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REPUBLIC OF MACEDONIA

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**Ministry of Health**  
**Government of the Republic of Macedonia**

**NATIONAL**  
HIV/AIDS Strategy  
**2007–2011**

**December 2007**



## National Multisectorial Commission on HIV/AIDS

The National Multisectorial Commission on HIV/AIDS has coordinated the preparation of the National AIDS Strategy 2007-2011. This document was officially endorsed at 97th Government meeting held on 9th of October 2007. The core team that formulated the National AIDS Strategy consisted of:

- Ass Dr Milena Stevanovik, National AIDS Coordinator,
- Snezana Cicevalieva, Ministry of Health
- Dr Jovanka Kostovska, Ministry of Health
- Dr Aleksandar Arnikov, Ministry of Health
- Prim Dr Zarko Karadzovski, Republic Institute for Health Protection
- Prof Dr Zvonko Milenkovic, Clinic for Infectious Diseases and Febrile Conditions
- Doc Dr Violeta Grunevska, Clinic for Infectious Diseases and Febrile Conditions
- Vlatko Dekov, NGO HOPS
- Zoran Jordanov, NGO EGAL
- Bojan Jovanovski, NGO HERA
- Natka Pacovska, NGO Doverba
- Dr Sandra Kuzmanovska, UNAIDS
- Dr Igor Veljkovic, UNICEF
- Dr Arta Kuli, WHO
- Dr Vladanka Andreeva, UNAIDS

The content of this strategy was discussed with wide range of national and international technical experts as well as other organizations and represents outcome of the work of broad expert and wider public of the Republic of Macedonia.

Special gratitude to the Joint Team on HIV/AIDS for support and assistance in the overall process of development of the National Strategy as well as for the printing of this publication.

Skopje, December 2007



Joint United Nations Programme on HIV/AIDS

# UNAIDS

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## 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. Health problems do not have borders, the same as diseases, especially HIV/AIDS.

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 undertakes 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 by the previous strategy for the period 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 previous AIDS strategy, situation analysis, as well as the priorities defined through the national consultation

process on Universal Access to prevention, treatment, care and support, are the basis for setting the future priorities.

The national response must be a continuous process of well-defined measures and efforts by the Republic of Macedonia on both horizontal and vertical levels, not only a short-term campaign. Therefore, this Strategy for the period 2007-2011 defines future directions for the overall response of our country in the prevention of an HIV epidemic and provision of appropriate treatment, care and support to people living with HIV/AIDS. Only through well-defined strategic priorities and their actual implementation, do we create conditions for successful prevention of HIV infection and populations' health protection.

If we understand health as an investment in overall economic growth and development, then this strategy with its cost-effective measures, such as the proposed preventive measures, contributes to building of health system focused on patient and citizen, with well-defined public health direction – there is no cheap health protection for poor patients. Everybody has a right to health. Society is responsible for the provision of HIV/AIDS prevention.

The responsibility for a well-organized response to this challenge stands with the Government of the Republic of Macedonia.

This Strategy is the best example for that.

**Dr Imer Selmani,**  
**Minister of Health of the Republic of Macedonia**

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# Glossary of Terms

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral
CCM	Country Coordinating Mechanism
CRIS	Country Response Information System
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug User
M&E	Monitoring and Evaluation
MSM	Men who have Sex with Men
NAC	National AIDS Council
NGO	Non-Governmental Organization
OVC	Orphans and Vulnerable Children
PEP	Post Exposure Prophylaxis
PMTCT	Prevention of Mother to Child Transmission
STI	Sexually Transmitted Infection
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint UN Program on AIDS
UNGASS	UN General Assembly Special Session
VCCT	Voluntary Confidential Counseling and Testing
ZELS	Association for Local Self-Government

# INTRODUCTION

## *National AIDS Strategy 2003-2006*

Macedonia's first National AIDS Strategy operated from 2003–2006 (1). It was developed through a consultative process including all key stakeholders, including government, NGOs, faith-based groups, academic institutions and members of the UN Theme Group on HIV/AIDS. It was strongly focused on those most vulnerable to HIV infection, and included a monitoring and evaluation framework, incorporating core indicators for reporting on progress in implementing the 2001 UNGASS Declaration of Commitment on HIV/AIDS. This declaration contained specific goals to which all UN member states committed, including Republic of Macedonia.

Support for the national strategy has come from a number of sources including the government budget and international organizations, including the UN Theme Group, UNAIDS, UNICEF, UNDP, WHO and the Swedish, Canadian, American and Irish Governments. From November 2004, the Global Fund to Fight AIDS, TB and Malaria provided Macedonia with a three-year grant, worth \$6.3 million. This grant has significantly boosted Macedonia's ability to implement its National strategy for the period of 2003-2006 through the Ministry of Health as Principal Recipient and 34 partner organizations contracted as sub-recipients.

Through the implementation of the program supported by the Global Fund to fight against HIV/AIDS, Tuberculosis and Malaria a strong government/civil society partnership has been built which provides a solid foundation for this new National AIDS Strategy for 2007-2011.

