Clinical records from the Clinic for Infectious diseases in Skopje |

II. Overview of the AIDS epidemic

Republic of Macedonia is low prevalence country with the lowest HIV positive cases reported among the countries in the South Eastern European Region.

The first HIV infection was registered in 1987, and the first AIDS case in 1989. According to data reported by the Institute for Public Health, the cumulative total number of registered HIV/AIDS cases as of 30 December 2009 is 120 with 95 AIDS and 25 HIV positive. Almost one half of all HIV/AIDS cases have been reported in the last 7 years 2003-2009. It is most likely that the increased number is at least partially due to greater availability of VCT services in the country during this period. In the period 2008-2009, 18 new HIV cases were registered; 10 in 2008 and 8 in 2009 (Figure 1).

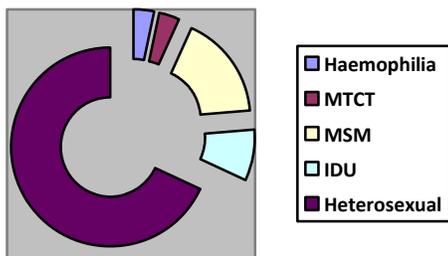
Figure 1: Total number of registered HIV cases by end of 2009 (total 120)



Source: IPH-Skopje, 31.12.2009

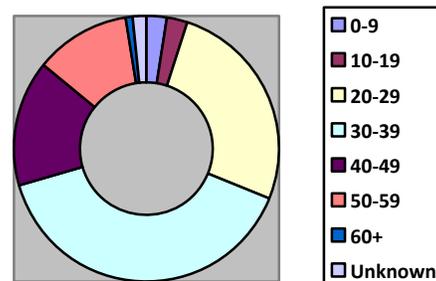
Out of 120 HIV/AIDS cases between 1987 and 2009, almost three quarters are males (72,3%). Heterosexual transmission was assessed to be predominant mode of transmission with 52,94%, following homosexual with 12,60% and intravenous with 7.56% (Figure 2). Reported cases in age group 30-39 years (39.49%) and age group 20-29 years (26%) contribute to almost three quarters of all reported HIV/AIDS cases (Figure 3).

Figure 2. Mode of transmission



Source: IPH-Skopje, 31.12.2009

Figure 3. Age groups



Source: IPH-Skopje, 31.12.2009

Since the onset of the epidemic till the end of 2005, most of the new reported HIV/AIDS cases were already AIDS patients. During 2006-2009, this trend has reversed with higher proportion of HIV positive than AIDS cases that again could be associated with increased availability of VCT services contributing to earlier diagnosis of HIV infection.

Up to now, the death rate of the diagnosed with HIV remains at the high end, which is explained with the fact that many of the HIV cases have been registered at very late stage of AIDS.

1. Biological studies

After the first national bio-behavioural studies carried out in 2005, which results have been reported in UNGASS Report 2005, the same studies with improved methodology and increased sample size especially among most-at-risk population groups have been conducted in 2006 and 2007 under the GFATM funded HIV program. The BBS scheduled for 2008 incorporates the response-driven-sampling (RDS) methodology and is the first of that kind to be implemented in the country. The bio-behavioural study that was scheduled for 2008 was postponed due to implementation delays for 2010. Data from this study will be available by September, 2010.

In 2006 through the biological study conducted among IDU, MSM, SW, Prisoners, STI patients, prisoners and pregnant women two HIV positive cases have been identified; one among MSM and the second among IDU. In 2007 in biological study among the same groups except pregnant women no positive results was found in any of the groups surveyed (Table 2).

Table 2. Overview of data from the biological studies

| | | CSW | MSM | IDU | Prisoners | STI patients | Pregnant women |
|------|--------------|-----------|---------------------------------|--------------------------------|-----------|--------------|----------------|
| 2005 | Sample size | 48 | 14 | 137 | 200 | 51 | / |
| | HIV positive | 0 (0.00%) | 0 (0.00%) | 0 (0.00%) | 0 (0.00%) | 0 (0.00%) | / |
| 2006 | Sample size | 51 | 46 | 236 | 359 | 136 | 486 |
| | HIV positive | 0 (0.00%) | 1 (2.17%) 2.78% ⁴ | 1(0.42%) 0.75% ⁵ | 0 (0.00%) | 0 (0.00%) | 0 (0.00%) |
| 2007 | Sample size | 67 | 37 | 297 | 220 | 126 | / |
| | HIV positive | 0 (0.00%) | 0 (0.00%) | 0 (0.00%) | 0 (0.00%) | 0 (0.00%) | / |

The results from the biological studies in 2006 and 2007 need to be interpreted with caution especially the one among the SW, MSM and IDU, due to the limitation and bias

⁴ % refers for the capital city as reported in UNGASS indicator number 23 - MSM

⁵ % refers for the capital city as reported in UNGASS indicator number 23 - IDUs

associated with the small sample size and its representativeness (convenient sample size used, including most-at-risk populations that already use HIV preventive services).

The results from the 2010 study will be of significant importance, given that the study is using the respondent-driven sampling methodology (RDS), which will decrease the bias, especially associated with representativeness.

However, the same as it was concluded in the report from 2005 study and given the data available from passive case reporting, it seems unlikely that these studies would have missed significantly high HIV prevalence in any of the population groups surveyed, for example above 5%. *Therefore, it seems reasonable to conclude from the results of the studies in 2006 and 2007 that Macedonia still has a low-level HIV epidemic.*

Starting from February 2007, the outreach VCT service⁶, with major focus on providing counselling and testing to most-at risk and hard to reach population groups is available in the country. By the end of 2009, this service covered 752 MSM; 361 SW; 822 IDU and 324 Prisoners. Through this service, five HIV positive cases have been identified, all of them in the MSM group.

2. Behavioural studies

The key findings of the behavioural studies among SW, MSM, SW, Roma and Prisoners in 2006 and 2007 are the same as the one conducted in 2005 and include the following:

- Young people are a very heterogeneous group, a small subset are much more vulnerable to HIV infection than others, namely those who buy/sell sex or inject drugs and young men who have sex with other men;
- Similarly, the Roma population is heterogeneous and those more at risk of HIV include men who have sex with men, women forced to sex and those who inject drugs;

⁶ The service is provided through two mobile vans that offer HIV counseling and testing (including condom distribution) 5 days during the week in 11 cities (the capital city Skopje as well as: Tetovo, Gostivar, Ohrid, Strumica, Prilep, Bitola, Kavadarci, Kumanovo, Veles and Stip). The teams are comprised of NGO counselor (working with different target groups), community gatekeeper and a laboratory technician from the Institute for Public Health. This activity is a joint venture between 11 public health institutions and 14 NGOs.

