

***Macedonia HIV/AIDS National Strategy  
2003 - 2006***

**July 2003**

## TABLE OF CONTENTS

<b>LIST OF ABBREVIATIONS</b>	
<b>EXECUTIVE SUMMARY</b>	
<b>INTRODUCTION</b>	
<b>Country Profile</b>	
<b>Current HIV/AIDS Situation</b>	
• <b>Epidemiological Situation</b>	
• <b>STIs trends</b>	
• <b>Blood safety</b>	
• <b>Testing</b>	
• <b>Priorities identified</b>	
<b>Political commitment</b>	
<b>Partners</b>	
<b>STRATEGIC FRAMEWORK</b>	
<b>Planning process</b>	
<b>Guiding Principles</b>	
<b>Broad Strategies</b>	
<b>Institutional Framework</b>	
<b>PRIORITY AREAS AND STRATEGIES</b>	
<b>GROUPS OF INTEREST</b>	
<b>Youth</b>	
<b>Injecting Drug Users (IDU)</b>	
<b>Commercial Sex Workers (CSW)</b>	
<b>Men who have Sex with Men (MSM)</b>	
<b>Prisoners</b>	
<b>Roma Community</b>	
<b>Mobile groups</b>	
<b>HEALTH CARE SETTING</b>	
<b>POLICY ON TESTING</b>	
<b>HIV SURVEILLANCE</b>	
<b>HEALTH CARE</b>	
<b>HUMAN RIGHTS AND SOCIAL SUPPORT FOR PLWHA</b>	
<b>MANAGEMENT MECHANISMS</b>	
<b>RESOURCE MOBILIZATION</b>	
<b>CONCLUSION</b>	
<b>ANNEX 1 - Broad activities related to YOUTH and expected output</b>	
<b>ANNEX 2 - Broad activities related to IDU and expected output</b>	
<b>ANNEX 3 - Broad activities related to CSW and expected output</b>	
<b>ANNEX 4 - Broad activities related to MSM and expected output</b>	
<b>ANNEX 5 - Broad activities related to PRISONERS and expected output</b>	
<b>ANNEX 6 - Broad activities related to ROMA and expected output</b>	
<b>ANNEX 7 - Broad activities related to MOBILE GROUPS and expected output</b>	
<b>ANNEX 8 - Broad activities related to HEALTH CARE SETTING and expected output</b>	
<b>ANNEX 9 - Broad activities related to POLICY ON TESTING and expected output</b>	
<b>ANNEX 10 - Broad activities related to SURVEILLANCE and expected output</b>	
<b>ANNEX 11 - Broad activities related to HEALTH CARE and expected output</b>	
<b>ANNEX 12 - Broad activities related to HUMAN RIGHTS AND SOCIAL SUPPORT FOR PLWHA and expected output</b>	
<b>ANNEX 13 - Broad activities related to MANAGEMENT MECHANISMS and expected output</b>	

## **LIST OF ABBREVIATIONS**

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AIDS	Acquired Immunodeficiency Syndrome
ARV	Anti Retro Viral Treatment
BTS	Blood Transfusion Station
CID	Clinic for Infectious Diseases
CIDA	Canadian International Development Agency
CSW	Commercial sex worker
GDP	Gross Domestic Product
HBS	Hepatitis B
HCV	Hepatitis C
HERA	Health Education and Research Association
HIV	Human Immunodeficiency Virus
HOPS	Healthy Options Project Skopje
IDP	Internally Displaced Person
IDU	Injecting Drug Users
IEC	Information Education and Communication
IMF	International Monetary Fund
IOM	International Organisation for Migrations
KABP	Knowledge, Attitude, Behaviour and Practices
MIA	Macedonia Interethnic Association
MMSA	Macedonian Medical Students Association
MoE	Ministry of Education
MoH	Ministry of Health
MoI	Ministry of Interior
MoSP	Ministry of Social Protection
MSM	Men Who Have Sex with Men
NAC	National AIDS Committee
NMC	National Multisectoral Commission on HIV/AIDS
NGO	Non-governmental Organization
NIPH	National Institute of Health Protection
PLWHA	People Living with HIV/AIDS
RAR	Rapid Assessment and Response
PEP	Post Exposure Preventive Treatment
SECI	South Eastern Cooperative Initiative
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNHCHR	United Nations High Commission for Human Rights
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
UNTG	United Nations Theme Group on HIV/AIDS
UNTWG	United Nations Technical Working Group on HIV/AIDS
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

## **EXECUTIVE SUMMARY**

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The National HIV/AIDS Strategy for the Republic of Macedonia has been designed as a three-year framework for the development, implementation, monitoring and evaluation of HIV/AIDS focused programming in the national context. The National Strategy is based on the results of the Situation Analysis and Response Analysis for HIV/AIDS, completed in late 2002 and early 2003, the Global Fund proposal submitted in May 2003, and the strategic planning workshop conducted by the UN TG on HIV/AIDS and UNAIDS in the spring of 2003.

The Macedonian Strategy for HIV/AIDS combines the efforts of many stakeholders active within the National Multisectoral HIV/AIDS Commission, established in early 2003 to develop and oversee the design and implementation of a National Strategy. Membership in the National Multisectoral HIV/AIDS Commission includes 28 representatives from government ministries, NGOs, faith based organizations, academic institutions, media and the UN Theme Group on HIV/AIDS (as observers).

The Strategy framework will guide the design and implementation of interventions within overall national programming, government and non-government, and serve as the basis for monitoring and evaluating the effectiveness of the national response.

Although current infection rates appear to be low, regional trends suggest the real potential for a rapid spread of HIV/AIDS. Regional trends further illustrate that the failure to respond at the early stages in the epidemic can have profound medical, social and economic costs in the long-term.

Since implementation of the first National HIV/AIDS Program developed by the Ministry of Health in 1985, steps have been taken to expand programming to include actors outside of the health field however, much remains to be done. The National Strategy offers Macedonia the opportunity over the next three years to establish a truly multisectoral response to tackle the complex medical, social, legal and human rights issues raised by HIV/AIDS.

The six priority areas identified in the National HIV/AIDS Strategic Plan are:

1. Preventing the spread of HIV/AIDS among groups of interest (youth, IDUs, commercial sex workers, MSM, mobile groups, Roma and prisoners)
2. Improving access to, and the quality of, counselling and testing services
3. Improving national epidemiological and behavioural surveillance systems
4. Improving the provision of care and support for PLWHAs
5. Preventing HIV transmission in the health care settings.
6. Strengthening capacity and coordination within the national response to HIV/AIDS

# **INTRODUCTION**

- 1 - COUNTRY PROFILE***
- 2 - CURRENT HIV/AIDS SITUATION***
- 3 - GOVERNMENT COMMITMENT***
- 4 - PARTNERS***

## ***1 - COUNTRY PROFILE***

The last available official census data for Macedonia puts the population total at 1,936,877<sup>1</sup>. Macedonian society is composed of several ethnic groups: Macedonian (67%), Albanian (23%), Turks (4%), Roma (2%), and Serbs (2%), other (2%)<sup>2</sup>. Geographically, ethnic Macedonians are concentrated in the Eastern and Southern regions of the country (bordering Serbia, Bulgaria and Greece), ethnic Albanians are mainly concentrated in the Western part (bordering Albania and Kosovo). The prevailing religions are Christian Orthodox (67%) and Islam (30%). The capital of Macedonia is Skopje with an estimated 550,000 citizens. There is an ongoing process of rural to urban migration: according to the 1994 census 57% of the population lived in towns, an increase from 53.8% the previous decade<sup>3</sup>.

Macedonia gained independence in 1991. Since then the country has undergone dramatic changes to adjust itself to a new political and economic environment. The first years of independence were marked by a steady decline in GDP and hyperinflation. The nineties were characterized by a significant fall in the standard of living. In part, this was a result of trade sanctions imposed by the UN on the Federal Republic of Yugoslavia, a principal trade partner for Macedonia and partly a result of the blockade imposed by Greece (resulting from a dispute about the name of the new state), preventing Macedonia access to markets in the south.

Macedonia is governed through a multi-party democracy. Legislative powers rest with a unicameral assembly. Suffrage is universal and the assembly is elected through the alternative vote plus system of proportional representation. The term of office is four years. The executive branch of the State is formed by the government and the President. The presidency is decided on a five year basis by popular vote.

Over the last few years the inflation rate and GDP have stabilized but unemployment figures have steadily increased. The Kosovo crisis of 1999 intensified economic pressures on Macedonia. More than a quarter of a million Kosovo refugees severely stretched an already overburdened economy<sup>4</sup>. In 2001, internal conflict between ethnic Albanian armed groups and Macedonian government forces further disrupted the economic situation and led to 80,000 internally displaced persons and 50,000 Macedonians seeking asylum in other countries. At the beginning of 2003, 2,140 displaced persons remain in temporary centers, claiming it is unsafe for them to return to their original place of domicile<sup>5</sup>.

The transition to a market economy has seen a decline in the Gross Domestic Product (GDP) per capita from USD 2,235 in 1990 to USD 1,801 in 2001. Unemployment is high with 371,000 jobless persons (53.4% of the working age population) according to the State Employment Bureau. Extreme poverty affects one quarter of the population of

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<sup>1</sup> This total is based on the 1994 census. The 2002 census was completed in October 2002 but final results were not yet available at the time of writing.

<sup>2</sup> 1994 Census data.

<sup>3</sup> Health care Systems in Transition, Macedonia, WHO.

<sup>4</sup> According to UNHCR 5000 refugees remain in country.

<sup>5</sup> Economist Intelligence Unit: Country Report Macedonia, first quarter 2003.

the country. Large numbers of the unemployed are persons under the age of 30 (44.65%). Economic statistics for 2003, while showing signs of improvement, indicate that unemployment is alarmingly high even by regional standards. The registered unemployed officially stand at 33.9% of the workforce meaning that only 13.7% of the total population in Macedonia has employment. The average net wage in December 2002 was 11,237 denars (178US\$) monthly. However, an average of one-quarter of employees do not receive regular payment of wages. This situation essentially means that only every tenth Macedonian receives income from regular work on a regular basis.

Economists predict that the unemployment rate is not expected to fall in the short term. Poor economic indicators continue to have significant implications both with regards to health needs of the population and the cost of health service provision. According to the most recent Economist Intelligence Unit quarterly report on Macedonia, the 'fragile political stability and the outlook for continued normalization of inter-ethnic relations could come under threat' in the near future, as a result of upcoming government austerity measures required by the 2003 IMF agreement<sup>6</sup>.