## International legislative frame

References to law on health, non-discrimination and protection of the patients' rights are:

- The UN international pact on economic, social and cultural rights, 1966
- The UN Civilian and Political Rights Pact, 1966
- The UN Convention on elimination of all the forms of discrimination towards women, 1979
- The UN Convention on elimination of all the forms of racial discrimination, 1965
- Convention for protection of the human rights and freedoms of the Council of Europe, 1950
- The European Social Charter of the Council of Europe, 1961
- UN Convention on the rights of children, 1989, Framework Convention for protection of the national minorities of the Council of Europe, 1995
- The WHO Amsterdam Declaration for promotion of the patients' rights in Europe, 1994
- The European Charter on the patients' rights of the Council of Europe, 2002
- Declaration on AIDS efforts, adopted by UNGASS 2001
- The Dublin Declaration of the EU member states for the activities against HIV/AIDS in prisons, 2004
- The Bremen Declaration of the EU member states on responsibility and partnership in the fight against HIV/AIDS, 2007

## Achievements

Key achievements under this strategy by end of 2006 included:

- Establishing and scaling up harm reduction services for intravenous injecting drug users, which since 2003 included over 4,000 persons from which more than 3,909 persons used needle and syringe exchange programs and 921 accessing drug substitution therapy (methadone).
- Scaled-up Voluntary Confidential Counseling and Testing Services for HIV/AIDS (VCCT) including the establishment of six new VCCT centers at Regional

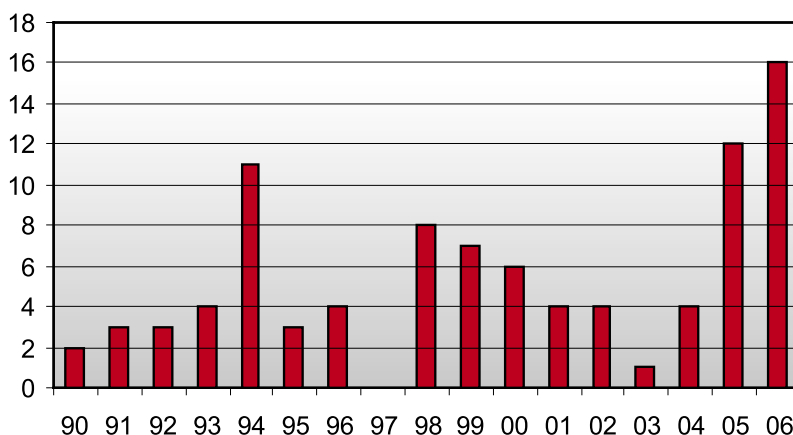
Institutes for Health Protection and four outreach teams working with most-at-risk populations.

- Conducting national bio-behavioral studies in 2005 and 2006 among the most at-risk populations.
- Introduction of combination of antiretroviral therapy for people living with HIV, with 12 people on treatment by end of 2006.
- Significant advances in introducing the 'Three Ones' principle of UNAIDS, including establishment of: One agreed National HIV Action Framework coordinating the work of all partners, One National AIDS Coordinating Authority for fight against HIV/AIDS with a broad-based, multi-sectoral mandate and One agreed, country-level Monitoring and Evaluation system.

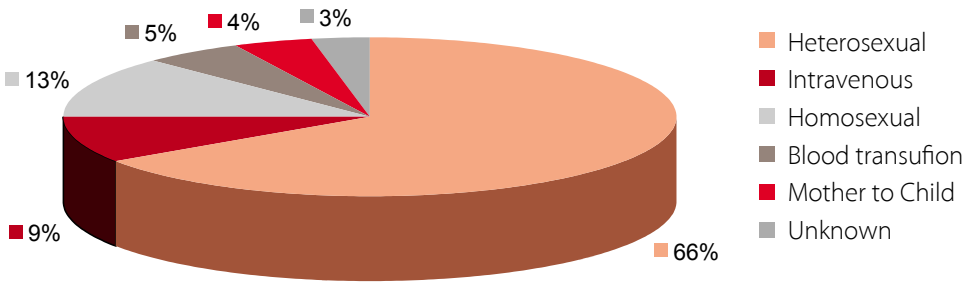
### Trends in Macedonia's Epidemic

HIV prevalence has remained very low in Macedonia, including among populations considered most-at-risk. By the end of 2006, 96 people in total had been identified as infected with HIV. Of these, 69 were cases of AIDS and 53 were known to have died. Almost three quarters of reported cases (70%) were among men and almost all were reported to have occurred through heterosexual transmission. However, this does not explain why the ratio of men to women infected is almost 2:1. It is likely that other routes of infection, e.g. sex between men and injecting drug use are under-reported. More than two thirds of reported cases (69%) were among people living in cities. Two-thirds (66%) of all cases were among people aged between 20-39.

**Chart 1. Number of registered HIV cases (1990-2006)**



**Chart 2. Mode of transmission**



In 2006, the highest number of new cases (16) since the start of epidemic was registered. However, it is most likely that the increased number is at least partly due to increased and earlier diagnosis of HIV due to greater availability of VCT services in the country, financed by the grant of the Global Fund to fight against HIV/AIDS, Tuberculosis and Malaria.

