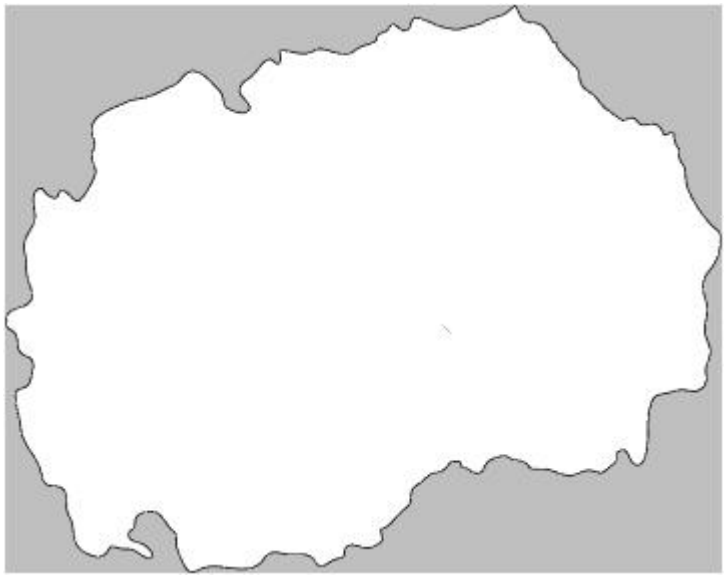
REPUBLIC OF MACEDONIA

GLOBAL AIDS PROGRESS REPORTING 2012
UNIVERSAL ACCESS IN THE HEALTH SECTOR REPORTING
DUBLIN DECLARATION



Reporting period: January 2010-December 2011

31 March 2012

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
GAPR	Global AIDS Progress Reporting
HAART	Highly Active Antiretroviral Therapy
HERA	Health Education and Research Association
HIV	Human Immunodeficiency Virus
IDU	Injection drug user(s)
ILDTB	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
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 GAPR Report 2012 was prepared by the members of the National HIV/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 2010-2011 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 February 2012 with active participation of all relevant national stakeholders and international partners through initial discussions 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 GAPR indicators, representatives from the Institute for Public Health, civil society organizations, 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 March 21, 2012, where Part B of the NCPI has been completed with inputs from representatives of 2 UN agencies and 4 NGOs. At the second meeting held on March 22, 2012, Part A of the NCPI was completed with inputs from representatives of 3 Government agencies. 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 are dating from 2010. As they are the latest available data, they are also reflected in this report. 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 146 HIV/AIDS reported cases that represents the second 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 key 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 study in 2010 indicate that high risk behaviours and in some groups and sub-groups low level of knowledge on preventioncvare still present among key 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 2010-2012 include the following:

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

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.
- Newly approved Round 10 HIV grant will furthermore enhance the HIV/AIDS response, coverage of key populations and will contribute to the next National HIV/AIDS Strategy 2012-2016.

Data reported for the GARP indicators are coming from the Clinical records, Surveillance study on HIV prevalence and risk behaviours among most-at-risk-populations, conducted in 2010 and MICS-Multiple Indicator Cluster Survey 2005-2006. In almost all cases, unless otherwise indicated, data are disaggregated by gender and age group.

II. Overview of the AIDS epidemic

Republic of Macedonia is low prevalence country with the one of the lowest number of 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 31 December 2011 is 144. Almost one half of all HIV/AIDS cases have been reported in the last 7 years .

Out of 144 HIV/AIDS cases between 1987 and 2011, almost three quarters are males.

Heterosexual transmission was assesed to be the predominant mode of transmission, following Homosexual and intravenoius. This seems to turn in the last 5 years and the epidemic now follows the Westen and Central European predominant mode-homosexual transmission (transmission among men-having-sex-with-men. Reported cases fall in the age group of 30-39.

Since the onset of the epidemic till the end of 2005, most of the new reported HIV/AIDS cases were already AIDS patients. During 2006-2011, this trend was 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.

III. National response to the AIDS epidemic

NATIONAL COMMITMENT

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 and 10 cycle. This scale-up of the existing HIV program provided continuation of all prevention services, with a special focus on key 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 National HIV/AIDS Strategy and its priorities.

