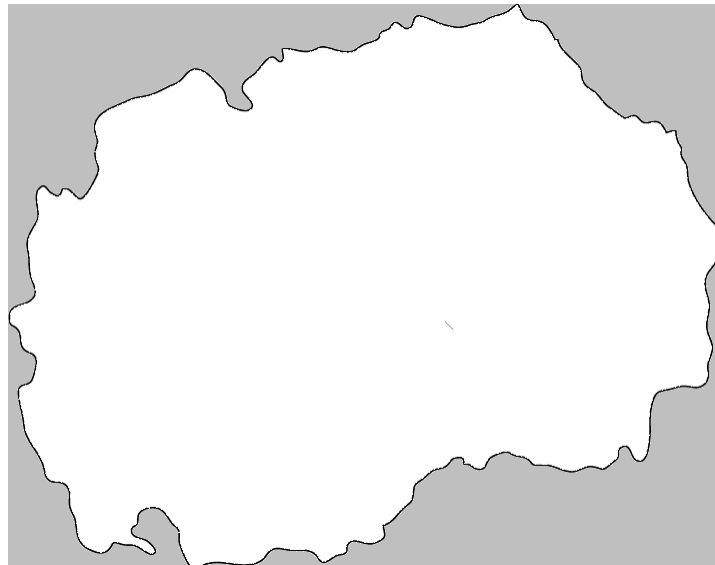




REPUBLIC OF MACEDONIA

UNGASS COUNTRY PROGRESS REPORT

Reporting period: January 2006-December 2007



31 January 2008

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 has signed the UNGASS Declaration on Commitments for HIV/AIDS, the 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 2003 – 2006. 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, as well as the priorities defined through the national consultation process on Universal Access to prevention, treatment, care and support, were the basis for setting the future priorities in the new National AIDS Strategy for 2007-2011.

This UNGASS Report for the period 2006-2007 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.

Minister of Health

Dr Imer Seljmani

Glossary

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral therapy,
BSS	Behaviour surveillance surveys
BCC	Behaviour Change and Communication
CCM	Country Coordination Mechanism
CID	Clinic for Infectious Diseases
CRIS	Country Response Information System
EU	European Union
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)
IPH	Institutes for Health Protection
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)
PIH	Partnership in Health
PLWH	People living with HIV
PMTCT	Prevention of mother to child transmission of HIV
RIHP	Republic Institute for Health Protection
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 2008 was prepared by the members of the National AIDS Commission with technical guidance from the Ministry of Health and the Republic Institute for Health Protection. This report encompasses the valuable progress made in the national response to HIV/AIDS during the period 2006-2007 in addressing the priorities defined within the national consultation process on Universal Access to prevention, treatment care and support.

The work on this report started in October 2007 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 Republic Institute for Health Protection, 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 January 17, 2008, where Part A of the NCPI has been completed with inputs from representatives of 10 governmental institutions. At the second meeting held on January 18, 2008, Part B of the NCPI was completed with inputs from representatives of 7 UN agencies, 7 NGOs, Macedonian Harm Reduction Network¹ and the Ombudsman office. Once the NCPI form was completed, it was resent to all involved parties for further feedback and comments.

Data from the bio-behavioural studies on HIV-prevalence, knowledge and behaviours, as well as their interpretation have been discussed at a special

¹ Consisted of 16 NGOs working on HIV/AIDS issues

meeting held on January 23, 2008 with the representatives of the RIHP, MoH and NGO representatives included in the studies.

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 and was discussed on the final consultation meeting organized on January 29, 2008. On January 30, the report and its findings have been presented on the meeting of the Country Coordination Mechanism (CCM)². Comments and inputs from both meetings are included in this final report, prior to its official submission on January 31 2008.

During the whole process, 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 102 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. Further more, 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 2006-2007 include the following:

Impressive work accomplished through the HIV program supported by the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), contributed to

² CCM was established in 2003 for the GFATM program by joining the National AIDS and National TB Commission and consists of 57 members.

successful implementation of the key priorities and activities planned with the National AIDS Strategy 2003-2006 and resulted in overall increase in coverage of clients reached and types of services provided.