### **Most-At-Risk Populations**

To date, the response of the Republic of Macedonia to HIV has focused on certain groups considered most vulnerable to HIV infection. However, membership of a particular group does not increase a person's risk of infection. Rather, it is a person's behavior and exposure to the virus, which puts them at risk, or puts the certain group at risk. The link between one person and a certain most-at-risk population is made only from the aspect of implementation of prevention and treatment measures and does not have by itself any purpose for marking or stigmatization.

Data from behavioral studies conducted in 2005 show the need for focusing of the preventive interventions to most at-risk populations, such as injecting drug users, sex workers, men that have sex with men and prisoners, regardless of their age, sex, religion or ethnicity (2). In addition, the study among these populations showed that they expose themselves and engage in multiple high risk behaviors and from these reasons, targeting most of the prevention activities at these groups is justified. Moreover, the mapping and community-based research among most-at-risk-adolescents of HIV/AIDS/STI show the same (3). Additionally, most at-risk populations deserve special attention and priority in this strategy because of the associated level of stigma and discrimination, which represents a special challenge for access and provision of health and social services to these groups.

This approach towards the most at-risk populations fits well with current international practice and recommendations for priority programs in countries of low prevalence, such as the Republic of Macedonia. Namely, in June 2006, UNAIDS

identified injecting drug users, sex workers, men that have sex with men and prisoners as four key segments of the populations that were neglected and at risk<sup>1</sup>(4). Recently, UNAIDS published practical guidelines for intensifying HIV prevention through universal access, which outlines effective approaches in different scenarios, including low-level epidemics<sup>2</sup>(5). This guideline included the following four priorities:

- Regularly collect and analyze data on HIV prevalence, risk behaviors and its drivers;
- Build the knowledge and capacity of the most-at-risk populations, as successful prevention with this population will reduce the spread of HIV within vulnerable groups;
- Prioritize actions to combat stigma and coercive measures, which are significant barriers to the participation of those most at risk and people living with HIV/AIDS in prevention efforts:
- Implement programs with active participation of the most-at-risk population at sufficient scale and intensity.

## **Achieving 'Universal Access' in Macedonia**

In common with other countries, the Republic of Macedonia has committed to achieving universal access in prevention, treatment, care and support for people living with HIV/AIDS. From December 2005 to July 2006, national consultations were held with key civil society, governmental and other stakeholders. These were focused on identifying barriers to scaling up services, and defining ways to overcome the barriers in the three main areas: prevention, treatment, care and support. Obstacles identified included:

- Lack of consistent multi-sectoral coordination at national level;
- Lack of coordination in dissemination of information and harmonization of HIV prevention efforts between various key stakeholders such as Government bodies, NGOs, international partners and donors;
- Protocols and guidelines in HIV programs are well-developed but are often not utilized;
- Lack of capacity and participation of the local government in addressing HIV infection, and
- Insufficient governmental commitment to HIV prevention, as evidenced through weak financial commitment and limited public expenditure.

1 UNAIDS (2006) 2006 Report on the Global AIDS Epidemic Chapter 5, At Risk and Neglected: Four Key Populations

2 UNAIDS (2007) Practical Guidelines for Intensifying HIV Prevention towards Universal Access UNAIDS/07.07E

This national process and its outcomes are important guidelines in the designing of this strategy, which will guide the Republic of Macedonia in scaling up the services towards universal access. This will aim to provide a comprehensive package for HIV prevention, treatment, care and support services to all who need it, based on a number of key principles identified in this document.

## **Decentralization of Services**

The Republic of Macedonia is undergoing a political decentralization process. The National Universal Access consultation process identified the need to address the lack of capacity and participation of local governments in addressing HIV/AIDS. This strategy includes activities to promote greater involvement of local government in the response to HIV/AIDS including the establishment of municipal coordination mechanisms to improve cooperation at a local level. This will be done initially in three pilot municipalities. These will be selected based on estimations of location and size of most-at-risk populations. A large number of governmental documents indicate the lack of local self-government capacity in short period of time to undertake their obligations prescribed by law, both due to insufficient financial support and human resource capacities. At the same time, coordination of the national and the local authorities is not entirely established, which from the aspect of HIV/AIDS is a significant issue and should be further elaborated as to define sustainable coordinating mechanisms. Progress in this area will be evaluated in 2008. The results of this evaluation will be used to develop plans for concrete activities to improve the current situation.

# Overall Goal

The overall goal of this strategy is **to maintain low HIV prevalence in the Republic of Macedonia** over the next five years, i.e. until 2011.

Table 1 shows indicators<sup>3</sup> that will be used to track progress towards this goal including current baselines and proposed targets. Further details regarding the approaches needed to track these indicators are contained in Annex 1.