- Among IDUs, levels of combined high risk injecting and sexual behaviour are still of a great concern;
- Among prisoners, high risk injecting and risk sexual behaviour are present and they do not yet have ready access to quality condoms or sterile injecting equipment;
- Sex workers and men who have sex with men mutually overlap and engage in high risk sexual behaviour. Both groups have also some degree of overlap with injecting drug users;
- Patients with sexually transmitted infections are not a distinct most-at-risk population group in the same way as others described here;

Results from the behavioural study in 2005 compared with the one in 2007 indicate the following improvement in knowledge and risk behaviours:

- There is a general increase of knowledge among SW, MSM and IDUs, where the knowledge among young people is on the same level
- Slight decrease in prevalence of sexual intercourse initiation before the age of 15, among young people aged 15-24
- Increase in condom use among IDUs the last time they had sexual intercourse

Nevertheless, the data from 2006 and 2007 coming from the passive case reporting, biological studies and outreach VCT service, indicates increase of HIV reported cases through homosexual mode of transmission, (new cases detected through the surveillance study and outreach VCT). The ratio of 2/1 male to female might be also explained with the assumption that homosexual mode of transmission was reported under the heterosexual mode of transmission.

Although, it can be concluded that Macedonia is still low HIV prevalence country, the specific trends in prevalence of HIV among most-at-risk is still not clear. Even though in 2006 and 2007, actions have been undertaken to improve the national surveillance system, it still needs improvement in providing specific data and estimations that can be considered as official prevalence among the most-at-risk population.

III. National response to the AIDS epidemic

NATIONAL COMMITMENT

Government of the Republic of Macedonia acknowledged HIV/AIDS as an important public health issue that requires broad involvement of different stakeholders. Following the recommendations from the UNGASS Declaration of Commitments on HIV/AIDS and the “Three Ones Principle”, in 2003, the Government had established the National Multisectorial AIDS Commission and promoted first National AIDS Strategy for period 2003-2006. The next year, the National Monitoring and Evaluation System was developed and endorsed by all relevant partners in the country.

Republic of Macedonia has made the most important progress in the national response to HIV/AIDS in the period from 2005-2007. During this period, the country has succeeded to achieve the majority of the strategic actions proposed in the National AIDS Strategy 2003-2006, through implementation of the three-year HIV program supported by the Global Fund to fight AIDS, TB and Malaria (GFATM)-Round 3 cycle. Implementation of the GFATM HIV program enabled the country to substantially build and broaden the capacities of all relevant stake holders and involved organizations as well as to improve the collaboration among the governmental and non-governmental organizations.

Additionally, the country endorsed the National Strategy 2007-2011, which was also successful in achievement of the strategic actions proposed through the implementation of a five-year HIV program supported by the Global Fund to fight AIDS, TB and Malaria (GFATM)-Round 7 cycle. This scale-up of the existing HIV program provided continuation of all prevention services, with a special focus on most-at-risk populations, such as MSM, IDUs and CSWs.

In addition to and complementary with the GFATM HIV programs, National AIDS prevention programs run yearly, on the basis of the Law on Health Protection.

In the period 2008-2009, focus was given to the strengthening the quality of services, addressing bottlenecks in implementation of prevention programs envisaged with R7

HIV proposal, especially the expansion of drug substitution network, procurement of methadone and ARVs.

1. Universal Access process

National consultation process on Universal Access to prevention, treatment, care and support conducted at the beginning of 2006 through involvement of national partners from governmental and non-governmental organizations defined the key obstacles and proposed actions.

Table 3. Overview of Universal Access key obstacles and actions in R. Macedonia

| UNIVERSAL ACCESS | |
|---|---|
| Key obstacles | Key Actions |
| <p>1. Lack of specific non-discrimination laws or regulations to protect those vulnerable to discrimination (e.g. men who have sex with men, injecting drug users, sex workers)</p> <p>2. Lack of systematic data collection as basis for programme planning and priorities setting</p> <p>3. Process of decentralization of health care needs greater financial and budget programming resources</p> <p>4. Lack of public financial framework to adequately support implementation of the National Strategic plan and lack of budget mechanism for local self-government and civil society HIV/AIDS related activities</p> <p>5. Lack of sufficient number of clinical staff with experience of clinical management of people living with HIV to work on HIV/AIDS issues</p> <p>6. Lack of sufficient number of community based workers able to efficiently organize and coordinate community based HIV/AIDS programs</p> <p>7. Lack of ARV resistance monitoring mechanism due to lack of necessary lab equipment in the country.</p> <p>8. Monitoring and enforcement mechanisms does not exist specifically to ensure human rights protection</p> <p>9. Vulnerable populations not involved in Governmental HIV policy design and program implementation.</p> | <p>1. Assessment of legal obstacles and effectiveness of interventions for provision of prevention and care for most-at-risk populations and enforcement of existing legislation.</p> <p>2. Build national stakeholders' capacity for M&E and develop annual M&E plans as part of National Strategic plan</p> <p>3. Examine current expenditures and resource projection for the next 5 years, and develop national expenditure framework ensuring part of the local government budget allocated for HIV/AIDS related activities at community level</p> <p>4. Provision of initial and continuous training of staff for clinical management of people living with HIV with emphasis on ARV treatment and monitoring</p> <p>5. Training of community workers in planning and coordinating community based HIV/AIDS interventions</p> <p>6. Provision of necessary equipment and training of clinical and lab staff for ARV resistance monitoring</p> <p>7. Strengthening mechanisms to ensure human rights protection and include monitoring and enforcement of human rights in NSP</p> <p>8. Inclusion of the representative from vulnerable groups in all groups working on policies and program design. Specific emphasis given to the role of local communities, patients rights protection, age and gender-specific interventions, setting up of measurable objectives in NSP</p> |

These obstacles and priorities informed further policy development, shaping the framework of the second National AIDS Strategy for period 2007-2011, endorsed by the Government in October 2007.