In Macedonia, economic, political and institutional instability combined with other broad risk factors create a scenario where a serious HIV/AIDS epidemic is possible:

- Regional/internal conflict and instability, IDPs and refugees;
- Unstable political/economic situation resulting in internal/external migration;
- The position of Macedonia at a main crossroad for drug trafficking routes;
- Increasing numbers of injecting drug users;
- Increasing domestic commercial sex workers and trafficking of women;
- Regional trends indicating a fast growing HIV/AIDS epidemic (Russia, Ukraine, Romania, Moldova, Central Asia);

## ***2 - CURRENT HIV/AIDS SITUATION***

### **Epidemiological situation**

It is unlikely that HIV/AIDS statistics reflect the real infection rates. There is an under-developed surveillance system in place to measure prevalence and incidence of HIV/AIDS that does not address high-risk groups specifically. The data available on HIV/AIDS cases is based on test results, including blood/organ donor tests. Almost all registered HIV positive persons were not tested for HIV until after the development of health problems. Most of them develop AIDS 6 to 12 months thereafter, indicating that their HIV positive status was discovered late into the actual infection.

The first HIV positive case was officially registered in 1987, and the first AIDS case in 1989. The total cumulative number of registered cases of HIV/AIDS is 64 (46 AIDS and 18 HIV+). From the total number of 46 persons diagnosed with AIDS, 41 have died.

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<sup>6</sup> Economist Intelligence Unit: Country Report Macedonia, First quarter 2003.

There are officially 5 persons living with AIDS and 18 with HIV. Five new AIDS cases were detected in 2002.

The first HIV positive case and AIDS case were both hemophiliacs infected via blood transfusion; tainted imported blood products were the stated cause of transmission. Three cases of vertical transmission are documented. Information about the children's serological status was collected after the parents' diagnosis.

Cumulative AIDS cases are 72% male and most cases are in the 20-49 year age range, especially 30-39 years. The distribution of risk categories among AIDS cases is 56% heterosexual transmission, 13% injecting drug use, 13% men who have sex with men (MSM), 8.7% hemophiliac, 4.3% mother-to-child transmission and 5% unknown<sup>7</sup>.

**Table 1: Modes of HIV Transmission**

<b>MODES OF TRANSMISSION</b>	<b>HIV</b>	<b>AIDS</b>	<b>Total</b>	<b>Percentage (%)</b>
<b>Homosexual</b>	2	6	8	13 %
<b>Heterosexual</b>	13	26	39	56 %
<b>IDUs</b>	2	6	8	13 %
<b>Vertical</b>	1	2	3	4.3 %
<b>Transfusion</b>	/	/	/	/
<b>Hemophilia</b>	/	4	4	8.7 %
<b>Other (unknown)</b>	/	2	2	5 %
<b>TOTAL</b>	<b>18</b>	<b>46</b>	<b>64</b>	<b>100%</b>

The dominant mode of transmission reported is heterosexual sex. Stigmatization of homosexual behaviour makes it conceivable that some of the cases declared as heterosexual, and unknown cases, could be due to homosexual/bisexual encounters.

**Table 2: Distribution of HIV/AIDS cases by gender**

<b>HIV/AIDS CASES</b>	<b>MALE</b>	<b>FEMALE</b>	<b>TOTAL</b>
<b>HIV</b>	11	7	18
<b>AIDS</b>	33	13	46
<b>TOTAL</b>	<b>44</b>	<b>20</b>	<b>64</b>

Nowadays the male/female ratio of HIV/AIDS infection in Macedonia is almost 2.21:1. The analysis related to the distribution of AIDS cases by age groups shows that the most dominant age group is 30-39 followed by the age group 20-29. Information available only relates to AIDS, most HIV+ cases were registered in the latest stage of infection or at the onset of AIDS.

<sup>7</sup> The small sample size mean extrapolating relevant trends is methodologically problematic.

**Table 3: Distribution of HIV/AIDS cases by age**

<b>AGE GROUP</b>	<b>HIV</b>	<b>AIDS</b>	<b>TOTAL</b>
<b>0 – 9</b>	1	2	3
<b>10 – 19</b>	/	2	2
<b>20 – 29</b>	5	12	17
<b>30 – 39</b>	7	17	24
<b>40 – 49</b>	0	10	10
<b>50 – 59</b>	3	3	6
<b>60 +</b>	0	1	1
<b>Unknown</b>	0	1	1
<b>TOTAL</b>	<b>16</b>	<b>48</b>	<b>64</b>

### **Trends of STIs**

The official report of registered cases of STIs shows a decreasing trend. Indeed there are serious suggestions that STI data in Macedonia may be under-reporting the true incidence and prevalence of the problem by a factor of three to four.

By law, it is obligatory to report syphilis and gonorrhoea cases on the special form with detailed information about the patient. The reporting system for both private and governmental institutions shows some weaknesses. One of the reasons is that the STI infected patients either take the therapy alone or go to the doctor asking for confidentiality and paying for it. Probably reason for this is due to the cultural norms and prejudice that a person having STIs means to be an amoral person.

The medical institutions are not obliged to report chlamidia cases. According to the medical staff in charge of the diagnosis of chlamidia, genital herpes and other STIs, the number of cases is increasing very rapidly especially among the younger population.

### **Blood Safety**

The National Institute of Transfusiology ensures national coordination of blood donation. Since 1997 all donated blood products have undergone mandatory testing for HIV. Blood is tested three times with the same technique. In the case of inconclusive results, the blood is sent for confirmation with Western Blot tests at the Clinic for Infectious Diseases. Blood is also tested for hepatitis C (HCV), hepatitis B (HBS) and syphilis.

Since 1974, blood donation has been voluntary. Donors do not receive material compensation. However, those who donate more than ten times receive minor benefits including a free certificate indicating their negative HIV status. Campaigns for initiating blood donation drives are conducted irregularly by the Ministry of Health and the Macedonian Red Cross. Approximately 48,000-50,000 blood units are tested each year.

The interest for donation among the population is still there. Only for a few people the reason for donating blood is the possibility to make free HIV testing. Since the beginning

of the epidemic 3 HIV positive donors were found, one in 1993, one in 1994 and one in 1995.

## **Testing**

In Macedonia, there is stigma attached to HIV and concern regarding the confidentiality of the testing process<sup>8</sup>. Currently, new antiretroviral drugs are unavailable in Macedonia, providing little incentive for an individual to be tested for HIV. Furthermore, there is limited pre- and post-test counseling for HIV testing and little “social marketing” of the potential benefits of testing. People are reluctant to be tested for HIV until symptoms develop and information suggests that most diagnosed individuals first tested positive late in the course of HIV disease. Individuals take advantage of out-of-country testing due to confidentiality concerns<sup>9</sup>. HIV testing is free<sup>10</sup> with a doctor’s referral or by going directly for anonymous testing.

## **Priorities identified**

- | ➤ Vulnerability of some population groups, in particular youth, IDU, CSW, MSM, prisoners, mobile groups and Roma;
- | ➤ Safe sexual behaviour in the general population, with additional attention to the above identified groups;
- | ➤ Condom distribution and use, and other measures to reduce or prevent the spread of STIs. Again special attention should be given to vulnerable groups;
- | ➤ Safer drug injection behavior;
- | ➤ Ensuring clear and accurate information concerning HIV/AIDS/STI infection, updating of surveillance and VCT;
- | ➤ Improving the understanding and implementation of human rights mechanisms, in particular as concerns confidentiality, and treatment of those living with HIV/AIDS;
- | ➤ Coordination and communication between stakeholders.

## **3 - GOVERNMENT COMMITMENT**

Macedonia introduced an HIV/AIDS program in 1985, two years before the first HIV infection was identified in the country. Since 1987, the National HIV/AIDS Programme, oriented to addressing the health aspects of HIV/AIDS, has been implemented through the National AIDS Committee (NAC) under the Ministry of Health (MoH) and the National AIDS Coordinator as a focal point for this issue in the country.

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<sup>8</sup> There is extensive anecdotal evidence of breach of patient confidentiality. Article 43 of the Law for Health protection defines the importance of respecting ‘professional secrets’ to protect the rights’ of patients.

<sup>9</sup> The most commonly cited country of choice is Bulgaria.

<sup>10</sup> Testing is free with a doctor’s referral, otherwise the cost is approximately 20US\$- for instance to receive needed certification of negative status for travel abroad.

In other areas relevant to the spread of HIV/AIDS, an Inter-Ministerial State Commission for the Fight Against Illicit Production and Trafficking in Drugs and the Prevention of Drug Abuse was established in 1996. The National Drug Control Strategy is supportive of the inclusion of harm reduction as one measure to decrease vulnerability of drug users to HIV/AIDS. Since 1999 the Macedonian government ratified the *Agreement on Cooperation to Prevent and Combat Trans-border Crime* with SECI. MoI is working with SECI on developing intelligence sharing and a trans-national database. In December 2000 Macedonia became a signatory to the *UN Protocol to Prevent, Suppress and Punish Trafficking in Persons* (Palermo Protocol)<sup>11</sup>. In 2001, an *Inter-Ministerial National Commission to Combat Human Trafficking* was established chaired by the Ministry of the Interior State Secretary. This Commission drafted and adopted an Anti-Trafficking National Plan of Action. Also in 2001, the MoI jointly with the IOM, opened a Reception Transit Centre for Irregular Migrants and Foreigners, which also accommodates trafficking victims. In June 2001 Macedonia signed The Declaration of Commitment on HIV/AIDS adopted in New York at the UN General Assembly Special Session on HIV/AIDS (UNGASS). There is political will to address the issue comprehensively and in accordance with UNAIDS guidelines.

Despite severe economic hardship and health sector reforms geared towards decentralisation and reducing expenditures in the health system, the country has remained committed to tackling the HIV/AIDS issue. Since 2001 the Government and in particular the President have shown a growing awareness and political commitment to HIV/AIDS resulting in the development of the National Multisectorial Commission on HIV/AIDS in April 2003 (NMC).

#### **4 - PARTNERS**

A UN Theme Group on HIV/AIDS (UNTG) has been active in Macedonia since 1999. The UN Theme Group is currently chaired by UNDP and composed of UNDP, UNICEF, WHO, IOM, UNHCR and the World Bank. The Technical Working Group (TWG) is chaired by UNICEF in 2003 and functions together with the National HIV/AIDS Coordinator and non-governmental organisations.

A small but effective NGO community is highly active in working with vulnerable groups and HIV/AIDS related issues. These include – HOPS, HERA, MIA, DOVERBA, Macedonian Red Cross, MMSA and Passage. There are several international NGOs, the UN TG on HIV/AIDS and other donors that aimed at strengthening national capacities and targeting HIV/AIDS related activities.

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<sup>11</sup> The Protocol will be ratified in 2003, once national legislation has been harmonized with the recommendations set forth.