The GFATM HIV program has 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 2003-2006, as well as political support in successful implementation of specific HIV prevention programs. For example, the newly 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 and development of the new National AIDS Strategy 2007-2011 endorsed by the government in October 2007.

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 4, 6, 7 and 9, are partially filled out due to lack of data or estimates for the denominator. Indicators Number 5, 10, 12 & 22 are not reported at all as not relevant for Macedonia as 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 2005 : 181.352.922,00 MK denars	1) Assessment of national expenditures on HIV/AIDS following National Aids Accounts. 2006. 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)	See ANNEX NCPI	Results from two meetings for NCPI and final report consultation meeting
National Programmes		
Indicators	Status: 2006-2007	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	Partially reported indicator Numerator: 11 (2006) 15 (2007) Denominator: estimates not available	Clinical records from the Clinic for Infectious Diseases in Skopje
5. Percentage of HIV-positive pregnant women who receive antiretroviral to reduce the risk of mother-to-child transmission	Not relevant (no HIV-positive pregnant women in 2006 and 2007)	
6. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	Partially reported indicator Numerator: 2 (2007) Denominator: estimates not available	Clinical records from the Clinic for Infectious Diseases in Skopje
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: 2.81%	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: 22.17% Male: 18.72% Female: 25.80%	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 sexual transmission of HIV and who reject major misconceptions about HIV transmission	SW: 46.67% Males: 66.67% Females 42.67% MSM: 41.03% IDUs: 34.46% Males: 32.43% Females 47.17%	Surveillance studies on HIV prevalence and risk behaviours among most-at-risk-populations, 2007. RIHP
15. Percentage of young women and men who have had sexual	All: 4.91% Male: 8.29%	Surveillance studies on HIV prevalence and risk

intercourse before the age of 15	Female: 1.35%	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 ³	
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 ⁴	
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client	All: 77.91% Males: 92.86% Females: 75.00%	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	All: 50.76% Males: 50.68% Females: 51.16%	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	All: 72.73% Males: 73.37% Females: 68.63%	Surveillance studies on HIV prevalence and risk behaviours among most-at-risk-populations, 2007. RIHP
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: 44.44% Males: 42.86% Females: 50.00% Adults: 44.44% Children: 0.00%	Clinical records from the Clinic for Infectious diseases in Skopje

³ 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%

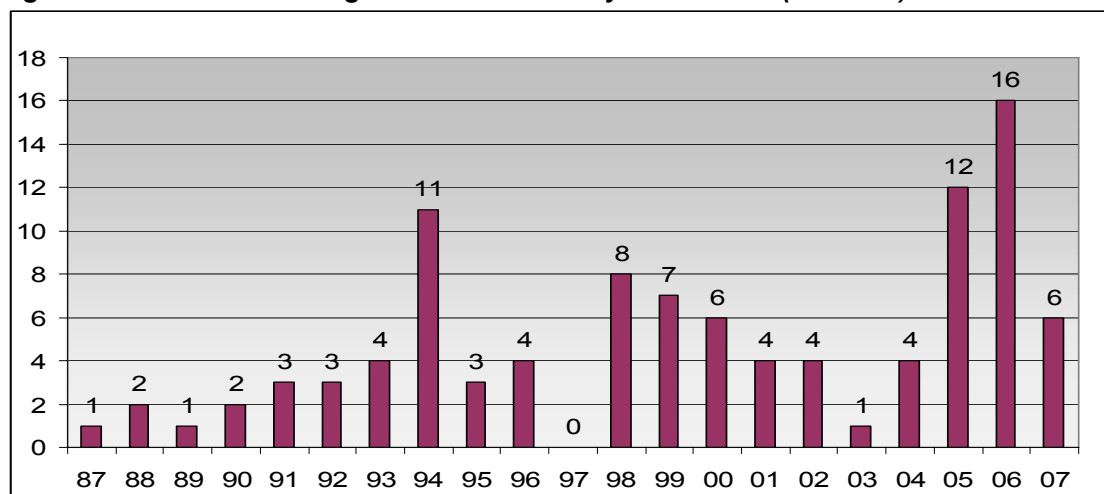
⁴ Data available from MICS study 2005-2006 only for women age 15-24 who used condom at last sex with non-marital, non-cohabiting partner and is 69.8%. (MDG indicator 19a)