2. Leadership

In the course of 2008 and 2009, the Minister of Health, as a Chair of the National AIDS Commission and the Country Coordinating Mechanism was actively involved in all

national processes and provided continuous political support. The Minister has provided political support in the process of approval of the National AIDS strategy (2007-2011) and its endorsement by the Government. Further, the Minister supported the implementation of activities within GFATM HIV program, especially the process of lobbying for new drug substitution centres in the capital Skopje, which undermined the paradigm created in the general public that drug users should be treated in isolated places, rather than in communities where they live. Additionally, in many occasions and also at the media, the Minister supported and emphasized the importance of the harm reduction programmes for drug users in HIV/AIDS prevention efforts and recognized the role and contribution of the civil society sector in the national response.

However, the expansion of the network of drug substitutions centres in the capital Skopje (4 planned, 2 opened only) experienced high level of stigma in the largest Roma community in the country-Shuto Orizari, located in the capital Skopje, where the local government and the community banned the opening of the newly refurbished drug substitutions centre, although the statistics mark significant drug-use problems and needs for this treatment in this area. The same case was experienced with other municipalities in the capital, at the planning stage.

At the end of 2009, thematic retreat of the Country Coordinating Mechanism took place, where this body was reconstituted in order to strengthen its influence over the Ministry of Health as the main implementing entity in overcoming implementation bottlenecks, such as the expansion of the drug substitution network, procurement of methadone and ARVs, but also close monitoring of the quality of the services and remedial actions in the implementation if needed. As a result of this process, chairing was rotated to NGO sector, where Red Cross of Macedonia together with the Health Insurance Fund was elected to lead the CCM in 2010. The number of CCM representatives was reduced, involving only institutions that will have critical impact on the implementation of the National strategic actions for HIV/AIDS.

In 2009, NGO HERA and the community of PLWHA initiated the establishment of the first community based group of PLWHA, which will actively take place in shaping the

HIV/AIDS response in the country. The activities of the group will be supported by the Joint UN programme on HIV/AIDS.

3. Financing

There has been significant re-shifting and increase in international sources of funds to support implementation of the national AIDS response. Major funding comes from five distinct resources—two domestic (Health Insurance Fund and Ministry of Health) and three international (GFATM, UN and several international organizations with smaller grant initiatives: IPPF, NCA, OSI etc). Health Insurance Fund remains the largest contributor to HIV/AIDS financing (51%), followed by GFATM (31%) and UN agencies (11%). Major international financial assistance is being received from the GFATM Round 7 HIV grant in an amount of \$9.4 million for the period 2008-2013. GFATM funding represents 72% of all international funding sources in 2008. Additional support was provided by international organizations and programs, such as: UNFPA, UNAIDS, UNICEF and WHO (25% of all international funding in 2008).

Together with the international funds that have contributed to increase the number and expand the capacity of public services, public sources have also been increased and contributed significantly to the total national spending on HIV/AIDS in 2008. However, the contribution of domestic funding to the overall funding need of preventive activities (less than 9% of all domestic funding for HIV/AIDS) is still not meeting the expectancies, although it showed increase in funding allocations from 6.000.000 MKD (app. \$140.000) in 2006 to 8.000.000 MKD (app. \$200.000) in 2008. This course was abrupt in 2009, following the impact of the financial crisis which influenced this program, in line with the overall influence on the 2009 budget, resulting in almost 32% reduction in funding.

Assessment conducted by the Ministry of Health in 2010 on the public expenditures for 2008⁷, revealed that the country had spent total of 157.947.178 Macedonian denars (MKD) or \$ 3.659.064. The funds came from two sources, distributed as per the tables:

⁷ Assessment was done following the “National AIDS Spending Accounts methodology”, UNAIDS

Table 4. Distribution of domestic funding to HIV/AIDS response (average exchange rate for 2008: 1 USD=43.1667 MKD)

| | MK denars | US dollars |
|----------------------------------|------------|------------|
| Health Insurance Fund | 80.886.306 | 1.873.812 |
| National AIDS preventive program | 8.000.000 | 185.328 |
| Other domestic funding | 299.155 | 6.930 |

International sources contributed for the same years with the amount of 68.761.717 MKD (\$ 3.659.064) in 2008 distributed in the following proportions:

Table 5. Distribution of international funding to HIV/AIDS response (average exchange rate for 2008: 1 USD=43.16 MKD)

| | MK denars | US dollars |
|----------------------------|------------|------------|
| GFATM | 49.532.822 | 1.147.496 |
| UN agencies and programs | 17.062.613 | 395.279 |
| Other international donors | 2.166.281 | 50.184 |

Total domestic sources spent on AIDS in year 2008 amounts to 89.185.461 MKD (\$ 2,066,070), which is 4% above the UA target set for 2008-\$ 1.975.943.

The first private initiative to built facility for a centre for harm reduction program has been tabled to the MoH in 2008 by a private company, willing to build and further donate the centre to the Ministry of Health.

The first private-public partnership resulted in opening of the rehabilitation centre for drug dependencies in Strumica in December, 2009, as a partnership between the Municipality of Strumica, the Macedonian Orthodox Church and Centre for Institutional Development-CIRa-Skopje.

4. Multisectorial collaboration

One of the most important factors contributing to more effective national response to AIDS was the collaboration between all relevant stakeholders in the country. As part of HIV/AIDS programme implemented with support from the GFATM, the Ministry of Health as a principal recipient collaborated with 34 organizations as sub-recipients, considered to be an example of best practice for collaboration between governmental and non-governmental organizations. For example, the Centre for drug substitution treatment in the city of Strumica⁸ was established through collaboration among the Ministry of Health, the Ministry of Labour and Social Policy, the Orthodox Church and the civil society sector. On one side, involvement of the public institutions, such as different ministries contributed to provision of political support, while on the other side, non-governmental organizations contributed to better access to most-at-risk populations, as final beneficiaries.

5. Policy and legislative framework

Republic of Macedonia has ratified all legally binding international instruments on human rights. In addition, the country has committed to a number of international initiatives and declarations among which the most significant to the prevention and control of HIV/AIDS are the following: the Millennium Development Goals (MGDs); the UNGASS Declaration of Commitment on HIV/AIDS, 2001; the Dublin Declaration of the EU member states for the activities against HIV/AIDS in prisons, 2004; Universal Access to prevention treatment and care, 2006; the Bremen Declaration of the EU member states on responsibility and partnership in the fight against HIV/AIDS, 2007; WHO Amsterdam Declaration for promotion of the patients' rights in Europe, 1994; as well as other documents on protection and promotion on health, non discrimination of human beings and protection of patient rights.

Republic of Macedonia has committed also to the policies and legal documents of the Council of Europe with respect to human rights protection, especially in the health area.