# **STRATEGIC FRAMEWORK**

- 1 - PLANNING PROCES***
- 2 - GUIDING PRINCIPLES***
- 3 - BROAD STRATEGIES***
- 4 - INSTITUTIONAL FRAMEWORK***

## ***1 - PLANNING PROCES***

The Government of the Republic of Macedonia, NGO community, academia and the faith based organizations have committed themselves to the development and coordinated implementation of a National HIV/AIDS Strategy, which will serve as a framework for national agencies, local authorities and organizations, and for local and international donors.

The National HIV/AIDS Strategy has been designed as a 3-year framework to guide the national multisectoral response to HIV/AIDS from the years 2003 to 2006. It is the outcome of a planning process which included the following:

- Situation Analysis completed in January 2003
- Response Analysis completed in March 2003
- National Multisectoral Commission on HIV/AIDS created in April 2003
- Strategic Planning workshop held in April 2003
- Global Fund proposal submitted in May 2003

The UN TG and UN TWG wanted to include the wider NGO community in the formulation process of the National Strategy. Thus, NGOs members of the UN TWG organized round tables to present the draft National Strategy to local NGOs in five cities (Strumica, Bitola, Prilep, Ohrid, and Kumanovo). These discussions were fed back into the National Multi Sectoral Commission and incorporated into the final version of the National Strategy.

## ***2 - GUIDING PRINCIPLES***

The success of the National Strategy depends on the involvement of all stakeholders in the HIV/AIDS issue ranging from state and local government and public officials to the NGO community and input from identified vulnerable groups. All groups had to be active in the design, implementation and evaluation of proposed strategies and interventions

Due to the low reported incidence of HIV/AIDS in Macedonia, the National Strategy framework focuses primarily on prevention measures. The population and in particular identified groups of interest for HIV infection must be given the knowledge and skills to protect themselves and prevent HIV infection. Likewise, all members of society must have access to affordable confidential testing and counseling and care options.

The following are the guiding principles for the design of HIV prevention and care strategies and interventions for Macedonia over the next three years:

- Prevention of HIV/AIDS is more than a health issue. An effective strategy must incorporate a multisectoral and holistic approach.
- Prevention constitutes the primary focus of the strategy.

- Individuals and groups must be empowered to protect themselves against HIV infection.
- Groups of interest for HIV infection must have HIV/AIDS interventions tailored to their needs.
- Groups of interest for HIV infection to participate in the design, implementation and evaluation of intervention programmes.
- HIV testing must be accessible, voluntary with guaranteed confidentiality and combined with adequate pre- and post-test counseling.
- The human rights of PLWHA must be guaranteed.
- All PLWHA must be guaranteed equal access to care and services.

### **3 - BROAD STRATEGIES**

To increase effectiveness and impact of programming the National HIV/AIDS Strategy expands the scope and dimension of interventions outside the medical response. The strategy will focus interventions in priority areas to ensure the greatest impact on preventing the expansion of HIV/AIDS in the most cost-effective way. The strategy framework employs a multisectoral approach and aims to improve collaboration between government bodies, communities, NGOs, IOs, institutions, the private sector, and the media. The strategy recognizes the need to monitor characteristics and trends of the epidemic. Finally, it also recognizes the need to make epidemiological and behavioural data and analysis available, at the policy level and to all stakeholders involved in HIV/AIDS and related issues

The priority areas identified by the National Multisectoral Commission for HIV/AIDS working groups are:

- Preventing the spread of HIV/AIDS amongst youth, IDUs, sex workers, prisoners, MSM, mobile groups and the Roma community
- Improving access to, and the quality of, counselling and testing services
- Improving national epidemiological and behavioural surveillance systems
- Preventing HIV transmission in the health care settings.
- Improving the provision of care and support for PLWHAs
- Strengthening capacity and coordination within the national response to HIV/AIDS

### **4 - INSTITUTIONAL FRAMEWORK**

The newly created National Multisectoral Commission for HIV/AIDS (NMC) expands on the previous medical focus of the National HIV/AIDS Committee to include members from other ministries and sectors. The process was guided by the desire to guarantee an inclusive and representative body, ensuring that key players from a variety of sectors were included. The NMC formation has been supported and officially recognized by the Government and its constituent ministries. Since the formation of the National Multisectoral HIV/AIDS Commission in April 2003, the government's HIV/AIDS response has been developed and directed through this Commission.

The NMC is comprised of 28 members and includes membership from the Ministries (Health, Interior, Justice, Finance, Education, Labour and Local Self Government) NGOs, faith based organizations, academic institutions, media and the UN TG on HIV/AIDS (as observers). A 2002 Law on Local Self Government (LLSG) decentralises areas relevant to HIV/AIDS prevention and care, such as healthcare, education and social service provision<sup>12</sup>, and thus opens the door for local officials/communities to design and implement programming tailored to their specific needs.

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<sup>12</sup> The LLSG defines the Municipalities as the units of local self government, Article 22 outlines the broad areas of responsibility as: social welfare and child protection, education, primary healthcare; health improvement; preventative activities; protection of health workers and protection at work.

The National Multisectoral HIV/AIDS Commission has Coordinating Committee consists of 8 members of the NMC (4 NGOs, National AIDS Coordinator, two Ministries' representatives and the UNAIDS Focal Point) charred by the National AIDS Coordinator. Its main purpose is to ensure that all major stakeholders in the development and implementation process are included in consultations and discussion. Its functioning is set out in the Terms of Reference and Rules of Operation. The Ministry of Health acts as the Secretariat to the NMC through administrative staff nominated by the State Secretary of Health.

The NMC will meet on a regular basis and has overall responsibility for follow-up on HIV/AIDS programming within the national strategic plan. The Coordinating Committee will prepare draft documents for approval by the NMC and will be responsible for ensuring that decisions are implemented. All proceedings will be a matter of public record and NMC will endeavour to ensure that the activities of the membership and any programs it operates are transparent and effectively communicated with key stakeholders.

# **PRIORITY AREAS AND STRATEGIES**

## ***GROUPS OF INTEREST***

- 1 - YOUTH***
- 2 - INJECTING DRUG USERS***
- 3 - COMERCIAL SEX WORKERS***
- 4 - MAN WHO HAVE SEX WITH MEN***
- 5 - PRISONERS***
- 6 - ROMA COMMUNITY***
- 7 - MOBILE GROUPS***

## ***1 - YOUTH***

The situation analysis found that Macedonia's youth often possess incomplete knowledge about STI and HIV/AIDS and lack the life skills necessary to avoid infection. The situation analysis found that while young people are, for the most part, aware of condoms as a prevention measure for STI/HIV, they fail to use them on a regular basis. Young people need to be educated about healthy behaviour and attitudes and encouraged to use prevention measures. Existing health and social services are not youth friendly and young people report that they do not talk to their parents or teachers about sexual health and related issues. As a result, young people obtain information about STI/HIV and pregnancy prevention largely from their peer group and/or older siblings. The response analysis found that media information campaigns have targeted youth with HIV/AIDS information, as has the education system. However, these campaigns are not reaching all young people and in particular may not reach vulnerable youth outside the education system.

The national strategy therefore contains elements that move beyond providing youth with basic knowledge and strives to strengthen the skills of young people in life skills and negotiation of safe health behaviour. It further recognizes the need for young people to contribute through their active involvement in future STI/HIV prevention programmes. These programmes will be more effective if they move beyond information dissemination and encourage group norms for safe healthy behaviour.

### ***Goals***

- To prevent the spread of STI and HIV infection in young people and adolescents.
- To ensure that young people have access to STI and HIV/AIDS information *and* the social competencies needed to apply this knowledge.

### ***Impact indicators***

- Percentage of young people aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV
- Percentage of young people aged 15-24 reporting the use of a condom

## **TARGET INTERVENTIONS**

### **1. BEHAVIOUR CHANGE (YOUTH - INDIVIDUAL AND GROUP)**

#### ***Objective***

- To empower young people to avoid STI and HIV infection through knowledge and life skills training, decision making and a sense of personal responsibility for their health.

### *Strategies*

- Promote and expand KAPB research on young people (and parents).
- Promote safe sexual norms and healthy behaviour among young people (within and outside the formal education system).
- Support activities that help young people develop life skills.
- Standardise and expand peer education training and application.
- Develop youth focused production, distribution and use of Information Education and Communication (IEC) materials.
- Include young people in the IEC development and evaluation process.
- Expand mass-media (television and radio and the internet) as mediums to effect behavioural change in youth and promote safe sex practices and condom use.

## **2. ENCOURAGE SAFE SEXUAL PRACTICES AND CONDOM USE TO AVOID UNWANTED PREGNANCY, STI AND HIV INFECTION**

### *Objective*

- To succeed substantially reduce of unsafe sexual behavior.

### *Strategies*

- Support and expand the social marketing of condoms, including condom use.
- Expand use of peer education models for provision of information and condom use.

## **3. AVAILABILITY OF YOUTH FRIENDLY SERVICES (YFS) - HEALTH AND SOCIAL**

### *Objective*

- To ensure health and social services are easily accessible, relevant and responsive to the specific needs of youth and adolescents.

### *Strategies*

- Ensure that young people have access to youth friendly reproductive health services, including testing and treatment of STI/HIV and other health information.
- Strengthen the capacity of general practitioners (GP) and primary health care (PHC) services to provide youth friendly services, particularly in the areas of reproductive health counseling, STI, substance abuse (IDU) and HIV prevention.
- Create/expand youth friendly information services (centres/hotlines) where young people can get additional information on STI, HIV/AIDS and related issues.
- Train health, social work professionals and educators in life-skills based techniques and YFS objectives.

#### **4. EDUCATION SYSTEM**

##### *Objective*

- To ensure that all young people within the education system have the necessary knowledge about STI, HIV/AIDS and methods of prevention of infection.

##### *Strategies*

- Support the development of a participatory, progressive, (age-appropriate) life skills training methodologies curriculum at the primary and secondary school levels.
- Encourage the involvement of young people in curriculum development, and development of up to date IEC materials.
- Ensure new curriculum is progressive while at the same time culturally sensitive to religious and ethnic groups.
- Expand and standardize NGO support for training in issues related to youth health and development (in the short/medium term).
- Ensure standardized in-service and pre-service teacher training in life skills based methodologies.

#### **5. LAW ENFORCEMENT FORCES AND MILITARY**

##### *Objective*

- To promote safe behavior among young people doing national military service as well as professionals in law enforcement forces.

##### *Strategies*

- Include HIV/AIDS/STIs education into the basic training program of young people doing national military service.
- Ensure include HIV/AIDS/STIs education into the basic training program of professionals in the law enforcement forces and military.
- Train the law enforcement forces and military medical/social staff representatives already working in health centers in information, education and communication (IEC) related to HIV/AIDS/STIs topics.
- Develop national law enforcement forces and military service focused production, distribution and use of Information Education and Communication (IEC) materials related to HIV/AIDS/STIs topics.
- Insure condom distribution among the law enforcement forces and military troupes dislocated because of intervention.