**Table 1: Proposed Indicators for tracking goal of the National strategy on HIV/AIDS of the Republic of Macedonia for 2007-2011.**

Goal: To maintain low HIV prevalence in the Republic of Macedonia							
Indicator description	Baseline		Target				
	Value	Year	2007	2008	2009	2010	2011
HIV prevalence among IDUs	0% (0/137) <sup>4</sup>	2005			<3%		<5%
HIV prevalence among sex workers	0% (0/48) <sup>4</sup>	2005			<3%		<5%
HIV prevalence among MSM	0% (0/14) <sup>4</sup>	2005			<3%		<5%
HIV prevalence among prisoners	0% (0/200) <sup>4</sup>	2005			<3%		<5%
Percentage of young women and men aged 15-24 reporting the use of a condom the last time they had sex with a non-marital, non-cohabiting sexual partner	77% (2162/2808) <sup>5</sup>	2005			>82%		>85%
Percentage of injecting drug users who have adopted behaviors that reduce transmission of HIV, i.e., who avoid sharing equipment and use condoms in the last month	36% (155/431) <sup>5</sup>	2005			>50%		>55%

3 Where appropriate all indicators proposed in this document should be disaggregated for sex and age

4 Results from biologic study. The numerator is the number of people detected as HIV positive. The denominator is the total sample size in the study

5 Results from behavioral study. The numerator is the number of people reporting particular behavior. The denominator is the total sample size in the study

## Goal: To maintain low HIV prevalence in the Republic of Macedonia

Indicator description	Baseline		Target				
	Value	Year	2007	2008	2009	2010	2011
Percentage of sex workers reporting the use of a condom with their most recent client	78% (56/72) <sup>5</sup>	2005			>82%		>85%
Percentage of men reporting the use of a condom the last time they had sex with a male partner	79% (149/189) <sup>5</sup>	2005			>82%		>85%
Percentage of prisoners reporting the use of condom during last sex (with regular, out-of-prison sexual partner during visit	25%	2005			>35%		>40%
Percentage of adults and children with HIV still alive 12 months after initiation of antiretroviral therapy	0% <sup>6</sup>	2005			>85%		>90%

<sup>6</sup> HAART was initiated in the Republic of Macedonia at the end of 2005

# PRINCIPLES

This strategy will be applied based on the following guiding principles:

- All HIV efforts/programs will have the promotion, protection and respect of human rights, including gender equality;
- In the implementation of the planned HIV activities/programs, are respected the common principles for cooperation with the non-governmental and private sector, as well as the principles of transparency, independence, partnership and mutual confidence;
- HIV prevention programs must be differentiated and locally adapted to the relevant epidemiological, economic, social and cultural contexts in which they are to be implemented. In the Republic of Macedonia, this includes taking into account the decentralization process, ensuring that the programs are designed at the municipal level, with activities tailored to the needs of local populations and groups, using activities, messages and channels based on community knowledge and culturally sensitive to community beliefs;
- HIV prevention actions must be supported with evidence, based on what is known and proven effective from all available data<sup>7</sup>, and the evidence base should be expanded and strengthened;
- HIV prevention programs will be comprehensive in their scope, using the full range of effective policy and programmatic actions with built-in quality assurance and improvement mechanisms to meet accepted standards and opportunities for qualitative improvement;
- HIV prevention is for life and requires continued activities of the society/community and the individual as well: hence, the delivery of existing programs, research and development of new technologies require a long-term and sustained effort, recognizing that results will be seen over the longer term. They need to be sustainable and maintainable in order to contribute to the development of capacity building systems, to formalize the informal groups, develop skills, financial systems and supervisory mechanisms;
- Implementation design will take into account the changes occurring in this field and make the necessary adjustments to be responsive to challenges and make the best of what the changes impose;
- HIV prevention programming will be at a coverage, scale and intensity that is enough to make a critical difference. There should exist a possibility to observe,

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<sup>7</sup> Data sources include researches, formative research, epidemiological data, demographic and health surveys, and well-documented, successful interventions conducted locally or elsewhere

document and present the situation as concrete outputs, with monitoring and evaluation systems to help demonstrate the objective delivery of the results;

- Community participation of those for whom HIV prevention programs are planned to define the needs, perceptions, attitudes, beliefs and obstacles is critical to make positive impact. The needs will be identified through initial data collection, previous research and new formative research.
- The national strategy implies confronting the epidemic and relying on partnerships, cooperation with all entities that may contribute to achieve its strategic goals.



## STRATEGIC ACTION AREAS

The strategy's overall goal will be achieved by carrying out programmatic and policy actions in five strategic action areas, namely:

1. **Prevention from HIV infection of the most-at-risk populations<sup>8</sup>;**
2. **Other prevention strategies/activities;**
3. **Provision of treatment, care and support to people living with HIV/AIDS;**
4. **Collection and use of strategic information;**
5. **Coordination and capacity building.**

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<sup>8</sup> For the purpose of this document, these population groups are taken as the four 'at-risk and neglected population groups identified by UNAIDS in chapter 5 of the 2006 Report on the Global AIDS Epidemic, namely sex workers (and their clients), injecting drug users, men who have sex with men and prisoners.