⁸ The biggest city in the Sothern East part of the country

In 2007, the National AIDS Strategy for the period 2007-2011, the National Drug Strategy for the period 2006-2012 and also the Strategy for collaboration between Government and the non-governmental sector (2007-2011) have been officially endorsed by the Government of the Republic of Macedonia.

As one of the previously indicates weaknesses to UA was lack of specific non-discrimination laws or regulations to protect those vulnerable to discrimination (e.g. men who have sex with men, injecting drug users, sex workers) an the assessment of national legislation on HIV/AIDS from the perspective of human rights was carried out in 2008 and the results were further validated with wide range of national experts and stakeholders.

The assessment for legal analysis included desk review of the national legislation, policy documents and other available and relevant documents and reports. In additional semi-structured interviews have been carried out with representatives from more than 15 local governmental and non-governmental institutions.

The key findings of the assessment report are inexistence of non-discrimination Law, as well as the inexistence of independent body for protection from discrimination. Additional findings focus on the legal constituencies and decriminalization for providing prevention, treatment and care services for most-at-risk populations, as well as services for PLWHA. Specific findings for PLWHA in the assessment focus on access to employment, retirement, reduced working hours, family planning etc.

These areas will be included in the technical assistance planning process of the Joint UN programme on HIV/AIDS in 2010.

PROGRAM IMPLEMENTATION

A. Prevention

Prevention programs have been substantially scaled up in the past 2 years through the GFATM HIV program targeting young people, IDU, SW, MSM, and Prisoners. Activities have been implemented in collaboration with the governmental institutions, civil society and public health sector and included different Behaviour Change and Communication

(BCC) activities including distribution of different media products (brochures, posters, and radio and TV messages, etc), condom distribution, peer education activities among different groups, provision of counselling services, hot lines services, organization of festivals, etc.

Many HIV prevention services have been scaled up and new ones have been established. For example, there were 11 operational Harm Reduction services with Needle Exchange, 8 centres for Drug substitution treatment, 10 stationary VCT centres and one outreach VCT mobile unit in the period 2006-2007.

By the end of 2009, 13 Harm Reduction services⁹, 10 centres for Drug substitution treatment¹⁰, 10 stationary VCT centres and 2 outreach VCT mobile units operate in different regions of the country.

In 2009, the VCT centres throughout the country have been upgraded to serve as centres for counselling on sexual and reproductive health. In 2008, the work of the initial one outreach VCT service was strengthened with additional mobile VCCT vehicle that provides VCCT services in the other cities throughout the country, with focus on providing these services to hard-to-reach and most-at risk populations.

This report does not contain updated data on knowledge, practices and behaviour of most-at-risk populations in the country, compared to the 2008 UNGASS report.¹¹

a) Knowledge change

Due to implementation delays, mostly connected with procurement of medical blood tests for HIV and HCV for the biological study, done by the Ministry of Health, Institute for public health and NGOs, there is a significant delay in the implementation of the BBS

⁹ 11 existing: Skopje, Bitola, Strumica, Ohrid, Kumanovo, Stip, Kavadarci, Gostivar, Kichevo, Prilep and Veles and 2 new Harm Reduction services: Gevgelija and Tetovo

¹⁰ Skopje-Idrizovo, Skopje-ILDTB, Kumanovo, Tetovo, Kavadarci, Stip, Ohrid, Strumica, Bitola and Gevgelija

¹¹ The BBS originally scheduled for 2008 was postponed for 2010 due to implementation delays of the R7 HIV Grant.

originally scheduled for 2008 into 2010. *Therefore, as mentioned before, this report will report the latest available data extracted from the BBS 2007 and BBS 2006.*

The percentage of young people (aged 15-24) who correctly identified ways of HIV transmission and were able to correctly reject three misconceptions on HIV transmission in the behavioural study from 2007 is 22%¹² and is the same as in the behavioural study from 2005. It might be concluded that the scope and the quality of the peer education activities in and out of schools have not been sufficient to influence the improvement of knowledge among youth. Additionally, the school curriculum on prevention of HIV/AIDS/STI and reproductive health in the primary and secondary schools does not integrate the life-skills based approach¹³. For this reason, UNGASS indicator number 11 has not been reported in the CRIS database. Lastly, we can also assume that the period of less than 2 years is not sufficient to contribute to a major increase of knowledge among the general youth population. It will be interesting to compare these results against the 2010 BBS, as there will be three years of time span to compare the findings and evaluate changes.

On the other hand, behavioural studies from 2007 clearly show that the knowledge among most at risk populations such as SW, MSM and IDUs has been increased. In 2005, 26.68% of IDUs and 33.87% of MSM correctly identified ways of preventing the sexual transmission of HIV and reject two major misconceptions about HIV transmission¹⁴. Two years later in 2007, 34.46% of IDUs and 41.03% of MSM could do so¹⁵. The results from the behavioural study among SW show even higher increase in knowledge for the same indicator from 9.85% in 2005 to 46.67% in 2007¹⁶. The aforementioned results for the most at risk population groups, especially for the SWs should be interpreted with caution due to possible bias associated with selection of survey respondents¹⁷ and the

¹² UNGASS indicator number 13

¹³ More detailed explanation on development of life skills based education framework, within the context of HIV/AIDS prevention is provided in chapter: Challenges and Remedial Actions

¹⁴ UNGASS indicator number 10 in 2005 UNGASS Report

¹⁵ UNGASS indicator number 14 - IDUs and MSM

¹⁶ UNGASS indicator number 14 - SW

¹⁷ Some participants in the survey have been already reached with prevention services, so, higher knowledge is expected due to this intervention;

sample size¹⁸. However, this increase clearly shows that the prevention services established in 2005 have resulted in improvement of the knowledge among the SW.

Although there is an increase in knowledge on HIV/AIDS among key most-at-risk populations still knowledge remains low in general terms and further prevention programs are needed.

b) Coverage of programs

Data on knowledge about and coverage of services are available from the behavioural studies in 2006, but only for knowledge where to receive HIV test, with the highest percentage among MSM (96.14%), followed by IDUs (90.98%) and lowest in SW with (78.75%)¹⁹. For this reason UNGASS indicator number 9 was partially completed with plan these questions to be included in the next behaviour study in 2010.

- **Population size estimation**

In 2009 UNAIDS supported the country with a research grant to conduct population size estimation among intravenous drug users in the country. The survey methodology consists of unique object capture-recapture method in four cities in the country²⁰ with significant IDU scene as well as unique object multiplier and classical multiplier methods in Skopje. The survey was conducted in cooperation of NGOs²¹ and Institute for Public Health, with the technical assistance of UNAIDS. The survey initiated in December 2009 and will conclude in March 2010, when the survey results will be made available. The survey in Skopje is in conjunction with the BBS 2010.