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 Republic Institute for Health Protection, the cumulative total number of registered HIV/AIDS cases as of 31 December 2007 is 102 with 76 AIDS and 26 HIV positive. More than one third of all cases have been reported in the last 3 years 2005-2007. 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 2006-2007, 22 new HIV cases were registered; 16 in 2006 and 6 in 2007 (Figure 1).

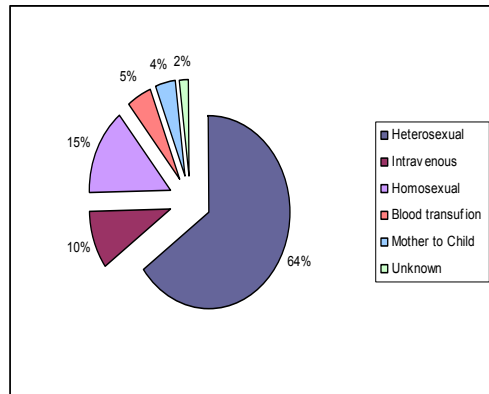
Figure1. Total number of registered HIV cases by end of 2007 (total 102)



Source: RIHP Macedonia, 2007

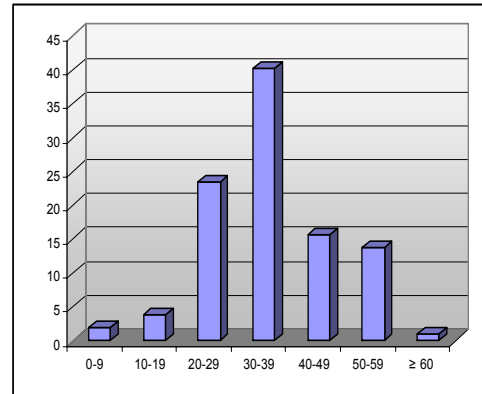
Out of 102 HIV cases between 1987 and 2007, more than two thirds are males. Heterosexual transmission was assessed to be predominant mode of transmission with 64%, following homosexual with 15% and intravenous with 10% (Figure 2). Reported cases in age group 30-39 years (40%) and age group 20-29 years (24%) contribute to more than two thirds of all reported HIV cases (Figure 3).

Figure 2. Mode of transmission



Source: RIHP Macedonia, 2007

Figure 3. HIV cases by age groups



Source: RIHP Macedonia, 2007

Since the onset of the epidemic till the end of 2005, most of the new reported HIV/AIDS cases were already AIDS patients. In 2006 and 2007, 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 those diagnosed with HIV is high, 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.

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

		SW	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%⁵	1(0.42%) 0.75%⁶	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 associated with the small sample size and its representativeness (convenient sample size used, including most-at-risk populations that already use HIV preventive services).

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 service⁷, 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 2007, this service covered 277

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

⁶ % refers for the capital city as reported in UNGASS indicator number 23 - IDUs

⁷ The service is provided through a mobile van that offers HIV counseling and testing (including condom distribution) only in the capital city Skopje, 5 days during the week. The teams are comprised of NGO counselor (working with different target groups) and a laboratory technician from the Republic Institute for Health Protection

MSM; 103 SW; 208 IDU; 185 Prisoners. Through this service, two HIV positive cases have been identified and both 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;
- 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 more 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). 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. In addition to and complementary with the GFATM HIV program, a National AIDS prevention programs run yearly, on the basis of the Law on Health Protection.

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 (PCR, CD4 counter) 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 2006 and 2007, 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 for establishment of new drug substitution centres, 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. He made a public call to the Mayors to join the MoH efforts in establishment of these centres in the capital city, as a good example for the best harm reduction practices. As a result of this initiative, the first such centre is in process of establishment in one Roma settlement in the capital city - Skopje. 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.