**Broad activities related to YOUTH and expected output can be found in ANNEX 1**

## **2 - INJECTING DRUG USERS (IDU)**

Injecting drug use constitutes the driving force behind the alarming increase in regional HIV/AIDS infection rates. IDU numbers have increased substantially over the past decade across Macedonia. The situation analysis found that apart from unsafe injecting practices, many drug users engage in risk related sexual behaviour including a cross over between injecting drug users and commercial sex work. IDUs also face a variety of obstacles in accessing treatment options, health insurance and medical and social services.

### ***Goal***

- To maintain the current low HIV incidence of HIV/AIDS infection rates among the IDU community in Macedonia.

### ***Impact indicator***

- Percentage of IDUs who have adopted behaviors that reduce transmission of HIV, i.e. who both avoid sharing injecting equipment and use condoms.

## **TARGET INTERVENTIONS**

### **1. DEMAND REDUCTION**

#### ***Objective***

- To reduce the number of new injecting drug users.

#### ***Strategies***

- Support school-based awareness raising activities, including information about drugs and the implications of drug use in life skills curriculum.
- Support public campaign
- Develop (age-appropriate) IEC materials based on research.

### **2. CREATE A NETWORK OF TREATMENT SERVICES OPTIONS AND SUPPORT FOR IDUs.**

#### ***Objective***

- To create an environment for the implementation of effective treatment and care programmes for IDUs

#### ***Strategies***

- Decentralise drug treatment options and expand outside of Skopje.
- Destigmatise IDU issues through education/information campaigns for the public and health care and social sector employees.
- Encourage collaboration between law enforcement officials and health/social care professionals in treatment option knowledge and referral.

- Increase cooperation between NGOs, law enforcement and the health and social services structures.

### **3. HARM REDUCTION**

#### ***Objective***

- To expand programming to reduce the harmful effects of injecting drug use and to ensure that IDU community understands how to avoid HIV infection.

#### ***Strategies***

- Expand harm reduction programmes, including needle exchange, substitution therapy, counseling and support centers.
- Develop and maintain close links between harm reduction programming and activities with the Interministerial Commission to Fight Against Illicit Production and Trafficking in Drugs and the Prevention of Drug Abuse.

**Broad activities related to IDU and expected output can be found in  
ANNEX 2**

### **3 - COMMERCIAL SEX WORKERS (CSW)**

Although there are no accurate figures for the number of sex workers in Macedonia, the socio-economic crisis has led to an increase in prostitution. Commercial sex work has increased as has the incidence of trafficking in women and girls (both internally and from outside the country) for work in the sex trade<sup>13</sup>. Commercial sex workers are at considerable risk to STI and HIV infection for a number of reasons: they often lack primary education, health insurance and face discrimination and violence.

Most commercial sex workers experience increased vulnerability to STI and HIV/AIDS due to a low level of education, which restricts access to information and health care services. They often have little control over the risk in sexual encounters because the client and/or pimp determine whether or not to use any form of protection.

#### ***Goal***

- To prevent HIV transmission among sex workers and their clients.

#### ***Impact indicator***

- Percentage of sex workers who report using a condom with their most recent client, of those surveyed having sex with any clients in the last 12 months

### **TARGET INTERVENTIONS**

#### **1. INCREASE AWARENESS ABOUT STI, HIV/AIDS**

#### ***Objective***

- To ensure that commercial sex workers know how to avoid STI and HIV infection and the means and ability to act on this knowledge.

#### ***Strategies***

- Support a KAPB study to identify behavior, knowledge and practices (CSW, clients, pimps).
- Support the development of IEC materials for sex workers on safe practices through research obtained on sex workers (and clients).
- Establish cooperative interaction with law enforcement officials and local authorities in support of prevention interventions for sex workers.
- Expand pilot outreach counselling and referral services provided through the NGO community.

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<sup>13</sup> There are a number of international and national organizations working on the issue of human trafficking, therefore, the Multisectoral Commission has not included 'trafficking' under commercial sex work within the context of the National Strategy.

## **2. CAPACITY-BUILDING**

### ***Objective***

- To strengthen the capacity of sex workers to address their needs and empower them to improve and protect their health and personal safety.

### ***Strategies***

- Support training activities for NGOs involved with projects for sex workers.
- Expand and support peer education activities that include negotiating skills.
- Educate brothel owners about the importance of providing free condoms for visitors.

**Broad activities related to CSW and expected output can be found in  
ANNEX 3**

#### **4 - MEN WHO HAVE SEX WITH MEN**

Although the numbers of HIV cases reported within the men who have sex with men (MSM) category are not high, the Situation Analysis found MSM to be a potentially vulnerable group. MSM are vulnerable to HIV because they are isolated from society, face discrimination within the social service and health sector and remain politically inactive. A recent study on MSM was conducted by Centre for Human Rights and Conflict Resolution at the Institute for Sociological and Political Legal Research in Skopje. The study found that ... (a) 'major part of Macedonian citizens consider that homosexuality is an illness of immoral character which is not easily cured' and furthermore 'some citizens think that people suffering from this illness should be punished by law'.

A noted occurrence among bi/homosexuals interviewed was promiscuity. This is supported by survey data from the RAR indicating that 30% of interviewees had had 5 – 12 sexual partners in the course of the year, and 21% said that they have had 3 – 7 one-night stands. A large degree of risk is brought by the practice of group sex (27% stated that they have had group sex). And, although 73% believe that their behaviour puts them at risk for HIV infection, 58% never use condoms.

##### ***Goal***

- To prevent HIV transmission among MSM.

##### ***Impact indicator***

- Number of MSM who are HIV infected

#### **TARGET INTERVENTIONS**

##### **1. CREATE A SUPPORTIVE ENVIRONMENT FOR EFFECTIVE PROGRAMMES**

##### ***Objective***

- To create a supportive and proactive environment for MSM to address their needs.

##### ***Strategies***

- Reduce public discrimination against MSM through awareness-raising activities and human rights.
- Increase awareness of decision-makers of the risks that face MSM if they do not have access to HIV/AIDS appropriate information.

## **2. CAPACITY-BUILDING FOR MSM NGOs AND ORGANIZATIONS**

### ***Objective***

- To strengthen NGO MSM based organizations to identify and address their specific needs in preventing the spread of HIV.

### ***Strategies***

- Support an increase in the number of activities for the prevention of HIV, including outreach projects for gay populations.
- Expand peer education activities.
- Support the development of appropriate IEC materials.
- Encourage joint projects and coordination between gay organizations and other NGOs working on HIV/AIDS and human rights issues.

**Broad activities related to MSM and expected output can be found in  
ANNEX 4**

## **5- PRISONERS**

There are a total of eight prisons in Macedonia. They house 1,573 prisoners, of whom 98% are male. There are also special facilities for juveniles. A report in 2000 (produced by the Clinic for Infectious Diseases, WHO, MoH and MoJ) highlighted that a high percentage of prisoners are drug users involved in high risk sexual behavior associated with forced and voluntary sex between men. Spreading of Hepatitis C is noticeable among the prisoners. Access to health services is poor, with a lack of medical staff and available drug treatment. Currently, there is no specific program of HIV prevention in the country's prisons.

### ***Goal***

- To prevent HIV transmission among prisoners.

### ***Impact indicator***

- Number of prisoners who are HIV infected.

## **TARGET INTERVENTIONS**

### **1. RAISING AWARENESS OF DECISION-MAKERS**

#### ***Objective***

- To ensure that decision-makers are aware of the risks of HIV/AIDS/STIs in prisons, so that measures are taken to reduce transmission.

#### ***Strategies***

- Train prison staff about HIV/AIDS and STI prevention.
- Ensure that offenders with HIV/AIDS have access to quality care, treatment, and support.
- Establish counselling services as part of the medical services of the correctional system, through NGOs.

### **2. INFORMATION-EDUCATION-COMMUNICATION ACTIVITIES**

#### ***Objective***

- To ensure that every prisoner is aware of the risks of HIV/AIDS/STIs and will have the power, means, and desire to act on the knowledge, within a supportive environment.

#### ***Strategies***

- Develop and distribute appropriate education materials in prisons.
- Implement HIV/AIDS inmate peer education activities.

- | • Allow possession and distribution of condoms and lubricants in prisons.

**Broad activities related to PRISONERS and expected output can be found in  
ANNEX 5**

## **6 - ROMA COMMUNITY**

The Roma community does not indicate high levels of STI/HIV however; they are considered a special group vulnerable to HIV infection due to a number of inter-related factors. Their social isolation and economic disadvantage exacerbates factors contributing to the potential spread of HIV/AIDS, high unemployment, low levels of education, poor health standards and poor access to health and other social services.

The Roma community overall have a lower level of education and literacy. They have a distinctive language and social, cultural background. Some of these factors may contribute to restricted access to information and services. Efforts must be made to provide information and services to the Roma community. Under the strategy, focus will be placed on developing a partnership with Roma groups and to tailor interventions to meet their unique needs and situation.

### ***Goal***

- To prevent HIV transmission among the Roma community.

### ***Impact indicator***

- Number of Roma people educated in HIV prevention

## **TARGET INTERVENTIONS**

### **1. RAISING THE AWARENESS OF THE ROMA LEADERSHIP**

#### ***Objective***

- To ensure that Roma leaders are aware of factors increasing the vulnerability of the community to HIV/AIDS and of effective methods of stopping the spread of infection.

#### ***Strategies***

- Directly involve the leaders of the Roma community and members in all aspects of research, programme planning, implementation and evaluation.

### **2. INFORMATION, EDUCATION, COMMUNICATION AND RESEARCH**

#### ***Objective***

- To ensure that members of the Roma community know how to avoid STIs and HIV infection and have the means to act on this knowledge.

#### ***Strategies***

- Support KABP studies within the Roma community.
- Directly involve the leaders and members of the Roma community in conducting research, and in analyzing the findings.

- Build research capacity within the Roma for identifying the determinants of HIV/AIDS risk behavior, to determine the most effective entry points and methods for educating the community.
- Develop means of addressing healthy life styles within the context of specific language, education and socio-cultural background.
- Target messages appropriately for men and women, based on their different roles in the family.
- Improve access to and development of specialized services (medical, testing, and counselling).
- Integrate STI/HIV prevention methods in programmes that address the socio-economic status of Roma.

### **3. CAPACITY-BUILDING**

#### *Objective*

- To strengthen the capacity of Roma organizations to address the needs within their communities, in order that such communities and individuals can be empowered to protect themselves from HIV/AIDS.