Implementation of the GFATM HIV program enabled increase of number of most-at-risk populations covered with the services in the period 2008-2009. For example, Needle Exchange Programs covered 259 new IDUs by September 30, 2008 and cumulative of

¹⁸ In 2007, SW from so called “closed scene” with higher education and from higher social class were also included in the study comparing to 2005 when only street SW from “open scene” have been included.

¹⁹ UNGASS indicator number 9

²⁰ Kumanovo, Gostivar, Ohrid and Strumica

²¹ Izbor,-Strumica, Opcija-Ohrid, Help-Gostivar, Pulcs-Kumanovo, Doverba-Skopje, HOPS-Skopje and HERA-Skopje.

939 IDUs by end of September 2009. Substitution treatment in 2008 was available for only 168 clients by September 30, 2008 and the number increased to 669 clients by end of September, 2009, which is almost 400% increase in only 12 months. Furthermore, number of MSM covered with different HIV prevention services was 403 in September 2008, moving to 877 by the end of September 2009²², which is more than 200% increase in 12 months.

Due to establishment of one additional outreach VCT service that operates throughout the country, there has been an increase in the coverage from 911 clients in September, 2008 to remarkable 4094 clients covered by end of September 2009.

In the behavioural study from 2007, from the total number of respondents included in the study, 47.25% among SW, 55.90% among MSM and 43.73% among IDUs received HIV test in the last 12 months and know the result²³. These percentages could not be compared with the ones reported for the same indicator in UNGASS Report 2005 (66.66% in SW; 7.40% in MSM and 31.78% in IDUs)²⁴. Information for men and women age 15-49 that received HIV test in the last 12 months and know the result is available only for women and is 2.81%²⁵

An important challenge for the national AIDS program remains to increase coverage and accessibility of services for adolescents who are most at risk of contracting HIV/AIDS. A study commissioned by UNICEF²⁶ has shown that among the groups most-at-risk of HIV transmission in Macedonia, identified as men who have unprotected sex with men, people selling sex, and injecting drug users, adolescents co-exist with older community members and both share many of the same experiences and vulnerabilities, as well as exhibit some specificities to their age group. However, there do seem to be particular barriers to accessing appropriate preventive and treatment services that are related to both legislative restrictions on service provision to adolescents, and the caution with

²² Data from the last HIV Program Progress report submitted to GFATM

²³ UNGASS indicator number 8

²⁴ Data reported back in 2005 UNGASS Report referred only to the percentage of respondents who have been tested in the study conducted in 2005

²⁵ UNGASS indicator number 7. Data come from MICS survey 2005-2006

²⁶ Mapping and community based research on most at risk adolescents of HIV/AIDS/STIs in Macedonia, UNICEF, 2008;

which harm reduction NGOs working with at-risk groups operate in order to avoid being criticized of exploitation or abuse of young people. These barriers are further aggravated by *prevailing social attitudes* that stigmatize most-at risk adolescents and marginalize them.

c) Behaviour change

With regards to the positive behaviour change, there has been very slight decrease from 5.76% in 2005 to 4.91% in 2007 among young people age 15-24 that have had sexual intercourse before the age of 15²⁷. What is more interesting, there is a significant difference in the percentage between the sex with high proportion among male (8.29%) than female (1.35%) who have had sexual intercourse before the age of 15. That proportion is almost the same as the one from the UNGASS Report 2005 (10.09% in male and 1.24% in female).

UNGASS Indicator number 16 has not been reported since information on high risk sex among men and women age 15-49 is only available for women age 15-24 that have had sex with more than one partner in last 12 months and the percentage is 0.05%²⁸.

Data for UNGASS Indicator number 17 “Percentage of women and men aged 15-49 who had more than one partner in the last 12 months reporting the use of condom during their last sexual intercourse” are also not available. The only data on condom use during high-risk sexual behaviour is available from the MICS study 2005-2006 and the reported percentage of 69.8% refers only for women age 15-24 who have used condom at last sex with non-marital, non-cohabiting partner²⁹.

Percentage of condom use among SW with their most recent client in behavioural study from 2007 is 77.91%³⁰ that is slightly lower than the figure of 85.91% in 2005 UNGASS Report. This slight decrease could be explained with difference in the sample in 2005 and 2007. Namely, a good number of SW that have never used HIV preventive services have been included in the behaviour study in 2007 comparing to same study in 2005, where most of the SW have used HIV preventive services.

²⁷ UNGASS indicator number 15

²⁸ Data form MICS study 2005-2006

²⁹ MDG indicator 19a

³⁰ UNGASS Indicator number 18

Condom use in MSM is 56.48%³¹ and it refers to the MSM reporting the use of condom the last time they had anal sex with male partner from the one who reported having had anal sex with male partner in the last six months. This could not be compared with the percentage of 78.5% for same indicator from 2005 UNGASS report, since it refers to the MSM reporting the use of condom the last time they have had anal sex with non-regular male partner from the one who reported having had anal sex with male partner in the last twelve months.

However, it can be concluded that the use of condom among MSM population is still low and further behaviour change communication services should be provided to this population group.

Behavioural studies shows that behaviour practices among IDUs have been improved with 40.66% in 2005 to 50.76% reported condom use last time they have had sexual intercourse. Regarding safe injecting practices, in 2005 81.21% reported not sharing injecting equipment last time they injected. In the same year, percentage of IDUs reporting not sharing injecting equipment last time they injected from the one who injected in the last month is 62.17%. In 2007, 72.53% of IDUs have reported not sharing injecting equipment in the last month (73.37% among male IDUs and 68.63% among female IDUs). Comparing these two figures could be explained as improvement in injecting practices among IDUs. Nevertheless, this comparison should be taken with caution since the percentage from 2005 refers to the IDUs who have not shared injecting equipment last time in the last month and the percentage in 2007 refers to the IDUs who have not shared injecting equipment in the last month at all.

In 2005, the percentage of IDUs who have adopted behaviours that reduce transmission of HIV, i.e. who both avoid sharing injecting equipment and use condoms was 28.23% (29.70% in male IDUs and 26.75% in female IDUs)³². In 2007 it has increased to 38.74% (40.09% in male IDUs and 31.71% in female IDUs). Generally, it can be concluded from the results both in 2005 and 2007 that the proportion of those with behaviours that reduce transmission is higher among male IDUs than female IDUs.