## STRATEGIC AREA **1** :

### *Prevention from HIV infection among Most-at-Risk Populations*

This strategic action area is focused on preventing HIV transmission among the most-at-risk populations, particularly injecting drug users, sex workers, men who have sex with men and prisoners. Specific activities to be conducted under this strategic action area include:

- Training of health, social and legal professionals in how to work with 'hard-to-reach' and 'most at-risk' populations;

#### **1. Injecting drug users- IDUs**

- Expansion of the 11 existing harm reduction programs<sup>9</sup> for intravenous injecting drug users through needle and syringe exchange programs and establishing two new programs in Tetovo and Gevgelija;
- Sensitization training of the local authorities, the police officers and health/social professionals to create a more supportive environment for harm reduction activities within the harm reduction programs for intravenous injecting drug users;
- Expansion of eight existing harm reduction centers from intravenous drug use through drug substitution treatment and establishment of four new centers;

<sup>9</sup> Currently the programs are ongoing in Skopje, Bitola, Strumica, Ohrid, Kumanovo, Stip, Kavadarci and Gostivar. Macedonian Red Cross has recently established three new programs in Prilep, Veles and Kicevo.

- Establishment of a network of family doctors providing drug substitution therapy to injecting drug users;
- Holding a national conference on harm reduction among injecting drug users every two years (i.e. twice during life of strategy);
- Supporting study tours for professionals on training and experience exchange on harm reduction for injecting drug users;
- Distribution of condoms and education information for HIV/AIDS prevention;

## **2. Sex workers - SW**

- Distribution of condoms and information to street sex workers and their clients;
- Provision of medical and other services, including the treatment of STIs, to street sex workers;
- Ongoing support and providing services to drop-in center for street sex workers in Skopje;
- Establishment of outreach services for sex workers outside Skopje, i.e. in Gostivar, Bitola and Strumica;

## **3. Men that have sex with men - MSM**

- Expanding the counseling activities and the help-line for information on HIV/AIDS for MSM;
- Conducting outreach activities in 'cruising' areas of MSM including the distribution of educational materials, condoms and lubricants;
- Provision of peer education activities for MSM. This will involve training of new peer educators in the first two years of the strategy;
- Establishment of two new offices providing services to MSM outside Skopje;

## **4. Prisoners**

- Further development of the existing harm reduction centers from intravenous drug use through drug substitution treatment within KPU Idrizovo and establishment of new center in the investigating prison in Suto Orizari, Skopje;

- Organization of educational session on HIV/AIDS prevention and distribution of condoms among prisoners.

Table 2 shows indicators that will be used to track progress in this area, including current baseline and proposed targets.

**Table 2: Proposed Indicators for tracking Strategic Area 1**

<b>Strategic Area 1: Prevention among most-at-risk populations</b>							
<b>Indicator description</b>	<b>Baseline</b>		<b>Targets (excluding baseline)</b>				
	<b>Value</b>	<b>Year</b>	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>	<b>Year 4</b>	<b>Year 5</b>
Number of IDUs reached with harm reduction (needle exchange programs)	3909	2006	495	1085	1580	2075	2555
Number of IDUs reached with harm reduction programs (substitution treatment)	921	2006	340	610	880	1140	1400
Number of sex workers reached with targeted HIV/AIDS outreach activities	156	2006	148	293	438	583	728
Number of MSM reached with targeted HIV/AIDS outreach activities	618	2006	360	734	1159	1649	2174
Number of prisoners reached with harm reduction programs (substitution treatment)*	220	2006	250	250	250	250	250

\* Baseline included in targets

## STRATEGIC AREA 2:

### Other prevention strategies/activities

In addition to the focused prevention activities among the most at-risk populations highlighted above, this strategy proposes wider prevention activities in a number of other areas including prevention of mother-to-child transmission; voluntary HIV/AIDS counseling and testing; HIV prevention in health care settings and HIV prevention among young people.

Specific activities to be conducted under this strategic action area include:

#### **1. Capacity building for provision of services for prevention of mother-to-child transmission (PMTCT)<sup>10</sup>**

- Training of health workers for provision of services for prevention of mother-to-child transmission.

#### **2. Voluntary confidential counseling and testing (VCCT) for HIV/AIDS**

- Provide voluntary confidential counseling and testing through a network of VCCT centers throughout the Republic of Macedonia;
- Provide outreach VCCT to most-at-risk populations;
- Revise and update the manual for counseling and testing.

<sup>10</sup> Given the very low HIV prevalence in Macedonia, it is preferable to target PMTCT services to those most vulnerable, e.g. sex workers, sexual partners of IDUs etc.

### **3. Prevention of HIV infection in health care settings through application of universal and specific measures of caution**

- Application of universal measures of caution in health care settings;
- Application of specific measures of caution, more precisely Post Exposure Prophylaxis (PEP).