#### *Strategies*

- Design a training programme for Roma organizations to strengthen their ability to address HIV/AIDS prevention, care, treatment and support services.

**Broad activities related to ROMA COMMUNITY and expected output  
can be found in ANNEX 6**

## ***MOBILE GROUPS***

There is increasing recognition that migrants and mobile people may be more vulnerable to HIV/AIDS than are populations that do not move. They may acquire HIV while on the move, and take the infection back with them when they return home, often without even knowing it.

It is internationally recognized that this vulnerability is due to several factors such as stigmatization, loss of cultural identity, cross cultural changes, rapid and regular changes of environment that may impact on attitudes, practices and behaviors as well as limited access to health services and related as for the adaptation of different systems and care support.

It is estimated that the 25% of the Macedonian population lives abroad, due to economic disadvantage, socio cultural and educational reasons. According to the recently conducted survey, the waste majority of the Macedonian youth, already live abroad or plan to move in the future. It exist and extensive phenomenal of seasonal labor migration from Macedonia to foreigner countries and long standing migrants regularly return to Macedonia for holidays.

Given that this high mobility trend characterizes the socio-geographic functioning of Macedonia, there is an urgent need for responses that address the mobile grupus' particular vulnerabilities to HIV/AIDS. Efforts must be made to provide information and services to mobile communities (Seasonal migrants to third countries, Migrants from third countries, transit migrants and refugees and IDPs).

### ***Goal***

To prevent the spread of HIV/AIDS among mobile populations.

### ***Impact indicator***

Number of mobile people educated in HIV/AIDS prevention.

## **TARGET INTERVENTIONS**

### **1. Raising HIV/AIDS awareness of mobile populations coming/living/transiting into/through Macedonia.**

#### ***Objective***

- Ensure that mobile groups are aware of factors increasing the vulnerability to HIV/AIDS.
- Provide mobile groups with appropriate and effective methods to prevent themselves from HIV.

### *Strategies*

- Support peer-education approach. Directly involve the leaders of immigrant community and members in all aspects of research programme planning, implementation and evaluation.
- Increase target education and counseling programs to these populations;
- Target programs to particular areas attracting travelling populations where high risk behavior may occur.

## **2. TO PREVENT NEW HIV INFECTION “EXPOSED ABROAD” IN ORDER TO MAINTAIN A LOW INCIDENCE IN MACEDONIA.**

### *Objectives*

- Educate mobile groups who will live abroad for a fix period of time to prevent HIV exposure.
- HIV prevention among people living/working abroad and coming to Macedonia for vacation/others reasons.

### *Strategies*

- To strengthen HIV/AIDS preventive intervention at the pre-departure stage of migration.
- To support the development of HIV/AIDS prevention material to be used during transit and destination stages of the migration process.
- To intensify HIV prevention interventions towards people living/working abroad and coming to Macedonia for vacation/other reasons, as well develop relevant and appropriate informative materials. Particularly stressing equal exposure to HIV infection according to behaviours, regardless of geographical position

## **3. INFORMATION AND RESEARCH**

### *Objective*

Increase information and knowledge on the issues of mobility and HIV/AIDS in the contest of Macedonia.

### *Strategies*

- Promote research within relevant stakeholders for identifying the determinants of HIV/AIDS risk behavior, to determine the most effective entry points and methods for educating this population.
- Develop means of addressing healthy life styles within the mobility contest of specific language, education and socio-cultural background.

### **3. CAPACITY-BUILDING**

#### ***Objective***

Strengthen the capacity of health care providers, NGOs and other relevant actors to address prevention and care issues among mobile groups.

#### ***Strategies***

- To design a training programme for the selected target and strengthen their ability to address HIV/AIDS prevention and care among mobile population
- To support networking among entities dealing with mobile groups and HIV/AIDS issues.

**Broad activities related to MOBILE GROUPS and expected output can be found in ANNEX 7**

# **HEALTH CARE SETTING**

## **HEALTH CARE SETTING**

Research has shown that there is awareness among the general public about the risk of contracting HIV through the reusing of syringes, and that all physicians are aware of this risk. Universal precautions stipulating that the same precautions must be taken with every patient when handling blood or body fluids, and not only with those known to be infected, are not well understood. People generally believe it is important that injections be given with new disposable syringes and needles, but there may still be isolated cases where syringes and needles are reused, unbeknownst to the patient. This is much more likely to occur when lay health workers in rural areas are involved.

The Ministry of Health, due to its leading role has tried to issue recommendations on universal precaution procedures in hospitals and medical institutions. However the doctors and medical staff in hospitals, emergency rooms labs or polyclinics are still not following them. Most of the institutions have no specific instructions on HIV precautions for their staff. More than 40% of the dentists still work without gloves and masks.

The below mentioned goal is based on careful attention to infections control procedures, including the blood safety, proper sterilization of equipment used for surgical and other invasive procedures. The National Institute of Transfusiology ensures national coordination of blood donation. Since 1997 all donated blood products have undergone mandatory testing for HIV. Approximately 48,000-50,000 blood units are tested each year. In the case of inconclusive results, the blood is sent for confirmation with Western Blot tests at the Clinic for Infectious Diseases. Blood is also tested for hepatitis C (HCV), hepatitis B (HBS) and syphilis.

### ***Goal***

To prevent HIV transmission in the health care settings.

### ***Impact indicator***

Number of HIV infections due to a professional exposure in health care settings.

Number of medical staff wearing gloves per intervention.

## **TARGET INTERVENTIONS**

### **1. GUIDELINES FOR UNIVERSAL PRECAUTIONS**

#### ***Objective***

To ensure that guidelines for universal precautions are followed in all health care facilities.

### *Strategies*

- Support the development and distribution of guidelines for universal precautions.
- Ensure that resources are allocated to support the following of universal precautions, define the means needed, and allocate the respective resources.
- Ensure PEP treatment as an emergency medical response for medical workers who accidentally became exposed to HIV during the course of their work, for example, by accidental needle jabs. PEP Treatment must be initiated within hours of possible HIV exposure (ideally within two hours and not later than 72 hours) following such exposure and must continue for a period of approximately four weeks.
- Creation of centre and development of protocol for reporting of occupational accidents of health workers<sup>14</sup>.
- Establish a mechanism for assessing the use of universal precautions as part of individual contracts signed by hospitals with the health insurance system.

## **2. UNIVERSAL PRECAUTIONS TRAINING**

### *Objective*

To make all health staff fully aware of and responsible for following universal precautions, to motivate them and offer the resources needed to follow these.

### *Strategies*

- Support the development and dissemination of IEC materials on universal precautions.
- Establish a mechanism for training all health staff, including dentists, on universal precautions.

## **3. INJECTION SAFETY**

### *Objective*

To ensure that only essential injections are given and that these are given safely.

### *Strategies*

- Support the development and dissemination of IEC materials for the general public on the importance of limiting the number of injections and on receiving them only from qualified health care staff.
- Support the development of pre-service and in-service training materials on safety of injection for all health staff.
- Support the training of health care providers, including dentists, on injection safety.

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<sup>14</sup> This Centre will be under the new "HIV/AIDS/STI Centre" (see under the section for Epidemiological Surveillance) that will be established.

#### 4. BLOODBORNE TRANSMISSION OF HIV

##### *Objective*

To prevent bloodborne transmission of HIV and other bloodborne diseases.

##### *Strategies*

- Improve the recruitment and retention of voluntary, non-remunerated regular blood donors to ensure a safe blood supply.
- Provide donors with pre-donation counseling, written consent and self-deferral and referrals for continued counseling as required.
- Screen donated blood for HIV prior to transfusion following the last recommendation of Council of Europe and WHO.
- Training the staff of blood transfusion services in correct procedures, including techniques for rendering blood products safe for use during the whole blood chain “vein to vein”.
- Education on prescribes of blood and blood products in order to reduce unnecessary transfusions and support the autologe transfusion if possible.
- Establishing practical guidelines for limiting resource to transfusions and autologe transfusion.
- Strengthen and extend the existing chain for registration of donors (including deferred donors), screening, evaluation, feedback and traceability on the local and national level.

#### 5. MONITORING AND CONTROL

##### *Objective*

To ensure adequate enforcement of universal precautions and quality assurance system by which every health care unit is periodically assessed.

##### *Strategies*

- Support the establishment of a system of quality assurance for hospital services.
- Enforce a system of disqualification and/or penalties for individuals and hospital administrators breaching universal precautions.

**Broad activities related to HEALTH CARE SETTING and expected output can be found in ANNEX 8**

# **POLICY ON TESTING**

## **POLICY ON TESTING**

In Macedonia, there is stigma attached to HIV and concern regarding the confidentiality of the testing process<sup>15</sup>. Currently, new antiretroviral drugs are unavailable in Macedonia, providing little incentive for an individual to be tested for HIV. Furthermore, there is limited pre- and post-test counseling for HIV testing and little “social marketing” of the potential benefits of testing. People are reluctant to be tested for HIV until symptoms develop and information suggests that most diagnosed individuals first tested positive late in the course of HIV disease. Individuals take advantage of out-of-country testing due to confidentiality concerns<sup>16</sup>. HIV testing is free<sup>17</sup> with a doctor’s referral and a patient can access HIV testing via a doctor’s referral or by going directly to a district PHI office or the Clinic for Infectious Diseases (CID) in Skopje. Laboratories at these three latter venues do screening ELISA tests for HIV; there are also several private laboratories that perform screening tests. Positive screening tests (defined by two positive ELISA tests) from all laboratories are sent to the Clinic for Infectious Diseases (CID) for confirmatory testing using Western Blot methods. However, it is possible that some results from private laboratories may not go on to confirmatory testing due to confidentiality concerns. There is a potential gap here for surveillance. There are no quality assurance programs in place for either the laboratories performing the HIV screening tests or the central laboratory performing the confirmatory test.

### ***Goal***

To develop national policy on HIV testing.

### ***Impact indicator***

Annual number of implemented VCT.

## **TARGET INTERVENTIONS**

### **1. CONFIDENTIAL, VOLUNTARY AND COUNSELED HIV TESTING**

#### ***Objective***

To establish an accessible, voluntary, confidential HIV testing system that includes pre- and post-test counselling.

#### ***Strategies***

- Ensure availability of voluntary HIV testing, including anonymous testing, to include pre- and post-test counselling.
- Develop guidelines for public and private institutions (including NGOs) to standardize testing and counselling procedures.

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<sup>15</sup> There is extensive anecdotal evidence of breach of patient confidentiality. Article 43 of the Law for Health protection defines the importance of respecting ‘professional secrets’ to protect the rights’ of patients.

<sup>16</sup> The most commonly cited country of choice is Bulgaria.