³¹ UNGASS Indicator number 19

³² 2005 UNGASS report

d) Blood Safety transfusion

From 1987, the policy regarding blood safety in the country is that every donated blood unit should be screened for transfusion-transmissible infections such as HIV. In March 2007, standard operating procedure including instructions for the performance of specific procedures for Quality Control and Quality Assurance (including 4 specific Algorithms for different institutions) has been officially endorsed by the Ministry of Health. This procedure has been gradually introduced in almost all public laboratories performing HIV test. This procedure includes External Quality Assessment scheme (the external assessment of a laboratory's performance using samples of known, but undisclosed, content and comparison with the performance of other laboratories) that has not been put in practice by the end of 2009.

Republic of Macedonia had its own national EQAS which was regulated and ruled by the Institute for transfusion of the University Hospital in Skopje. The current EQAS refer only to part of the blood examinations (coagulation factors), excluding the viral markers. Therefore, this protocol does not meet the criteria of the reported indicator. For this reason UNGASS Indicator number 3 has not been reported.

B. Treatment, care and support

The total number of PLWHA enrolled in HIV treatment, care and support is 36. The number of patients ever enrolled in ARV treatment as of December 2009 is 27.

HAART was initiated back in 2006 with first line ARV drugs, extended with second line drugs the same year. The administration of drugs to patients follows the national protocol on ARV treatment and care (WHO compliant). The cumulative number of patients receiving Highly Active Antiretroviral Therapy (HAART) by the end of 2009 is 24. Due to relatively small number of patients, at present, treatment is provided centrally at the Clinic for Infectious Diseases (CID) in the capital city. Its capacities have been improved by establishment of a new AIDS in-patient department, provision of equipment for monitoring of HIV infection and ARV treatment.

Care and support to PLWH is provided through the special out-patient counselling centre for PLWH at the CID as well as through home visits organized by civil-society organizations.

During 2009, following training for population size estimations, national experts projected the estimated number of adults and children with advanced HIV infection using EPP and Spectrum. In previous reports this indicator was partially reported due to the inexistence of these projections.

The percentage of adults and children with advanced HIV infection receiving antiretroviral therapy is 5,53% for 2008 and 5, 43% for 2009. The indicators have almost identical values due to the constant number of patients on ARV treatment. At present, there is only one child living with HIV/AIDS with initiated ARV treatment.

In the course of 2008 and 2009 as well as in general since the onset of the epidemic, there were no pregnant women identified to be HIV positive, thus the UNGASS indicator number 5 is not relevant for the country.

In the reporting period there were no cases of adults with HIV-positive incident TB. Mechanisms are in place for administration of ARV and TB treatment according to the national protocols³³.

The percentage of adults and children with HIV known to be on treatment 12 months after initiation of ARV for the reporting year 2007 is 77.78% (71.43% among males and 100.00% among females). This indicator is moving towards meeting the Universal Access target for 2010, which is set at 90%. It is expected that this percentage will gradually continue increasing in the next years, given that HAART are available in the last 4 years. Although, considerable achievements have been made in the last four years the country is expected to further scale-up the care, treatment and support, addressing the challenges for sustainable provision of ARV drugs as well as the capacity building on ARV treatment monitoring, given the fact that provision of ARVs will fall under the responsibilities of the Government as of 2009.

³³ UNGASS indicator 6 partially filled out due to lack of estimates on number of incident TB cases in people living with HIV

TB/HIV COLABORATIVE ACTIVITIES

TB/HIV collaborative activities have been initiated with the GF R5 TB Grant, where all TB patients were offered HIV testing on VCT basis, as well as all HIV patients undergo a TB test along with other testing procedures in the algorithm of clinical investigations of an HIV patient.

These activities were additionally strengthened by opening a MMT centre in the capital Skopje at the ILDTB premises, offering a wide range of services for IDUs: MMT, VCCT, TB screening etc.

WHO mission in the country in 2007 determined the following recommendations for the TB/HIV collaborative activities:

- Develop a written protocol, between the NTP and NAP for the proper case management of TB/HIV co infected people (consider using/adapting the TB/HIV Clinical management guidelines for the European region).
- Consider offering HIV testing and counselling in TB facilities. Record the number of TB patients, number of TB patients counselled and tested and number of TB/HIV co infected
- Increase the knowledge (TB symptoms, diagnosis and treatment) of health care workers, outreach workers, peer educators, staff working in methadone maintenance treatment centres and with different vulnerable/high risk groups.

R5 TB Grant and R7 HIV Grant will incorporate HIV testing throughout the country with all TB dispensaries, involving the mobile VCCT unit in this activity.

IMPACT ELEVATION

The overall impact of the national response to AIDS in the last two years could not be projected with a certainty as there are no impact indicators available that reflect the reporting period. However, looking at the process indicators, we could assume that there is an elevation of HIV preventive programs coverage through improved availability and accessibility of the HIV prevention services nationwide. In addition, there has been

improvement in the availability of the voluntary testing and counselling on HIV/AIDS and quality of the ART treatment in general.

The approval of the Phase 2 of the Round 7 GF HIV Grant is additional recognition for the well established, coordinated and improved national AIDS response.

The country could evaluate the impact elevation in mid-2010, after the results of the study are available.

IV. Best practices

The best practices examples in the area of scaling up of effective prevention programmes have been implanted through the GFATM HIV program. Those are the following:

1. Harm Reduction programs with substitution treatment in 8 regions and main prison in capital city.

By the end of 2007, nine centres for prevention and treatment of drug abuse³⁴ were established with 1283 clients on substitution treatment and 200 prisoners on substitution treatment. These centres were opened as a result of joint collaboration among the Ministry of Health (MoH), Ministry of Labour and Social Policy (MLSP), NGOs, mayors as well as Faith Based Organizations.

In April 2008, with the initiation of the R7 HIV Grant, additional 168 clients enrolled in treatment by end of 2008, increasing to 669 by end of September 2009. Also, additional 222 new prisoners have been included on substitution treatment in Idrizovo prison in the course of the reporting period.

2. Harm Reduction programs with needle exchange - scale up and increase number;

There were 11 Needle Exchange programs³⁵ functional by the end of 2007 with coverage of new 2259 IDUs.

³⁴ Centres are established in Strumica, Kumanovo, Ohrid, Stip, Gevgelija, Tetovo, Bitola, Kavadarci and Skopje-Prison Idrizovo.