At the end of 2007, thematic session on the role of the parliament in the national response to HIV/AIDS has been organized in collaboration with NGO HERA and the Ministry of Health for the members of the parliament. The session resulted with proposal for establishment of a parliamentarian lobby group which will be composed of representatives of different political parties with main mandate to support the national endeavours in the area of HIV/AIDS.

3. Financing

There have been considerable sources of funds to support implementation of the national AIDS response that has come from different resources both domestic and international development agencies in the last three years,. The major financial assistance was received from the GFATM HIV grant in an amount of \$5.9 million for the period 2005-2007. Additional support was provided by international organizations, such as, UNAIDS, UNICEF, WHO, UNFPA,

Partnership in Health (PIH), International Parenthood Planning Association (IPPF) and Norwegian Church Aid (NCA).

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. Assessment conducted by the Ministry of Health in 2006 on the public expenditures for 2005⁸, revealed that the country had spent total of 84,133,572 Macedonian denars (MKD) or 1,682,671\$ from two sources⁹. The first one is the Health Insurance Fund that covered all hospital expenditures in value of 76.693.572 MKD (\$1,533,871) and the second is the annual National AIDS Preventive Program that contributed with 7.440.000 MKD (\$148,800).

International sources contributed for the same year with the amount of 97,220,350 MKD (\$1,944,407) and they came from GFATM (67,228,000 MKD or \$1,344,560); UN donors (24,007,600 MKD or \$480,152) and Partnership in Health (5,984,750 MKD or \$119,695). Total sources spent on AIDS in year 2005 including public and international sources (no private sources allocated this year) are estimated in value of 181,353,922 MKD (\$3,627,078).

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.

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

⁸ Assessment was done following the "Methodological Guidelines for Conduction a National Health Accounts Sub-analyses for HIV/AIDS". Partners for Health Reform Plus/USAID (2004)

⁹ This assessment in 2005 has been used for reporting on public sources in the National Funding Matrix for AIDS Spending in this report

collaboration between governmental and non-governmental organizations. For example, the Centre for drug substitution treatment in the city of Strumica¹⁰ 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.

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.

¹⁰ The biggest city in the Southern East part of the country

PROGRAM IMPLEMENTATION

1. Prevention

Prevention programs have been substantially scaled up in the past 2 years through the GFATM HIV program targeting young people, IDU, SW, MSM, Prisoners and Roma community. Activities have been implemented in collaboration with the governmental institutions, civil society and 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 3 operational Harm Reduction services with Needle Exchange at the beginning of 2005 and five more have been established in other 5 cities by 2006. By the end of 2007, 8 new Harm Reduction services for Drug substitution treatment and ten new VCT centres have been opened in different regions of the country. In 2007, the work of the outreach VCT service was initiated in the capital city with focus on providing VCT services to hard to reach and most-at risk populations.

a) Knowledge change

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%¹¹ 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

¹¹ UNGASS indicator number 13

the primary and secondary schools does not integrate the life-skills based approach¹². For this reason, UNGASS indicator number 11 have 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.

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 transmission¹³. Two years later in 2007, 34.46% of IDUs and 41.03% of MSM could do so¹⁴. 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 2007¹⁵. 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 respondents¹⁶ and the sample size¹⁷. However, this increase clearly shows that the prevention services establishes 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.

¹² 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

¹³ UNGASS indicator number 10 in 2005 UNGASS Report

¹⁴ UNGASS indicator number 14 - IDUs and MSM

¹⁵ UNGASS indicator number 14 - SW

¹⁶ Some participants in the survey have been already reached with prevention services, so, higher knowledge is expected due to this intervention;

¹⁷ 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.

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%)¹⁸. For this reason UNGASS indicator number 9 was partially completed with plan these questions to be included in the next behaviour study in 2009.