### **4. Preventive activities with the young people.**

- Develop, adapt, and print education manuals for young people;
- Train trainers in youth peer education for HIV prevention among young people;
- Train youth peer educators (including educators who will work with young people most-at-risk);
- Conduct peer education activities as outreach services, within schools/institutions;
- Train teachers from primary and secondary schools on education for HIV prevention;
- Revise and implement curricula on HIV prevention and reproductive health;
- Training of health and social workers for providing services in the Youth Friendly Services;
- Further provision of services in the Youth Friendly Services and services for especially vulnerable young people;
- Develop educational brochures for young people;
- Promotion and distribution of condoms among young people including most-at-risk adolescents.

Table 3 shows indicators that will be used to track the progress in this strategic action area, including current baselines and proposed targets.

**Table 3: Proposed Indicators for tracking Strategic Area 2**

<b>Strategic Area 2: Other prevention strategies/activities</b>							
<b>Indicator description</b>	<b>Baseline</b>		<b>Targets (excluding baseline)</b>				
	<b>Value</b>	<b>Year</b>	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>	<b>Year 4</b>	<b>Year 5</b>
Number of people completing testing and counseling <sup>1</sup>	1668	2006	1500	3300	5400	7800	10500
Number of young people reached through peer education	11252	2006	4780	10010	15640	21680	27920
Number of condoms distributed	461365	2006	256.000	512.000	768.000	1.024.000	1.280.000

<sup>11</sup> Disaggregated data on use of VCT services by most-at-risk populations will be collected in two main ways. First, this data will be collected, if possible, from service providers' records. Second, data will also be collected by suitable questions asked during bio-behavioral studies.

## STRATEGIC AREA 3:

### *Provision of treatment, care and support to people living with HIV/AIDS*

This strategic action area focuses on the provision of essential services for people living with HIV/AIDS. This includes not only the treatment with antiretroviral therapy, but also other activities, such as the prevention and treatment of opportunistic infections. It also includes other elements of care and psychological support to people living with HIV/AIDS.

Specific activities to be conducted under this strategic action area include:

- Provide antiretroviral therapy and treatment for opportunistic infections to those people living with HIV/AIDS and therefore require such therapy/treatment;
- Establish and maintain a comprehensive, electronic clinical database of people living with HIV/AIDS in the Republic of Macedonia in line with EURO-HIV protocols;
- Continuous training of a team of clinical and laboratory staff able to provide treatment of ART and other services according to international standards;
- Revise protocol for treatment with ART at least once during the life of the strategy;
- Develop a booklet for people living with HIV/AIDS focused on living with HIV, including issues relating to ART;

- Improve the infrastructure and laboratory facilities at the Clinic for Infectious Diseases;
- Provide care and support for people living with HIV/AIDS through provision of home care, establishment of self-help groups and establishment of appropriate forms and instruments to provide legal and social support..

Table 4 shows indicators that will be used to track the progress in this strategic action area, including current baselines and proposed targets.

**Table 4: Proposed Indicators for tracking Strategic Area 3:**

<b>Strategic Area 3: Provision of treatment, care and support to people living with HIV/AIDS</b>							
<b>Indicator description</b>	<b>Baseline</b>		<b>Targets (excluding baseline)</b>				
	<b>Value</b>	<b>Year</b>	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>	<b>Year 4</b>	<b>Year 5</b>
Number of people receiving ART	12	2006	5	10	15	20	25
Number of people living with HIV reached with psychosocial support	35	2006	15	30	45	60	75

## STRATEGIC AREA 4:

### *Collection and use of strategic information*

In order to respond effectively to a possible HIV epidemic in the Republic of Macedonia information is required about the nature of the epidemic in the country. This needs to include information about the extent of the spread of HIV infection within most-at-risk populations, their risk behaviors as well as what is driving the spread of the epidemic in the country. There is also a need for information about the status of Macedonia's response to HIV/AIDS, more precisely about the degree to which the response is appropriate for the type and scale of epidemic faced by the country.

Specific activities to be conducted under this strategic action area include:

- Conduct bio-behavioral studies among most-at-risk populations during life of the strategy;
- Continue to use CRIS to collect and analyze information related to Macedonia's response to HIV/AIDS;
- Use of information to generate reports to meet international commitments made by Macedonia, (e.g. the UNGASS Declaration of obligations for HIV/AIDS in 2001, and reporting on the Universal access in 2008 and 2010);
- Estimation of the size of most-at-risk populations of HIV infections in Macedonia;
- Conduct mid-term and end-term evaluations of national strategy implementation;

- Conduct other operational research including: Cost-effectiveness analysis of the program, survey of health workers' knowledge of the patients' legal rights, analysis of social protection factors in social protection legislation.

Table 4 shows indicators that will be used to track the progress in this strategic action area, including current baselines and proposed targets.

**Table 5: Proposed Indicators for tracking Strategic Area 4:**

<b>Strategic Area 4: Collection and use of strategic information</b>							
<b>Indicator description</b>	<b>Baseline</b>		<b>Targets (excluding baseline)</b>				
	<b>Value</b>	<b>Year</b>	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>	<b>Year 4</b>	<b>Year 5</b>
Number of surveys conducted among MARPs	4	2006	1	2	0	2	0
Number of UNGASS Reports prepared and submitted using CRIS database	1	2006	0	1	0	1	0

## STRATEGIC AREA 5:

### *Coordination and capacity building*

In order to respond effectively to HIV/AIDS, the Republic of Macedonia needs to develop the national response capacity and ensure coordination of efforts.