³⁵ In Skopje, Bitola, Strumica, Kumanovo, Stip, Ohrid, Gostivar, Kavadarci, Prilep, Veles and Kicevo

During 2008 and 2009 more than 900 new have been covered with these programs with tendency of constant increase in the number of new clients.

What makes these programs exceptional is the fact that some of the staff included in the needle exchange activities are former drug users and serve as good models for positive behaviour change among their peers.

3. Outreach Voluntary and Confidential Counselling and Testing on HIV/AIDS program (VCCT) with two mobile units

The outreach VCCT program was organized by NGO HERA and the distinguishing mark of its success is the productive and coordinated collaboration between Governmental institutions and the civil society sector. In other words, the program includes all NGOs³⁶ working with different target population (MSM, CSW, IDU, Roma, prisoners, students in dormitories, and general population) and Institute for Public Health.

The outreach activities are completely designed tailored to the needs and confidentiality of the specific population by employing ‘gatekeepers’ representatives from the targeted group. The result of this approach is the deserved trust of representatives from the hard-to-reach populations.

Due to establishment of one additional outreach VCT service that operates throughout the country, there has been an increase in the coverage from 911 clients in September, 2008 to remarkable 4094 clients covered by end of September 2009.

An additional achievement was the collaboration on daily basis between the different NGOs and health workers that practically developed a partnership network that can be used as model for future activities.

³⁶ NGOs: HERA, HOPS, EGAL and DOVERBA from Skopje, Puls-Kumanovo, Izbor-Strumica, Help-Gostivar, Opcija-Ohrid etc.

V. Major challenges and remedial actions

The following challenges from UNGASS 2008 report were met in the course of 2008-2009:

1. Estimations of the population sizes in general (size of most-at-risk populations, estimated number of HIV positive people and people in need of ARV treatment, etc)- the estimations were calculated using EPP & Spectrum, conducted after a training of national experts on population size estimations. Estimates are available for this report and have been used for reporting in indicators 4 and 5. Technical support for the training on estimations and consultancy was provided by UN partners.
2. Planning of national preventive program on HIV/AIDS -the Joint UN program on HIV/AIDS envisaged and implemented the planning and implementation for preventive programs in HIV/AIDS together with UNICEF in 2009. As a result of this activity, a detailed work plan and budget, along with more transparent and effective preventive programs for HIV/AIDS was developed for 2010, an activity that will be scaled-up and continued in 2011 and beyond. Part of the impact of this activity relates to the increase in public funding for HIV/AIDS in 2008, which was affected by economic crisis in the process of the 2009 implementation and 2010 planning and budgeting.

In the reporting period of 2008-2009, Republic of Macedonia faced the following challenges:

1. Sustainability in allocation of the national resources for financing the response to HIV/AIDS that contribute to the present and the new GFATM HIV program-the World economic crisis in 2009 abrupt the steadily incline of domestic funding of the AIDS response. Although it is envisaged that the incline of funds will continue to rise in second half of 2010, we are still facing a starting point of 2006³⁷. **This is the most important challenge of this report.** National funding pledges are not meeting the original forecasts, as envisaged in the GFATM Round 7 proposal. The World

³⁷ The current Preventive program for HIV/AIDS 2010 has been approved by the Government at 6.000.000 MKD (\$140.000).

economic crisis affected all public expenditures-due to the burden of the crisis, Government decided to reduce all public costs, including all Preventive programs, especially the ones that were under spending. Apart from the challenge to lobby for an increase in public funding to the national HIV/AIDS response, there is a need to advocate for more efficient and timely bound spending of public funds on a transparent multi-stakeholder way.

2. Weak capacities of the local self government in planning, implementation and monitoring of the national response to HIV/AIDS-*this was the most important challenge identified initially with the national consultation process on Universal Access* back in 2008. Although processes of planning, implementation and monitoring of HIV/AIDS response have been initiated, mainly through the Preventive program for HIV/AIDS, challenges to expand these interventions and to relate them to broader process of intra-municipal planning, as well as implementation remains. These actions as well as insuring sustainability of the AIDS services, initiated with the GFATM Grants will be a subject to a new proposal to the GFATM in Round 10, mostly through public-private partnerships and local funding of the HIV/AIDS response.
3. Establishment of sustainable system for continuous provision of ARV treatment-as the country is entering Phase 2 of the GFATM R7 HIV Grant, it undertakes the responsibility for planning, procurement and administration of first and second line ARVs to HIV patients. The assessment of the current status of ARV treatment has been conducted by an external expert at the end of 2007 and is repeated by CCM expert team in 2010. Specific recommendations will be discussed with the authorities of the Hospital budgeting program and National Bureau of Drugs for streamlining ARV drugs registration and their availability on the local market. Also, recommendations will be discussed in the CCM and presented to the Minister of Health. Community of PLWHA will be closely involved in the monitoring process.
4. Establishment of new centres for substitution treatment in the capital city-although, nine new centres for substitution treatment have been established throughout the country, the substitution services offered in the capital city remained centralized and provided by only two centres, out of which only one new addition to the

program³⁸ with no additional capacity to serve new clients, though contributing to the already high rate of deaths in IDUs as well as overdose cases. The main problem was and still is the public pressure and disagreement on the location for the new centres in the capital.

5. Integration of HIV/AIDS issues into broader national Life-Skills Based Education Framework. A 2006 review of an existing draft Life-Skills Based Education (LSBE) curriculum for primary and secondary schools concluded that the existing curriculum is inadequate tool to inform a strategic national life-skills education programme, also being not a sufficient framework to address HIV/AIDS issues. The review further recommended that a new national programme on LSBE should be developed, while HIV/AIDS issues should also be fully incorporated into this broader strategy, as opposed to being pursued in an isolated manner. The whole LSBE initiative was then re-launched in 2007, adhering to its basic principles and expected to be gradually introduced first in primary and then in secondary school curricula. This will provide another occasion to advocate for meaningful HIV-AIDS prevention within the formal education.

VI. Support from the country's development partners

During this reporting period, key support has been received from the GFATM in value of \$2.8 million for the Phase 1 of HIV program that have significantly contributed to implementation of the National AIDS Strategy 2007-2011.