Implementation of the GFATM HIV program enabled gradual increase of number of most-at-risk populations covered with the services in the period 2005-2007. For example, Needle Exchange Programs covered 1909 new IDUs by 2006 and cumulative of 2259 IDUs by end of October 2007. Substitution treatment in 2005 was available for only 320 clients and the number increased to 921 clients by end of 2006 to 1283 clients by end of October 2007, which is 400% increase in only 2 years. Furthermore, number of MSM covered with different HIV prevention services was 250 in 2004, 767 by 2006 and 975 end of October 2007¹⁹, which is 390% increase in 3 years.

Due to establishment of new VCT centers and availability of outreach VCT services, there has been an increase in the coverage from 250 clients in 2004, 2281 in 2006 to 4094 clients covered by end of October 2007.

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 result²⁰. 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)²¹. 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%²²

¹⁸ UNGASS indicator number 9

¹⁹ Data from the last HIV Program Progress report submitted to GFATM

²⁰ UNGASS indicator number 8

²¹ Data reported back in 2005 UNGASS Report referred only to the percentage of respondents who have been tested in the study conducted in 2005

²² UNGASS indicator number 7. Data come from MICS survey 2005-2006

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 recent study commissioned by UNICEF²³ 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 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 15²⁴. 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%²⁵.

²³ Mapping and community based research on most at risk adolescents of HIV/AIDS/STIs in Macedonia, UNICEF, 2008;

²⁴ UNGASS indicator number 15

²⁵ Data form MICS study 2005-2006

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 behavior 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 partner²⁶. Percentage of condom use among SW with their most recent client in behavioural study from 2007 is 77.91%²⁷ 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.

Condom use in MSM is 56.48%²⁸ 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%

²⁶ MDG indicator 19a

²⁷ UNGASS Indicator number 18

²⁸ UNGASS Indicator number 19

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)²⁹. 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.

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 2007.

For this reason and also since the criteria have been changed from the UNGASS Guidelines in 2005, UNGASS Indicator number 3 have not been reported. However, considering the recent national developments in the country in this

²⁹ 2005 UNGASS report

area as mentioned above, it is envisaged that the External Quality Assessment scheme will be fully introduced in 2008.

2. Treatment, care and support

HAART following the national protocol on ARV treatment and care was initiated for the first time back in 2005 with ARV drugs from the first line according to WHO and extended with the second line drugs in 2006. The cumulative number of patients receiving Highly Active Antiretroviral Therapy (HAART) by the end of 2007 is 20. 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, and provision of equipment for monitoring of HIV infection and ARV treatment.

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

Since there is no official data on the estimated number of adults and children with advanced HIV infection, UNGASS indicator number 4 was partially reported with total number of 11 patients on ARV treatment in 2006 and 15 in 2007. At present, there is only one child living with HIV/AIDS with initiated ARV treatment.

In the course of 2006 and 2007 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 2007, there were 2 cases of adults with HIV-positive incident TB and all received both ARV and TB treatment according to the national protocols³⁰.

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 44.44% (42.86% among males and 50.00% among females). The reason of such low % is the fact that 5 patients that have started ARV treatment in 2006 have been identified as

³⁰ UNGASS indicator 6 partially filled out due to lack of estimates on number of incident TB cases in people living with HIV

HIV positive in a terminal stage of AIDS and received ARV treatment for a very short time period³¹. However, it is expected that this percentage will gradually increase in the next years, now that HAART are available for period more than 2 years.

Although, considerable achievements have been made in the last two 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.

IMPACT ELEVATION

The overall impact of the national response to AIDS in the last two years could be seen in 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 recent approval of the new HIV grant by the GFATM in Round 7 is additional recognition for the well established, coordinated and improved national AIDS response.

The increase in political commitment of the country to strategically approach the AIDS epidemics has resulted in endorsement of the National AIDS Strategy for period 2007-2011 and the National Drug Strategy for period 2006-2012.

³¹ From start of the ARV treatment to the patients death there was period from 1 to 25 days in these five patients.