Specific activities to be conducted under this strategic action area include:

- Management training and capacity-building for implementing organizations of this strategy;
- Enhancement and sustainability of the key institutions capacities, including the capacity of Ministry of Health for implementation of the grants from the Global Fund to fight against AIDS, Tuberculosis and Malaria, as well as other technical assistance in this area;
- Strengthen the functioning of coordinating bodies including National HIV/AIDS Commission, the Country Coordinating Mechanism, Joint UN Team on HIV/AIDS;
- Undertake actions to increase the governmental resources for financing of the HIV/AIDS response, in order to provide long-term sustainability of the activities;
- Providing greater involvement of the local government in the response to HIV/AIDS including the establishment of municipal coordination mechanisms, as well as coordination mechanisms at national and local level;

- Establish ombudsman for patients' rights (emphasizing the specific protection of people living with HIV/AIDS).

Table 6 shows indicators that will be used to track the progress in this strategic action area.

**Table 6: Proposed Indicators for tracking Strategic Action Area 5:**

<b>Strategic Area 5: Coordination and capacity-building</b>							
<b>Indicator description</b>	<b>Baseline</b>		<b>Target (excluding baseline)</b>				
	<b>Value</b>	<b>Year</b>	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>	<b>Year 4</b>	<b>Year 5</b>
Amount of national funds disbursed by government (EURO) <sup>12</sup> (6&7)	1.405.843	2005	1.762.427	1.975.943	2.217.059	2.489.363	2.796.908
National composite policy index	24,10	2003		Target will be reported		Target will be reported	

<sup>12</sup> Baseline value assessed following the methodology in "Methodological Guidelines for Conduction a National Health Accounts Sub-analyses for HIV/AIDS" (6&7). Targets for Y1-Y5 are set with projection of 12% increase on annual bases.

# COORDINATION OF THE NATIONAL RESPONSE

In the application of this strategy, there will be efforts to strengthen the capacity, the role and the operation of the National AIDS Commission (NAC). The NAC practically ceased to function with the establishment of a Country Coordinating Mechanism (CCM) in 2003, which was established for the purposes of applying for Global Fund financing. This brought together the National AIDS Commissions and National TB Commission.

In the frames of this goal, a special, central place is given to the National AIDS Commission in particular, in order to:

- Ensure mutual harmonization of all national and local efforts to respond to HIV/AIDS, to maximize their effectiveness and avoid duplication of efforts;
- Includes representation/active involvement of other (all) stakeholders such as the civil society, the private sector and other partners on national and local level;
- Establishes special technical working groups as needed;
- Draft, propose and monitor the implementation of the national action framework for responding to HIV/AIDS, in accordance with this strategy;
- Define and propose activities for strengthening of the national system for HIV/AIDS monitoring and evaluation.

# RESOURCE MOBILIZATION AND PARTNERSHIPS

The effective implementation of this strategy will require the action of a wide range of organizations working in partnership. It will also require considerable resources to be mobilized.

The Government of the Republic of Macedonia is the leading partner for this strategy and contributes with both human and financial resources, particularly through the health sector. This strategy envisages a greater role for other ministries and for local government agencies, e.g. The Association of Local Self-Government Units (ZELS). Other significant partners include civil society organizations, including NGOs, the private sector, and the Joint UN team on AIDS which includes UNAIDS, UNDP, UNICEF, WHO, IOM, UNHCR and the World Bank.

The absence of organizations founded by and made up of people living with HIV is noted as a shortcoming that should be overcome by supporting such organizations, bearing in mind the specific situations in the country and the possibilities for their establishment. Such associations, whose establishment is supported by this strategy is expected to exert pressure on policy-makers for better services for people living with HIV and may serve to change negative attitudes towards them.

The necessary financial resources for the implementation of this strategy are expected from:

- National and local government budgets;
- The Global Fund to fight against AIDS, Tuberculosis and Malaria;
- Funds from the European Commission available for candidate countries such as the Republic of Macedonia;
- Other donors (it is recognized that many international development agencies have limited funds available for middle-income countries with low HIV prevalence).

The skills enhancement and appropriate capacities for preparation of programs, projects, applications for external donors is very important for all the stakeholders in the application of this Strategy to receive additional funds to strengthen the activities planned under this Strategy.

# CONCLUSION

There has been significant progress in responding to HIV/AIDS in the Republic of Macedonia under the National Strategy 2003-2006. A significant grant was obtained from the Global Fund to fight against AIDS, Tuberculosis and Malaria in 2004. National bio-behavioral studies conducted in 2005, resulted in improved knowledge about the extent and the spread of the epidemic and of high-risk behaviors among particular most-at-risk populations. Essential prevention, care and support services have been established and have expanded their capacities and domain.