Additionally, specific technical support has been provided from the UN (UNAIDS, UNFPA UNICEF, WHO) in the following areas:

1. Support in strengthening of national HIV/AIDS and STIs surveillance system through capacity building trainings in research study design, data analysis and data use and review of the current surveillance system with specific recommendations for its adjustments and improvements;

³⁸ MMT Centre in University Clinical Centre, Institute for lung diseases and TB

2. Support to Government in development of relevant national policies, such as the Preventive program for HIV/AIDS, Preventive program for maternal and child health, new Strategy for sexual and reproductive health etc;
3. Assisted the government to review the current public expenditures in the area as to determine financial forecasts for full implementation of the new national HIV/AIDS strategy, as well as the national AIDS spending accounts;
4. Improved access and quality of HIV/AIDS services to most at risk and most vulnerable groups, that included operational support to training of services providers, technical assistance in development of guidelines for prevention, treatment and care of HIV/AIDS and modelling of services for most-at-risk population groups, such as adolescents and young people;
5. Support to planning, budgeting and coordination for a sustainable AIDS response, primarily to improve process of preparation of the annual National AIDS Preventive Programme³⁹, assure its coherence with the new National AIDS Strategy Action Plan and increase capacities for its decentralized implementation, at regional and local level;
6. Support to strengthen evidence based and accountability of the AIDS response, through improved evaluation of the current programmes, their cost-effectiveness and coverage in reaching different populations groups; estimation of the sizes among most-at-risk population, scale up and include different components of the HIV/AIDS/STIs surveillance system into an integrated national Health Information System, leading to more accurate and sustainable reporting for both national and international commitments and obligations;
7. Support in analysis of the current legislation related to HIV/AIDS from a human rights and gender perspective and access to services for different groups, in particular adolescents who are most at risk of contracting HIV/AIDS, including recommendations for its amendments and changes, based on international human rights law and “best practices” from EU countries;

³⁹ Directly funded from the state budget

8. Mainstream HIV/AIDS issues into the wider system reforms, in particular the ongoing reforms in the education sector, by integrating HIV/AIDS issue in development of the new life-skills based education curriculum covering primary and secondary education;

Future actions need to be taken and planned to be supported by the UN partners in order to scale up national response to HIV/AIDS and ensure achievement of the UNGASS targets, include:

1. Strategic planning, budgeting and coordination for a sustainable AIDS response, primarily to improve process of implementation of the annual National AIDS Preventive Programme, at regional and local level;
2. Invest in strengthening evidence based and accountability of the AIDS response, through improved evaluation of the current programmes, their cost-effectiveness and coverage in reaching different populations groups;
3. Act upon the findings of the legislation related to HIV/AIDS from a human rights perspective and access to services for different groups;
4. Support community of PLWHA in shaping up the national AIDS response and monitoring of the overall programs for HIV/AIDS in the country
5. Invest in bio-behavioural surveys, especially for MARPs in order to determine trends and to monitor the epidemic closely

VII. Monitoring and evaluation environment

In September 2003, a National Monitoring and evaluation group was established and in April 2005 Monitoring and evaluation System for the national response to HIV/AIDS⁴⁰ was designed and formally approved by all stakeholders. Guiding principles followed were that it should be based on the National AIDS Strategy, incorporate required indicators for key donor-funded programs and allow reporting on international agreements, e.g. declaration of commitment for UNGASS. In practice, the system draws

⁴⁰ Operational Guideline on M&E System integrating the M&E Plan for the GFATM HIV program

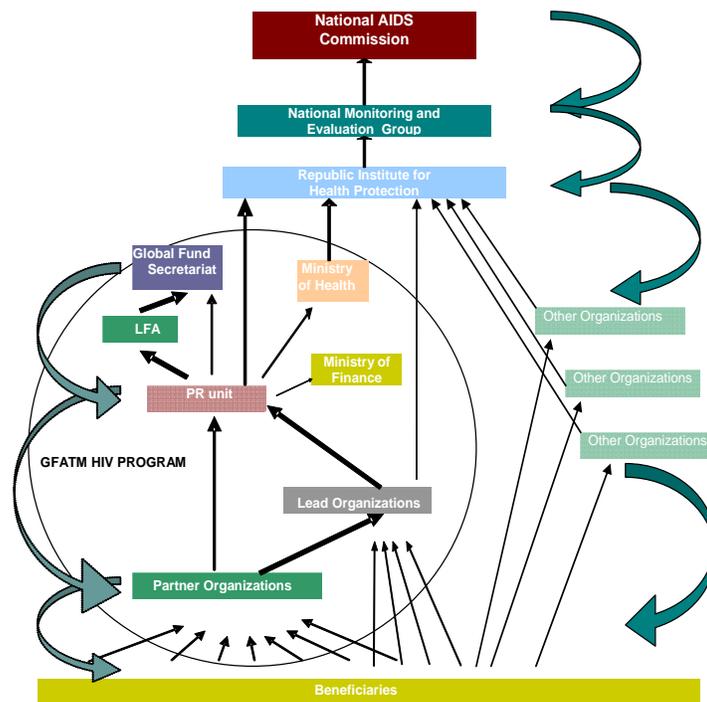
heavily on previous work done to develop an M&E system/plan for the Global Fund-supported program in Macedonia. A clear list of data flows for each service area and the national response as a whole, M&E roles and responsibilities, funds available and required for M&E activities, was also provided. The Institute for Public Health is the institution that has the overall mandate in collecting all available M&E data and reporting through the National M&E group to the National AIDS Commission as well as all national and international stakeholders (Figure 4).

The improvement of the M&E of the national response could be seen through the efforts made for improvement of the surveillance system in the country. The bio-behavioural studies to be conducted in 2010 will be with improved study methodology, increased sample size and revised indicators aligned for reporting on international agreements.

Also, initial steps have been undertaken in 2009 in tracking of the financial sources through conduction of assessment on national sources spent on HIV/AIDS in 2008 following the NASA⁴¹.

⁴¹ National AIDS Spending Assessment methodology, UNAIDS

Figure 4. Data flow within the National M&E System



The major challenges in implementation of a comprehensive M&E System are:

1. Establishment of functional M&E Unit or department within the management institutions (Ministry of Health or IPH) with responsible for overall implementation of the M&E system that will not depend the resources from international donors. Until this unit for monitoring of the national response is officially established, the National M&E working group will undertake the responsibilities for implementation of the M&E System and M&E plan with support by the UN Theme Group on AIDS.
2. Ensuring M&E funding remains earmarked in Government budgets, as it represents a crucial tool for program implementation.
3. M&E technical assistance need to be provided in improvement of the human resource capacities not only at central level such as the capacities of the members of the M&E working group, but also the M&E capacities of the local self government representative. Provision of support in this area is already planned from the UN technical partners in the country and from the GFATM R7 HIV program in the country.