IV. Best practices

[Instructions: This section should cover detailed examples of what is considered a best practice in-country in one or more of the key areas (such as political leadership; a supportive policy environment; scale-up of effective prevention programmes; scale-up of care, treatment and/or support programmes; monitoring and evaluation, capacity-building; infrastructure development. The purpose of this section is to share lessons learnt with other countries.]

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. Dispersion of the Harm Reduction programs with substitution treatment in 8 new regions and main prison in capital city.

By 2005, there has been only one centre for prevention and treatment of drug abuse located in the capital city with maximum of 320 clients on substitution treatment. In the next two years, under the technical guidance from the staff in the existing centre, through joint collaboration among the Ministry of Health (MoH), Ministry of Labour and Social Policy (MLSP), NGOs, mayors as well as Faith Based Organizations eight new centres have been established in other cities throughout the country³². Additionally, one centre has been opened in the biggest prison Idrizivo located in the capital city Skopje.

This wide collaboration and support received from different entities was the curtail element for establishment of the new centres. For example, for the centre in Strumica premises have been provided by the Orthodox Church, some of the staff has been recruited from the Local NGO already working with IDUs and their salaries have been covered by the MLSP. The Ministry of Health through Health Insurance Fund covered the rest of the hospital expenses. The refurbishment of the centres, training of the staff and methadone was provided by the GFATM HIV program.

The opening of the new centres have contributed to significant increase of the newly included clients with total of 921 by end of 2006 to 1283 by end of October 2007, which is 400% increase in only 2 years. Also, additional 200 new prisoners have been included on substitution treatment in Idrizovo prison.

³² New centres are established in Strumica, Kumanovo, Ohrid, Stip, Gevgelija, Tetovo, Bitola, Kavadarci and Veles.

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

There were only three Needle Exchange programs³³ functional by 2005 with maximum coverage of 2000 IDUs. With the guidance and technical assistance from the NGO HOPS, managing the biggest program in Skopje, five new needle exchange programs have been established and managed by the local NGOs³⁴. Also, the existing program in the capital city of Skopje have been expanded with 2 new needle exchange units in Skopje and mobile outreach unit. In 2007, the Red Cross have established 3 additional needle exchange programs³⁵, which makes total of 11 functional programs with a wide geographical distribution in the country.

During 2006 and 2007 total of 2259 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 mobile unit

The outreach VCCT program was also part of the GFATM HIV program and started in February 2007. The activity 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 included 4 NGOs³⁶ working with different target population (MSM, CSW, IDU, Roma, prisoners, students in dormitories, and general population) and Republic Institute for Health Protection.

³³ In Skopje, Bitola and Strumica

³⁴ New needle exchange programs established in Kumanovo, Stip, Ohrid, Gostivar and Kavadarci

³⁵ In Prilep, Veles and Kicevo

³⁶ NGOs: HERA, HOPS, EGAL and DOVERBA

The outreach activities were 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 was that even not accustomed to similar medical outreach activity the trust of representatives from these so called hard to reach populations was successfully gained.

From the program initiation, in only ten months total of 1335 clients have been provided VCCT services, including pre-test counselling, HIV test using rapid tests and post test counselling. .

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.

V. Major challenges and remedial actions

The challenge reported in 2005 UNGASS Report was “Introduction of the Second Generation of Surveillance” as a special endeavour that the country had to face in order to provide comprehensive behavioural data supported by biological data that will offer a better insight in the status of the epidemic, especially among hard to reach population.

After the first national bio-behavioural studies conducted among hard to reach population in 2005, again in 2006 and 2007, the same type of studies have been repeated with improved study methodology and increase sample size among most-at-risk populations. Data gained from these studies will contribute to better understanding of the risk-behaviour and the prevalence among most-at-risk populations. However, further improvements in the study instruments and representativeness of the samples should be considered.

In the course of 2006 and 2007, Republic of Macedonia faced the following challenges:

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) are not available yet, besides the fact that, significant amount of prevention, treatment and other services have been provided and bio-behavioural studies have been conducted.
2. Weak capacities of the local self government in planning, implementation and monitoring of the national response to HIV/AIDS was the most important challenge identified initially with the national consultation process on Universal Access back in 2006.