<sup>17</sup> Testing is free with a doctor’s referral, otherwise the cost is approximately 20US\$- for instance to receive needed certification of negative status for travel abroad.

- Provide the necessary resources (human and financial) to secure an appropriate pre- and post-test counselling system.
- Inform the public about testing procedures, sites and rights.

## **2. LEGAL AND ETHICAL ASPECTS OF HIV TESTING**

### ***Objective***

To ensure that no legal or hidden requirements call for HIV/AIDS testing which are in contradiction with respective laws and/or the constitution.

### ***Strategies***

- Ensure the screen of legislation and acts of lower hierarchy;
- Initiate legal changes, if needed;
- Establish dialogue with the private sector;
- Ensure support of legal action to fight hidden practices, if needed.
- Communicate legal and ethical aspects of HIV testing to all health care providers.

**Broad activities related to POLICY ON TESTING and expected output  
can be found in ANNEX 9**

# **HIV SURVEILLANCE**

## **HIV SURVEILLANCE**

As reported in the Situation Analysis, an accurate epidemiological representation of the incidence of HIV/AIDS is not clear. The national surveillance mechanisms and reporting system function in a passive way. For example, although the incidence of STIs appears to be decreasing, it is not clear whether this is simply a reflection of under-reporting in both the public and private health system. Thus, little concrete information on HIV/AIDS/STIs exists and/or is being gathered, particularly as concerns identified vulnerable groups.

Surveillance mechanisms are intrinsically linked to the implementation of VCCT services. These services require a number of key elements to be effective; community awareness, education and mobilization to ensure those wishing to be tested understand what the test process is and where testing can be undertaken. Likewise, training of health, social workers and other staff in minimum standards of counseling and management of onward referral is essential.

The Situation Analysis found that there were gaps in data analysis and feedback, and potential problems with the completeness of reporting. Currently, the quality of the data and the level of analysis available are insufficient to identify trends in HIV/AIDS, and therefore may hinder designing the most appropriate responses.

### ***Goal***

To know the epidemic situation, including trends and main determinants of HIV/AIDS/STIs infection.

### ***Impact indicator***

Yearly national reports of HIV/AIDS/STI biologic and behavior surveillance of vulnerable groups.

## **TARGET INTERVENTIONS**

### **1. HIV SURVEILLANCE**

#### ***Objective***

To ensure increase of national capacity to conduct biologic and behavioral surveillance relating to HIV/AIDS and STIs.

The system should collect, analyze and ensure the timely dissemination of information to key stakeholders.

#### ***Strategies***

- Improve the quality and quantity of reporting.
- Establish a mechanism for evaluation and feedback on reporting.
- Ensure that mechanisms protect confidentiality and that systems are designed to collect and disseminate information without identification of individuals.

- Ensure trained staff in second generation surveillance.
- Serological and behavior surveys and studies among vulnerable groups including IDUs, CSWs, prisoners, MSM and STI patients.
- Develop a written protocol for the HIV/AIDS/STI surveillance system.
- Creation of "HIV/AIDS/STI Centre" (monitoring HIV/AIDS/STI trends, HIV/AIDS/STI biologic and behavior surveillance, reporting the occupational accidents of health workers, availability of voluntary HIV testing, including anonymous testing, pre- and post-test counselling, etc).
- Strengthen the mechanism for dissemination of data and analysis to national/local decision-makers, health care personnel and epidemiologists, for use in planning.
- Develop a laboratory quality assurance program for HIV testing

**Broad activities related to HIV SURVEILLANCE and expected output  
can be found in ANNEX 10**

# **HEALTH CARE**

## **HEALTH CARE**

Currently, access to antiretroviral drugs in Macedonia is very limited even there are only a few officially registered people living with HIV/AIDS.

No mandatory testing on HIV or HIV counselling for pregnant women has been introduced in the country. The health staff needs additional skills and knowledge to provide safer delivery practices, infant-feeding counseling and support. The standard protocol and resources for routine ARV have to be made available to all pregnant women found to be HIV-positive.

Official reports of registered cases of STIs show a decreasing trend over the past decade. STI data in Macedonia may be incomplete. Some healthcare professionals speculate that STIs may be under-reported by a factor of three to four. By law, it is obligatory to report syphilis and gonorrhoea. It was anecdotally noted that some doctors do not report syphilis according to established procedures, and that doctors in private clinics are especially likely to not report cases. Gonorrhoea is even more likely to be under reported since it is generally not taken as seriously as syphilis by the health care providers. There is no requirement to report STIs such as herpes or chlamydia and so there is very little data on these diseases. Integration of STI case management, prevention and care into primary health care facilities, maternal and child health, family planning, Ob/gynaec facilities and others is one of key elements. It makes STI services available, accessible for more people. It has also great advantage that people can avoid stigma of addressing a dedicated STI clinics.

## **TARGET INTERVENTIONS**

### **1. STANDARDISED TREATMENT OF PLWHA**

#### ***Objective***

To ensure the use of a standard National protocol for treatment and care of PLWHA.

#### ***Strategies***

- Develop and implement a standard National protocol for treatment and care of PLWHAs.
- Inclusion of minimum seven ARV drugs on the drug list reimbursed by the Health Insurance Fund.
- Ensure that adequate resources are allocated, so that all people with HIV/AIDS have equal access to the defined standard treatment and to treatment for AIDS-related infections.
- Provision of training to health professionals on the clinical management of PLWHAs, with particular focus on ARV.

## **2. DECENTRALISE TREATMENT AND SERVICE OPTIONS**

### ***Objective***

To provide accessible and cost-efficient services for PLWHA; including clinical care, home care, day clinics and out-patient services.

### ***Strategies***

- Support the development of standard guidelines for palliative care.
- Support clinical management training for health workers.
- Support the development of NGOs and faith based organizations capacity to provide alternative care and support services for PLWHA.
- Develop the capacity of general practitioners (GP) to provide basic medical and counselling services to PLWHA.

## **3. MOTHER-TO-CHILD TRANSMISSION**

### ***Objective***

To ensure minimum HIV transmission from HIV-infected women to their child

### ***Strategies***

- Ensure that all pregnant women receive adequate counselling about the risks of HIV/AIDS, and that they have access to voluntary and confidential testing.
- Ensure standard protocol and resources for routine ARV are made available to all pregnant women found to be HIV-positive.
- Ensure health staff has the skills and knowledge to provide safer delivery practices, infant-feeding counselling and support.

### ***Objective***

To prevent unintended pregnancies among HIV-infected women

### ***Strategies***

- Ensure essential care and support services, including family planning and other reproductive health services, so that the women can make informed decisions about their future reproductive lives.

### ***Objective***

To provide care and support to HIV-infected women, their infants and families

### ***Strategies***

- Strengthen the linkages among activities for the prevention of HIV in pregnant women, mothers and their children with care and support services for HIV-infected women, and their families
- Improve the mother's survival and quality of life, as they are critical for her own well-being, as well as for her child and other family members.

#### **4. INTEGRATION OF STI CASE MANAGEMENT, PREVENTION AND CARE**

##### ***Objective***

To ensure comprehensive case management, prevention and care of STIs

##### ***Strategies***

- Promotion of comprehensive case management including identification and treatment of syndromes, education and counselling, condom supply, information on partner notification and treatment. Development and implementation of evidence based case management guidelines is crucial.
- Prevention and care of congenital syphilis and neonatal conjunctivitis (women should be educated and motivated to attend antenatal clinics early in pregnancy where screening will be offered and if necessary treatment for syphilis will be provided. Routing prevention for ophthalmia at birth should be provided).

**Broad activities related to HEALTH CARE and expected output can be found in ANNEX 11**

# **HUMAN RIGHTS AND SOCIAL SUPPORT FOR PLWHA**

## **HUMAN RIGHTS AND SOCIAL SUPPORT FOR PLWHA**

Low reported incidence of HIV/AIDS infection has meant that the care and support of PLWHA in Macedonia is characterized by clinical/hospital care. Decentralised community care, AIDS specific palliative care and social support are under developed or provided on an ad hoc basis.

There is no legislation that specifically targets HIV/AIDS in Macedonia. However, Macedonia is a member of the Council of Europe (CoE) and is therefore bound by the European Convention on Human Rights (ECHR). Macedonia has further ratified all major international human rights conventions and signed the UN Declaration of Commitment on HIV/AIDS.

### ***Goal***

To ensure adequate care and support services for PLWHA and those affected by HIV/AIDS.

### ***Impact indicator***

Percentage of health facilities with the capacity to deliver appropriate care to PLWHA  
Percentage of people receiving ARV.

## **1. SOCIAL SUPPORT NETWORK**

### ***Objective***

To ensure that all PLWHA and persons affected by HIV/AIDS have access to the necessary and confidential social support.

### ***Strategies***

- Support information campaigns to inform the public and destigmatize PLWHA.
- Establish an accessible, confidential social support network for PLWHA.
- Develop a policy framework and mechanism for governmental institutions to contract the services of NGOs or other organizations to provide services for PLWHA, or to provide training to government staff.

## **2. INTEGRATION OF CHILDREN WITH HIV/AIDS**

### ***Objective***

Ensure that children living with HIV/AIDS are fully integrated in everyday social and educational activities.

### ***Strategies***

- Ensure that children with HIV/AIDS have full access to regular public schools.
- Decrease the discrimination from parents, teachers, and other individuals in the community towards children with HIV/AIDS.

### **3. IMPROVING ACCEPTANCE OF PEOPLE WITH AIDS**

#### ***Objective***

To ensure that all people infected with and affected by HIV/AIDS are fully integrated in everyday social and work activities.

#### ***Strategies***

- Use the mass-media to disseminate messages for reducing discrimination and raising tolerance of PLWHA and their families.
- Ensure the team of professionals to work on Macedonian legislation to ensure presence of HIV/AIDS human rights as a vehicle for dealing with the multifaceted aspects of the disease taking into account the UN Guidelines on HIV/AIDS and Human Rights.
- Ensure the participation and full involvement of representatives of PLWHA in processes leading to policy decisions affecting them.

**Broad activities related to HUMAN RIGHTS AND SOCIAL SUPPORT FOR PLWHA and expected output can be found in ANNEX 12**

# **MANAGEMENT MECHANISMS**

## **MANAGEMENT MECHANISMS**

Key feature of the national response to HIV/AIDS has been the emergence of a number of NGOs who are working closely with a number of vulnerable groups. These NGOs not only operate from fixed bases but also carry out a wide range of outreach activities. Consequently, many people from vulnerable groups find services offered by NGOs to be readily accessible to them. This is particularly important in the current environment where many people from these vulnerable groups find themselves subject to considerable stigma and discrimination. However, there is need for these NGOs to develop further institutional capacity, to work more cooperatively with each other, to facilitate the development of other NGOs (particularly outside the capital) and to establish sustainable sources of funding.