This new strategy for 2007-2011 aims to keep HIV prevalence low in the Republic of Macedonia by maintaining long-term sustainability of the activities focusing on five strategic action areas: prevention among most-at-risk populations; other prevention activities; treatment, care and support for people living with HIV; collection and use of strategic information; and coordination and capacity building.

# References

1. National AIDS Strategy 2003-2006. Ministry of Health (2003)
2. Summery report on HIV prevalence and risk behaviors among most-at-risk population in the Republic of Macedonia in 2006. Ministry of Health (2006)
3. Mapping and community-based research among most-at-risk-adolescents of HIV/AIDS/STI. Final Report. UNICEF (2007)
4. Report on the Global AIDS Epidemic Chapter 5, At Risk and Neglected: Four Key Populations UNAIDS (2006)
5. Practical Guidelines for Intensifying HIV Prevention towards Universal Access UNAIDS/07.07E UNAIDS (2007)
6. Methodological Guidelines for Conduction a National Health Accounts Sub-analyses for HIV/AIDS. Partners for Health Reform Plus/USAID (2004)
7. Report on National Expenditure on HIV/AIDS for 2005. Ministry of Health (2006)

# Annex 1:

## Detailed Indicator Description


INDICATOR	BRIEF DESCRIPTION OF DATA COLLECTION METHOD	
HIV prevalence among IDUs	Data for all these indicators can be collected through bio-behavioral studies conducted among most-at-risk populations.	
HIV prevalence among sex workers		
HIV prevalence among MSM		
HIV prevalence among prisoners		
Percentage of young women and men aged 15-24 reporting the use of a condom the last time they had sex with a non-marital, non-cohabiting sexual partner		
Percentage of injecting drug users who have adopted behaviors that reduce transmission of HIV, i.e., who avoid sharing equipment and use condoms in the last month		
Percentage of sex workers reporting the use of condom with their most recent client		
Percentage of men reporting the use of a condom the last time they had sex with a male partner		
Percentage of prisoners reporting the use of condom during last sex (with regular, out-of-prison sexual partner during visit		
Percentage of adults and children with HIV still alive 12 months after initiation of antiretroviral therapy	Data needs to be collected for all people starting antiretroviral therapy including their date of starting treatment and their status one year after that date.	
Number of IDUs reached with harm reduction (needle exchange programs)	This data is collected from program records compiled at the point of delivering needle exchange services.	
Number of IDUs reached with harm reduction programs (substitution treatment)	This data is collected from program records compiled at substitution treatment centers.	

	RESPONSIBLE	FREQUENCY
	Republic Institute for Health Protection	Every 2-3 years
	Clinic for Infectious Diseases and Febrile Conditions	Annually
	NGOs providing needle exchange services	Quarterly
	Centers for drug substitution treatment	Quarterly

INDICATOR	BRIEF DESCRIPTION OF DATA COLLECTION METHOD	
Number of sex workers reached with targeted HIV/AIDS outreach activities	This data is collected from program records compiled at the point of delivering services to sex workers.	
Number of MSM reached with targeted HIV/AIDS outreach activities	This data is collected from program records compiled at the point of delivering services to MSM.	
Number of prisoners reached with harm reduction programs (substitution treatment)	This data is collected from program records compiled at substitution treatment centers.	
Number of people completing voluntary counseling and testing <sup>13</sup>	This data is collected from program records compiled at VCCT centers.	
Number of young people reached through peer education	This data is collected from program records compiled by those providing peer education services to young people.	
Number of condoms distributed	Ideally, this should be a record of all condoms sold or distributed in the country. Currently, it only covers those condoms distributed free.	
Number of people receiving ART	Data needs to be collected for all people starting antiretroviral therapy.	
Number of people living with HIV reached with psychosocial support	Data to be provided on number of people living with HIV receiving services with details of different types of services.	
Amount of national funds	National HIV/AIDS Account as described by UNAIDS in detailed description of UNGASS indicators.	
National composite policy index	As described by UNAIDS in detailed description of UNGASS indicators	

<sup>13</sup> Disaggregated data on use of VCCT services by most-at-risk populations will be collected in two main ways. First, this data will be collected, when possible, from service providers' records. Second, data will also be collected by making sure that suitable questions are asked during bio-behavioral studies.

	<b>RESPONSIBLE</b>	<b>FREQUENCY</b>
	NGOs providing services to sex workers	Quarterly
	NGOs providing services to MSM	Quarterly
	Centers for drug substitution treatment	Quarterly
	VCCT centers (including outreach VCCT services)	Quarterly
	NGOs providing youth peer education services	Quarterly
	Organizations distributing condoms through their programs	Quarterly
	Clinic for Infectious Diseases and Febrile Conditions	Quarterly
	Organizations providing people living with HIV with psychological support	Quarterly
	Ministry of Health	Annually
	Ministry of Health	Every 2-3 years

The image features a dark red background. A large, glowing, semi-circular shape with a gradient from dark red to white is positioned on the right side. A red ribbon is tied in a loop, overlapping the bottom right corner of the glowing shape. In the bottom left corner, the ISBN number is printed in white.

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