Technical support in 2008 for the first two challenges has been envisaged from UN partners.

3. Increase in allocation of the national resources for financing the response to HIV/AIDS that will contribute additionally to the present and the new GFATM HIV program.

4. Establishment of sustainable system for continuous provision of ARV treatment. Assessment of the current status of ARV treatment has been conducted by an external expert at the end of 2007. Specific recommendations have been discussed with the authorities of the National Bureau of Drugs for streamlining ARV drugs registration and their availability on the local market. Also, recommendations have been discussed with the Minister of Health who showed his individual preparedness for provision of political support during this process.

5. Establishment of new centres for substitution treatment in the capital city. Although, eight 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 one centre, with no additional capacity to serve new clients. The main problem was the public pressure and disagreement on the location for the new centres. Following the good expedience from the other regions it is expected that the most appropriate location will be defined and centres will be opened in near future.

6. 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.

7. Expand coverage of “best practice” interventions for young people, nationwide. During this reporting period, good practices have been developed in

promotion of integrated “youth friendly” health services within the public health system. Currently, two health services operate in the capital city-Skopje, and serve as “best practice” models for integrated health and social services within public health institutions, primarily reaching out to most at-risk and most vulnerable groups of young people. Efforts have to be put in place to expand the network of the “youth friendly” health services and to institutionalize their existence within the framework of the current health system.

VI. Support from the country's development partners

During this reporting period, key support has been received from the GFATM in value of \$5.9 for the 3-years HIV program that have significantly contributed to implementation of the National AIDS Strategy 2003-2006.

Additionally, specific technical support has been provided from the UN (UNAIDS, 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;
2. Support to Government in development of relevant national policies, such as the new HIV/AIDS strategy (2007-2001) and the Adolescent Health Strategy (2008-2015);
3. Assisted the government to leverage additional resources for HIV/AIDS (new HIV grant in value of \$9.9 million from the GFATM approved in November, 2007) and review the current public expenditures in the area as to determine financial forecasts for full implementation of the new national HIV/AIDS strategy;
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;

Future actions need to be taken and planed 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. Support to planning, budgeting and coordination for a sustainable AIDS response, primarily to improve process of preparation of the annual National AIDS Preventive Programme³⁷, assure its coherence with the new National AIDS

³⁷ Directly funded from the state budget

Strategy Action Plan and increase capacities for its decentralized implementation, at regional and local level;

2. 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;

3. 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;

4. 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;

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/AIDS³⁸ 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 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 Republic Institute for Health Protection 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).