The overall goal of the National Strategy is to extend and strengthen the coordination and capacity of the national response to prevent a major HIV/AIDS epidemic in Macedonia. This strategy builds on initiatives to extend HIV/AIDS activities beyond the health sector. It will seek to expand existing activities already proven effective, introduce a range of new activities and strengthen overall coordination and cooperation between stakeholders. All stakeholders involved in the Strategy are committed to ensuring that requisite measures are implemented for the benefit of individuals, communities or the general public.

### ***Goal***

To extend and strengthen the coordination and capacity of the national response to HIV/AIDS.

### ***Impact indicator***

Number of members of the National Multisectoral Commission on HIV/AIDS who believe that capacity is increasing and the response to HIV/AIDS is well-coordinated in the country.

### ***Strategies***

- Build the institutional and technical capacity of the various agencies that will implement this program in more general areas such as management, financial management, reporting, personnel management etc. This is particularly important in the NGO sector as more organizations are formed to work in this area.
- Ensure to succeed the reporting requirements of the program, both internal and external and both financial and narrative through strengthening the human resources capacity and collaboration of the groups involved in reporting, e.g. implementing agencies.
- Ensure that the program is adequately monitored and evaluated at three different levels – goal, objective and activity through strengthening of the capacity and networking of the implementing agencies.
- Sharing lessons learned from the program through publication and networking with other countries.

- Contribute to development of additional policies and strategies, particularly at national level (it is envisaged that these would expand on and strengthen the National HIV/AIDS Strategy and may in some cases require supporting legislation).
- Build political support for HIV/AIDS activities in the country.

The Macedonian National Strategy on HIV/AIDS is a critical enterprise and must be managed and coordinated efficiently and effectively to ensure maximum results from resources invested in its implementation. The National Multisectoral HIV/AIDS Commission has responsibility for:

- Coordination and monitoring implementation of HIV/AIDS activities at national level;
- Oversight, coordination and monitoring implementation of HIV/AIDS activities within the framework of the National Strategy at national and local level;
- Facilitating information-sharing among stakeholders and the donor community;
- Revision and updating the national strategy (if/when required);
- Discussion and policy recommendations on issues relating to HIV/AIDS at national and local level;
- Coordination/oversight of national and international resource mobilization.

The National HIV/AIDS Strategy provides a framework to guide the development of targeted interventions and activities within national programmes and will serve as the basis for monitoring and evaluation of the national response. Within the context of decentralization, the National Strategy on HIV/AIDS will allow and aid local authorities and organizations to develop responses tailored directly for their community needs. The cooperation and coordination developed between government structures and the NGO sector offer opportunities for far reaching programming to tackle the complex issues surrounding the prevention of HIV/AIDS and treatment for PLWHA.

**Broad activities related to MANAGEMENT MECHANISMS and expected output can be found in ANNEX 13**

# **RESOURCE MOBILIZATION**

## **RESOURCE MOBILIZATION**

Despite the harsh macroeconomic environment and the measures which are in place to control public expenditure, the government has envisaged significant increases in expenditure on HIV/AIDS over the next three years. HIV expenditure is budgeted to increase from current levels of MKD 5.5m to MKD 13.6m in 2006. This is equivalent to US\$272k at current rates of exchange and would also represent almost a 150% increase in direct HIV/AIDS expenditure within three years. Naturally, this budget increase is ambitious given the current economic uncertainties.

In the present economic and social situation it will be difficult to find sufficient resources within Macedonia alone, to adequately address priorities identified in the National HIV/AIDS Strategy. The current government was elected in October 2002. It faces a large number of competing political and social priorities, including economic reform and limited budgets. An IMF Stand-by Agreement, signed in February 2003, demands additional fiscal restraint in order to facilitate macro-economic stability. This will no doubt limit the scope of the government's resource allocation in the areas of HIV/AIDS.

That said, the government has recognized the existence of factors that could facilitate a sudden and rapid growth of HIV/AIDS and the window of opportunity low infection rates present, by pledging to increase domestic financial resources committed to HIV/AIDS. The total budget for the implementation of the National HIV/AIDS Strategy for 2003-2006 is estimated on 12 million US\$

To offset limited resources the National HIV/AIDS Strategy will be used as a vehicle for national and international fund-raising, and for ensuring the most effective use of those resources available.

# **CONCLUSION**

## CONCLUSION

Steady progress has been made for addressing HIV/AIDS in Macedonia, but much remains to be done. Although current infection rates appear to be low, regional trends suggest the very real potential for a rapid spread of HIV/AIDS. Regional trends further illustrate that the failure to respond at the early stages in the epidemic can have profound medical, social and economic costs in the long run.

Although there are a number of interesting, innovative and imaginative projects being implemented on HIV/AIDS in the country, a number of key gaps remain. These include:

- The relatively small scale of targeted interventions for youth and identified groups of special interest for HIV infection including IDUs, sex workers, MSM, prisoners, mobile groups and the Roma community.
- Limited access to counselling and testing services. In addition, the quality of these services is variable
- Limited access to medical care and support for PLWHAs. In particular, there is still a strong sense of stigma and discrimination within Macedonian society as a whole
- Limited availability of important biologic and behavioural surveillance data relating to the spread and development of the epidemic
- Relatively limited capacity within the HIV/AIDS response and a degree of fragmentation of services and approaches

This strategy gives Macedonia the chance to build a national, multisectoral response to address the complex issues raised by HIV/AIDS. By involving all stakeholders in the design and implementation of a flexible and inclusive national strategy, the National Multisectoral Commission for HIV/AIDS is confident that the spread and impact of HIV/AIDS in Macedonia can be reduced substantially over the next three years.

# **ANNEXES**

## ANNEX 1

### Broad activities related to YOUTH and expected output

Main activities	Process/Output Indicators	2003	Year 1	Year 2
		Workshop discussions among NGO's to upgrade and identify best practice for peer education	Number of annual workshops	0
Establishing pilot educational center for HIV/AIDS/STI and reproductive health.	Pilot educational center established	0	1	N/A
Peer education activities	Number of peer education training workshops annually	2	12	15
Condom promotion activities	Number of condoms distributed annually	100 000	120 000	150 000
Targeted information dissemination for young people	Number of printed and distributed brochures annually	0	300 000	350 000
National media campaign using TV and radio to spread information, skills and awareness of HIV/AIDS/STI through educational and entertainment methods.	Number of HIV/AIDS-related shows broadcast on national and local media annually	7	150	150
Developing an interactive web-page on HIV/AIDS/STI	Annual number of users of the information of the web-page	0	10 000	15 000
Development of publication that promotes inter-generational conversations on HIV/AIDS/ STI	Number of publications disseminated to parents annually	0	1 000	1 000
Training health and social service providers on Youth Friendly Services skills	Number of health and social service providers who are trained to be youth friendly annually	0	75	75
Develop and integrate life-skills health based education within the school curricula	Program defined for teaching on HIV/AIDS/STI and reproductive health issues	0	1	N/A
Training of teachers in primary and secondary schools on HIV/AIDS/STI and reproductive health issues	Number of teachers trained per year	0	393	786
Production of training manual for teachers	Number of manuals distributed per year	0	393	786
Promoting safe behavior among young people doing military service	Number of recruits receiving HIV/AIDS education annually	N/A	13 000	16 000

Including HIV/AIDS/STIs education into the basic training program of professionals in law enforcement forces and military	Special HIV/AIDS/STIs education curricula developed and included into the basic of training program	0	1	1
Training of law enforcement forces and military medical/social staff in (IEC) related to HIV/AIDS/STIs topics.	Number of law enforcement forces and military medical/social staff trained	0	100	170
Developing national law enforcement forces and military service focused production, distribution and use of IEC materials related to HIV/AIDS/STIs topics	Production, distribution and use of materials developed	0	25.000	25.000
Condom distribution among the law enforcement forces and military troupes dislocated because of intervention	Number of condom distributed	0	12.000	15.000

## ANNEX 2

### Broad activities related to IDU and expected output

Main activities	Process/Output indicators	2003	Year 1	Year 2
		Scaling up three existing harm reduction programs	Number of injecting drug users receiving harm reduction interventions annually	2000
Establishing 7 new harm reduction programs including development of special services for sex workers who are IDUs and female IDU's	Number of injecting drug users receiving harm reduction interventions annually	N/A	1000	1600
Training of health and social workers from primary health care and social welfare services in harm reduction principles and work with IDU's	Number of health and social workers who received training annually	N/A	50	30
Training of police professionals in the basic principles of harm reduction and work with IDU	Number of police professionals who receive training annually	N/A	25	25
Campaign to create more positive public opinion towards harm reduction programs, in particular, and IDUs, in general.	Number of people receiving information annually	N/A	1000	1500
Developing a national strategy to decentralize drug treatment activities	Strategy developed	0	1	1
Improving access to drug treatment – decentralization of treatment services for drug users through six new centres	Number of injecting drug users receiving treatment annually	680	800	1000
Providing pre treatment-counseling and referring to decentralized treatment facilities	Number of people receiving counseling and early intervention annually	150	300	500
Development of self-help support networks for drug users on treatment	Number of injecting drug users involved in self help/support groups annually	80-100	300	400
Training seminars for community leaders, staff working in decentralized centers and decision makers	Number of seminars held annually	0	5	1
Condom distribution	Number of condom distributed	40.000	60.000	70.000

## ANNEX 3

### Broad activities related to CSW and expected output

Main activities	Process/Output indicators	2003	Year 1	Year 2
Promotion of safer sex, condom use and distribution of free condoms among sex workers and their clients	Number of sex workers reached with targeted HIV/AIDS interventions annually	103	135	200
	Number of clients reached with targeted HIV/AIDS interventions annually	0	1 200	2 500
Providing medical and social support for sex workers including STI treatment	Number of sex workers using medical, social and legal services annually	103	125	160
Provision of drop-in center for sex workers	Number of sex workers using drop-in facilities annually	0	50	100
Prevention of entry into sex work among young women	Number of young people reached with prevention interventions annually	0	1000	2500
Condom distribution	Number of condom distributed	15.000	20.000	20.000

## ANNEX 4

### Broad activities related to MSM and expected output

Main activities	Process/Output indicators	2003	Year 1	Year 2
		Production and distribution of targeted HIV prevention literature.	Number of distributed brochures annually	200 (1999)
Free distribution of condoms and lubricants through clubs and other locals frequented by MSM	Number of distributed condoms annually	2000 (2001)	10 000	15 000
Establishment of national gay and lesbian centre focusing on HIV/AIDS	Working hours of the Hotline (per month)	60	150	240
	Number of pre and post testing sessions in the Counselling service (hours per month)	40	100	200
Expand the number of organizations working with MSM on HIV/AIDS	Number of organizations with HIV/AIDS activities focused on MSM	2	3	5