1. Leadership

In the course of 2010 and 2011, the Ministry of Health, as member of the National AIDS Commission and the Country Coordinating Mechanism was actively involved in all national processes and provided continuous political support. The Minister supported the implementation of activities within GFATM HIV program, as a principal recipient of funds.
In 2011, thematic retreat of the Country Coordinating Mechanism took place, where this body was reconstituted. As a result of this process, chairing was rotated to National HIV/AIDS Coordinator and NGO sector, elected to lead the CCM in 2011-2013.
Also, CCM Secretariat was established, to support the day-to-day operations of the CCM.
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.

2. Financing

There has been significant re-shifting and increase in international sources of funds to support implementation of the national AIDS response, with GFATM as outstanding contributor to the funding. Other funding comes from five distinct resources-two domestic (Health Insurance Fund and Ministry of Health) and several international (UN and few international organizations with smaller grant initiatives: IPPF, OSI etc).
While international funds that have contributed to increase the number and expand the capacity of public services, public sources remained the same in 2010 and were reduced in 2011 significantly to the debts on HIV/AIDS in 2010.
The contribution of domestic funding to the overall funding need of preventive activities is still not meeting the expectancies, mostly due to the economic crisis in 2009, the financial crisis in 2010 and the country priorities that do not list HIV among the top ones.

3. 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; the Political Declaration on HIV/AIDS endorsed at the High Level Meeting on HIV/AIDS in UN, 2010 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.

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 2010 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.

PROGRAM IMPLEMENTATION

A. Prevention

Prevention programs have been substantially scaled up in the past years through the GFATM HIV program targeting 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.

By the end of 2010, 13 Harm Reduction services, 12 centres for Drug substitution treatment, 10 stationary VCT centres and 2 outreach VCT mobile units operate in different regions of the country.

B. Treatment, care and support

The total number of PLWHA enrolled in HIV treatment, care and support is 46.

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 European AIDS Clinical society protocol on ARV treatment and care.

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.
In the course of 2010 and 2011 as well as in general since the onset of the epidemic, there were no pregnant women identified to be HIV positive.
In the reporting period there were no cases of adults with HIV-positive incident TB.
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 falls under the responsibilities of the Government as of 2010 and two stockouts have been experienced both in 2010 as well as in 2011.

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. However, the rate of testing of TB patients on HIV is not meeting the expectations.

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 and jail in capital city.**

By the end of 2011, twelve centres for prevention and treatment of drug abuse were established. 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.
These services are also available in the largest Prison “Idrizovo” and the Jail “Skopje”.

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

There are 13 Needle Exchange programs functional by the end of 2011.
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 NGOs 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.
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 following challenges from UNGASS 2010 report were met in the course of 2010-2011:

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 BBS 2010 data
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 UN agencies in 2010 and 2011. As a result of this activity, a detailed work plan and budget, preventive programs for HIV/AIDS was developed for 2010 and 2011.

In the reporting period of 2010-2011, 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 and the financial crisis in in 2010 abrupt the steadily incline of domestic funding of the AIDS response. **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 and 10 proposal. The World 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. Week capacities of the national 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* in 2011. 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 planning, as well as implementation remains.

3. Establishment of sustainable system for continuous provision of ARV treatment-as the country entered Phase 2 of the GFATM R7 HIV Grant, it undertook 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 2011. Specific recommendations will be discussed with the authorities 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, twelve 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 program 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. An independent review of the school curricula undertaken by a consorcium of academia, civil society organizations and UN agencies, lead by NGO HERA recommended that a framework for compehensive sexual education should and was developed, while HIV/AIDS issues should also be fully incorporated into this broader strategy, as opposed to being pursued in an isolated manner.

VI. Support from the country's development partners

During this reporting period, key support has been received from the GFATM with Round 7 Grant for 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;
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 key and most vulnerable groups, that included operational support to training of service 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 Programme, 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;
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 comprehensive sexual education curriculum covering primary and secondary education;

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 GAPR 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/AIDS 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 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. However, although well designed and architectured on paper, the system practically does not exist at national level and limits its actions at GFATM M&E system.

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 2010 have an improved study methodology, increased sample size and revised indicators aligned for reporting on international agreements.

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.
2. Ensuring M&E funding remains earmarked in Government budgets, as it represents a crucial tool for program implementation.