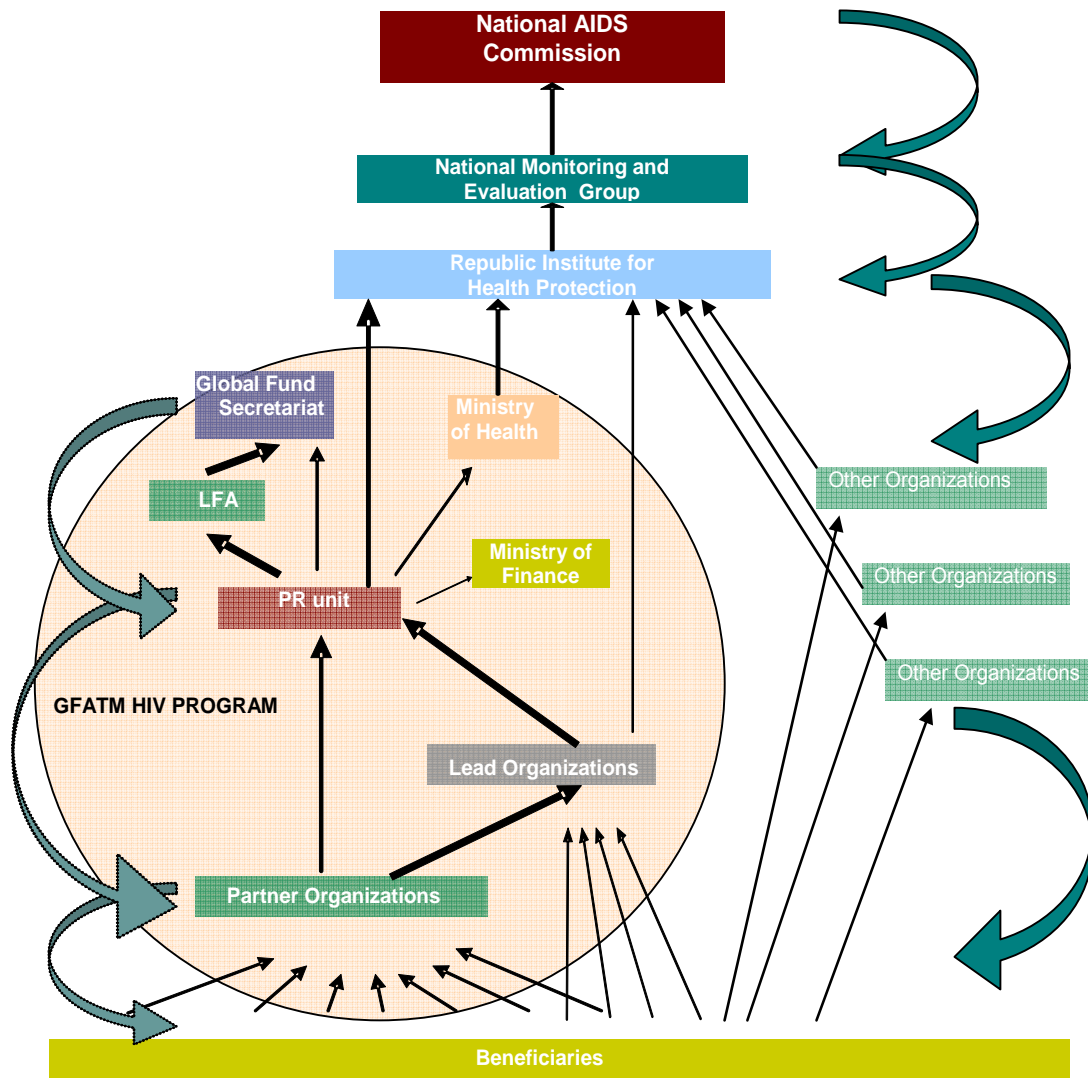
The improvement of the M&E of the national response could be seen through the efforts made for improvement of the surveillance system in the country. The bio-behavioural studies conducted in 2006 & 2007 were with improved study methodology, increased sample size and revised indicators aligned for reporting on international agreements.

Also, initial steps have been undertaken in 2006 in tracking of the financial sources through conduction of assessment on national sources spent on HIV/AIDS in 2005 following the National AIDS Account³⁹.

³⁸ Operational Guideline on M&E System integrating the M&E Plan for the GFATM HIV program

³⁹ Methodological Guidelines for Conduction a National Health Accounts Sub-analyses for HIV/AIDS. Partners for Health Reform Plus/USAID (2004)

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



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

1. The National M&E System needs to be updated in line with the strategic action areas in the new National AIDS Strategy 2007-2011. The new National Strategy for HIV/AIDS 2007-2011 envisages further strengthening and improved implementation of the National M&E System on HIV/AIDS. At present, the process for development of comprehensive Action and M&E plan for the next five years following the strategic action areas in the National AIDS Strategy for 2007-2012 is ongoing and expected to be finalized by March 2008.

2. Establishment of functional M&E Unit or department within the management institutions (Ministry of Health or RIHP) 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.

3. Epidemiological and clinical follow-up of the HIV/AIDS data are followed without available database applications and functional Health Information System in general in the country. Development of special database for epidemiological and clinical follow-up of the HIV/AIDS data is planed for the first quartile of 2008, thus will contribute to improved quality of data collected and reported.

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 planed from the UN technical partners in the country and form the new GFATM HIV program in the country.