## ANNEX 5

### Broad activities related to PRISONERS and expected output

Main activities	Process/Output indicators	2003	Year 1	Year 2
		Training of prison social and medical staff in conducting IEC	Number of prison social and medical staff trained per year	5
Training of peer educators among prisoners	Number of prisoners acting as peer educators (cumulative)	0	48	80
Improving access to health services	Number of prisoners receiving good health services including a drug treatment annually	N/A	500	900
Tailored information distribution for prisoners	Number of printed and distributed brochures annually	N/A	4 800	6 300
Promotion and distribution of condoms and lubricants	Number of condoms and lubricants distributed annually	N/A	7 000	10 000

## ANNEX 6

### Broad activities related to ROMA COMMUNITY and expected output

Main activities	Process/Output indicators	2003	Year 1	Year 2
Training of Roma peer educators	Number of peer educators trained per year	3	24	18
Expanded peer outreach activities in Roma communities	Number of Roma people educated per year	N/A	2 300	3 700
Training of social and health care professionals for better IEC with Roma people	Number of social and health care professionals trained per year	0	26	13
Early detection of STIs among Roma women of reproductive age	Number of STIs examinations performed among Roma population in reproductive age (annually)	N/A	3 700	7 300
Promotion and distribution of condoms and lubricants	Number of condoms distributed annually	10 000	65 000	100 000
Tailored information distribution for Roma people, including people with very limited literacy	Number of brochures distributed annually	N/A	34 000	25 000
Roma local media campaign for HIV/AIDS/STI awareness	Number of special educative shows broadcasted on local Roma TV and radio annually	1	48	96

## ANNEX 7

### Broad activities related to MOBILE GROUP and expected output

Main activities	Process/Output indicators	2003	Year 1	Year 2
Training /workshops of NGOs and other professionals on the issue of mobility and HIV/AIDS	Number of people trained	30	30	30
Tailored information distribution for mobile people, including people with very limited literacy	Number of brochures distributed annually	N/A	N/A	N/A
Provision of HIV/AIDS materials to people leaving the country	Number of mobile people contacted	2000	2000	2000
Production of relevant publications	Number of publications	1	2	N/A
Qualitative/quantitative research	Number of contacts/questionnaires	N/A	N/A	60/400
Seminars/conferences on mobility and HIV/AIDS	Number of events	1	1	1
Media campaign for HIV/AIDS/STI awareness among mobile group	Number of special shows broadcaster on TV and radio annually	N/A	N/A	N/A

## ANNEX 8

### Broad activities related to HEALTH CARE SETTING and expected output

Main activities	Process/Output indicators	2003	Year 1	Year 2
		Development and distribution of guidelines for universal precautions	Number of guidelines for universal precautions distributed per year	13.000
Allocate resources to support the follow up of universal precautions implementation	Resources are allocated to support the following of universal precautions implementation	55%	70%	90%
Ensure PEP treatment as an emergency medical response for medical workers	PEP treatment ensured as an emergency medical response for medical workers	0	100%	100%
Creation of centre and development of protocol for reporting of occupational accidents of health workers	Centre established and the protocol developed	0	1	1
Establish a mechanism for assessing the use of universal precautions as part of individual contracts signed by hospitals with the health insurance system	Mechanism established	0	1	1
Training of all health staff, including dentists, on universal precautions and safe injections	Number of health staff and dentists trained on universal precautions and safe injections	1.000	3.000	5.000
Development and dissemination of IEC materials on universal precautions.	IEC materials on universal precautions developed and disseminated.	0	20.000	23.000
Development and dissemination of IEC materials for the general public on the importance of limiting the number of injections and on receiving them only from qualified health care staff	Number of IEC materials related to injections distributed to general public.	0	200.000	250.000
Development of pre-service and in-service training materials on safety of injection for all health staff	Number of health staff using pre-service and in-service training materials on safety of injection.	0	20.000	23.000
Training of health care providers, including dentists, on injection safety	Number of health care providers and dentists trained on injection safety	1.000	3.000	5.000
Establish a protocol for blood donation to prevent bloodborne transmission of HIV and other bloodborne diseases	Protocol established	0	1	1
Training the staff of blood transfusion services in correct procedures, including techniques for rendering blood products safe for use	Number of staff trained	0	1	1
Educate the prescribers of blood and blood products in order to reduce unnecessary transfusions and promote use of autologous transfusion	Number of prescribers educated	0	350	500
Establish practical guidelines for autologous transfusion and limiting recourse to transfusions	Guidelines for autologous transfusion and limiting recourse to transfusions established.	0	1	1
Strengthen and extend the existing chain for registration of donors (including deferred donors), screening, evaluation, feedback and traceability on the local and national level	Deferred donors registered	30%	95%	100%
Establishment of a system of quality assurance for hospital services	Number of disqualified and/or penalized individuals and hospital administrators for breaching universal precautions	0%	85%	100%

## ANNEX 9

### Broad activities related to POLICY ON TESTING and expected output

Main activities	Process/Output indicators	2003	Year 1	Year 2
		Increasing number of testing centers	Number of testing centers and facilities	6
Outreach teams for counseling on HIV/AIDS	Number of outreach activities for HIV/AIDS counseling	0	0	30
Development of training manual with protocols for counseling/testing	Number of printed manuals distributed annually	0	1 000	1 000
Training of competent counselors	Number of counselors trained (cumulative)	10	20	50
Training of health providers on counseling and testing	Number of medical personnel trained (cumulative)	100	300	500
Integration of counseling/ testing into the medical/social service system	Material developed for integration into curricula	N/A	1	N/A
Production of brochures on HIV/AIDS counseling and testing	Number of printed brochures	120 000	200 000	400 000

## ANNEX 10

### Broad activities related to HIV SURVEILLANCE and expected output

Main activities	Process/Output indicators	2003	Year 1	Year 2
		Increase capacity of the Ministry of Health to use currently available HIV/AIDS/STI case report data for public health action	Workshops conducted annually	0
Training in second generation surveillance	Number of training workshops annually	0	4	2
Develop a written protocol for the HIV/AIDS/STI surveillance system.	Written protocol for HIV/AIDS/STI surveillance system developed	0	1	N/A
Serological surveys and prevalence studies among vulnerable sub-populations including IDUs, CSWs, prisoners, MSM and STI patients	Survey reports and results published	0	1	1
Behavior surveys and studies among vulnerable sub-populations including IDUs, CSWs, prisoners, MSM, Roma population and young people	Survey reports and reports published	0	1	1
Establishment of HIV/AIDS/STI Centre	HIV/AIDS/STI Centre established	0	1	1
Improving reporting and feedback within the national HIV/AIDS/STI surveillance system	Reporting forms for HIV/AIDS/STIs updated and improved	0	1	N/A
Develop a laboratory quality assurance program for HIV testing	Written protocol developed and reference laboratory nominated	0	1	N/A

## ANNEX 11

### Broad activities related to HEALTH CARE and expected output

Main activities	Process/Output Indicators	2003	Year 1	Year 2
		Inclusion of ARV on the drug list reimbursed by the Health Insurance Fund	Minimum seven of ARVs included on the drug list reimbursed by the Health Insurance Fund	3
National Guidelines for treatment and care of PLWHAs	Developed National Guidelines for treatment and care of PLWHAs	0	1	n/a
Building up the treatment and care infrastructure	Number of PLWHAs receiving ARVs	Currently, no baseline figures for this are available. These will be collected within six months of the start of the program and targets set on the basis of those and forecasts based on surveillance data.		
Provision of training to health professionals on the clinical management of PLWHAs, with particular focus on ARVs	Number of health professionals trained	0	5	10
Ensure that all pregnant women receive adequate HIV/AIDS counselling, access to voluntary and confidential testing.	Number of pregnant women receive adequate HIV/AIDS counselling, access to voluntary and confidential testing	N/A	70%	100%
Ensure that all HIV positive pregnant women receive ARVs	Number of HIV positive women receive ARVs	0	100%	100%
Training of health staff working with pregnant women on HIV/AIDS skills and knowledge to provide counselling and testing procedures, and ensure confidentiality	Number of staff trained	100	130	170
Ensure health staff has the skills and knowledge to provide safer delivery practices, infant-feeding counselling and support.	Number of staff trained	90	120	150
Developing services for essential care and support for pregnant woman, including family planning and other reproductive health services	Number of services developed	5	9	13
Development and implementation of evidence based STI case management guidelines.	STI case management guidelines developed	0	1	n/a
Education/information of women to attend antenatal clinics early in pregnancy	Number of women educated/informed	N/A	35%	70%

## ANNEX 12

### Broad activities related to SOCIAL SUPPORT FOR PLWHA and expected output

Main activities	Process/Output Indicators	2003	Year 1	Year 2
		Ensure that children living with HIV/AIDS are fully integrated in everyday social and educational activities.	Number of children living with HIV/AIDS excluded from everyday social and educational activities.	N/A
Team of professionals work on Macedonian legislation to ensure presence of HIV/AIDS human rights as a vehicle for dealing with the multifaceted aspects of the disease.	Report developed	0	1	/
Provision of psychosocial support for PLWHAs	Number of PLWHAs receiving psychosocial support	Currently, no baseline figures for this are available. These will be collected within six months of the start of the program and targets set on the basis of those and forecasts based on surveillance data.		
Provision of training for psychosocial support for PLWHAs including development of written training	Number of health and social workers, NGO volunteers and faith-based organisations' members trained (cumulative)	0	10	30
Campaigns to inform the public and destigmatise PLWHA	Number of people reached	N/A	48%	85%

## ANNEX 13

### Broad activities related to MANAGEMENT MECHANISMS and expected output

Main activities	Process/Output indicators	2003	Year 1	Year 2
		Building institutional capacity of participating organisations	Number of workshops held	0
Reporting	Reports submitted to NMCHA on time and to required standard	N/A	4	4
Establishing linkages	Number of people making international visits	0	10	15
Ensuring effective M&E	Reports on progress of program produced on time and to required standard	0	4	4
Meetings	Number of meetings held	0	10	10
Sharing lessons learned	Number of publications	0	0	1
Development and Review of National Strategy	National Strategy introduced in 2003 and reviewed (Y2)	1	0	1
Policy development	Number of policies introduced	0	2	2
NMCHA and standing committee	Number of meetings of NMCHA Standing Committee	5	5	5
Systems for tracking national expenditure on HIV/AIDS	Annual report on national expenditure on HIV/AIDS	0	1	1
Liaison with politicians	Number of politicians reached	0	20	20